ZERO TO THREE®
National Center for Infants, Toddlers, and Families

Commission to Eliminate Child Abuse
And Neglect Fatalities
Dr. David Sanders, Chairman
U.S. General Services Administration
1800 F Street, NW
Washington, DC 20405

September 30, 2015

Dear Chairman Sanders and Members of the Commission:

On behalf of ZERO TO THREE, I want to express my appreciation for the thoughtful and diligent approach the Commission has taken in gathering information and developing recommendations for changes in policy and practice to prevent future child fatalities resulting from abuse or neglect. We all grieve over those children whose lives end so tragically and search for ways to make them more visible and keep them safe. Yet, we also know that the stresses on families are great, and many more young children face diminished lives because we do not ensure that either their families or child-serving systems have the knowledge, capacity, or the resources to help them thrive and become productive members of society. In approaching its recommendations, we urge the Commission to take a broad view not only of how our nation identifies children at risk for great physical harm or neglect that could result in death, but also of how we support families to ensure the wellbeing of all children.

The outcome of your process is particularly important to our work, because three-quarters of fatalities are infants and toddlers. For almost 40 years, ZERO TO THREE has worked to ensure that all babies and toddlers have a strong start in life. We translate the science of early childhood development for parents, practitioners, and policymakers using an interdisciplinary approach and a holistic view of how young children grow and thrive, and therefore the ways we address their needs. Our comments will focus on addressing the protection and wellbeing of the youngest children, although many will have application beyond that age group.

ZERO TO THREE has focused intensely at both the policy and practice level on better meeting the needs of infants and toddlers known to the child welfare system. These children are at great risk of cognitive and social-emotional detriments as well as risks to their health and physical safety and wellbeing. Yet, as the Commission is well aware, many child fatalities involve children with no previous contact with the child welfare system. The very tragic fatalities that spurred the Commission's creation are the tip of the iceberg of a large group of young children whose development and therefore their futures are compromised. Many infants and toddlers and their families face multiple risks, but often are not identified until their problems have become severe. Where these families are identified, the supports they need to address their problems and keep their children safe and healthy often do not exist or are not up to the task of providing the service intensity called for. For these children,

strong prevention programs may well intervene and keep them from either becoming a part the child welfare system or the sad ranks of statistics you are working to diminish.

The Commission's report will receive much attention. We hope you will seize this prime opportunity to be a powerful voice for the youngest children and their families who are at great risk. We urge you to advocate for policies and practices built on the science of what we know babies and children need to thrive as well as proven practices that change how family support and child welfare systems work, changing lives in the process.

We have divided our recommendations by issues and approaches for systems and families outside the child welfare system and those that apply within that system. We also address several special populations we know are of interest to the Commission. Greater detail is provided in an attachment to this letter; however, our key recommendations are summarized below.

A national policy to prevent child fatalities and other physical, intellectual, and emotional harm to children must:

- *Build comprehensive, well-integrated early childhood systems that come into contact with very young children and their families before they reach the child welfare system, as well as changing policies and practice within the child welfare system itself.* These systems need to
    - Reach a broad range of families, triaging them according to a pyramid of needs;
    - Ensure the availability of more intensive services, including mental health, substance abuse, home visiting, and domestic violence, to meet the needs of the most at-risk families; and
    - Use a collaborative approach among community service providers for a comprehensive approach to individual families that ensures their service needs are met and no one falls through the cracks.

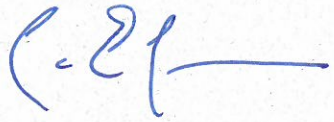
- *Support innovative approaches to serving families that meet their individual needs while advancing systemic change.* ZERO TO THREE has been part of the development of two such approaches:
    - **Healthy Steps** embeds a child development specialist in pediatric practices to provide parent support and child guidance through an integrative care model. This approach provides both families with support for their children's development and the pediatrician with a more complete picture of the family's needs. At a system's level, it uses the one place young children are almost certain to be seen—the pediatrician's office—as the entry point for developmental and family supports and identifying more intensive problems or needs.
    - **Safe Babies Court Teams** uses teams of community service providers led by judges to change policy and practice for babies in the child welfare system, providing individual children and families with closely monitored services and supports tailored to their individual situations. At the systems level, the Teams collaborate to identify and fill services gaps and ensure that decision-makers have the most complete picture of family functioning. *While the Court Teams work mainly with children in foster care, we believe this approach could be applied to cases where children are not removed from home and some aspects could be adapted in non-child welfare service delivery systems as well.*

- *Ensure the workforce that serves very young children and families in any capacity is well trained* on infant-toddler development, building relationships with families, the impacts of trauma on parental ability to cope and on young children's wellbeing, and the signs—such as the presence of situations identified as Adverse Early Childhood Experiences—that families need support and especially that their children need a greater level of protection. States and the federal government should support research on professional development models and programs—including mentoring, intensive coaching, and clinical training—that show potential for changing practice.

- *Provide robust funding investments at every step*, including shifting the emphasis for providing significant levels of funding from maintaining children in out-of-home care to diligent work to address child and family needs and prevent maltreatment, including that leading to fatalities. New and better directed funding should be used to increase support for systems-building; vigorously develop capacity for intensive services (especially for early childhood development, mental health, substance abuse treatment, and domestic violence); increase the staff capacity to work directly with families, through more social workers within child welfare and other child-serving agencies as well as appropriate training and competencies; and work with communities to develop innovative, widespread approaches such as home visiting to reach and support families with young children, thereby increasing the chances that families with multiple risk factors will be found earlier and harm to their children prevented.

We appreciate the opportunity to provide input as the Commission debates its recommendations. ZERO TO THREE staff—whose expertise extends from early childhood development to professional development and training to policy, practice and systems-building support—would be happy to provide more information on any of these points or assist the Commission in any way. Thank you for your service and efforts on behalf of our nation's most vulnerable children.

Sincerely,



Matthew E. Melmed
Executive Director

ATTACHMENT

ZERO TO THREE COMMENTS TO THE COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

I. BUILDING SYSTEMS THAT STRENGTHEN FAMILIES WITH YOUNG CHILDREN

A major part of preventing child fatalities must be creating better systems *outside of the child welfare system* to identify and address the needs of families more broadly. Sometimes, however, broad approaches start out with the goal of providing a light touch to many families and do not progress to the more challenging task of appropriately reaching families with the greatest challenges. A critical focus of these systems must be on ensuring a robust ability to provide assessments, services, and supports for families with multiple risks.

National data suggest that overall a relatively small proportion of children who died as a result of maltreatment were known to Child Protective Services (CPS): 11.6% in 31 states that could report these data had received family preservation services in the previous 5 years; 3.1% of child fatalities involved children who had been in foster care and were reunited. Some states report much higher levels of previous contact. Even so, the problem at hand must be approached as a broader prevention effort that supports child and family wellbeing across the board.

In building a broad system of supports that encompasses families with even the highest risks, it is helpful to think of a triangle or pyramid with three levels of need and functioning among families. The top of the pyramid—families with the highest levels of need and risk—is the population most relevant to the Commission's task. However, it is important for *states and communities* to consider how to develop more comprehensive systems that encompass the lower levels of the pyramid as well, while not losing sight of the imperative to ensure that the intensive services are available and integrated at the community level. (Our analysis and recommendations on this issue are described more fully in comments to the IOM NAS Committee on Supporting the Parents of Young Children.)

- **The base of the pyramid provides supports for all parents**, designed to reach the largest number of families with the least intensive level of services and supports.
- **The middle of the pyramid represents supports for families at some level of risk**, such as living in poverty or having a child with a developmental delay or significant behavioral challenges. These families need a higher level of assistance, such as home-visiting programs that provide education and support, parent groups, or parenting programs targeted to their specific needs.
- **The top of the pyramid includes families with multiple needs and factors that place their children at greater risk of physical, intellectual, or emotional harm.** These include parental mental health issues, substance abuse, and domestic violence—factors often present in child fatalities. These families require a comprehensive array of services, and the parents need the highest level of support through more intensive, therapeutic strategies such as parent-child psychotherapy, one-on-one parent guidance and home-visiting programs that provide psychotherapeutic interventions.

State and community leaders face a number of barriers in effectively providing widespread services for parents and children. They include: Limited availability, particularly for the most intensive services, such as mental health and substance abuse counseling; lack of a coordinated intake to refer services according to need; parenting services are seen as stigmatic and hard to access because of time constraints, cultural or linguistic barriers, and for at-risk families particularly, unpredictable schedules and transportation challenges; lack of a systemic approach to supporting program quality to ensure that parent and family

support programs are well-implemented, meet the needs of the specific population served, and are focused on continuous improvement.

Roadmap for Changes in Policy and Practice

A. Promote state and community early childhood systems building across child-serving sectors to organize, identify gaps, and expand services to meet families' needs.

1. *Encourage state and community assessment and planning efforts*. The first step in tackling the problem of families under multiple stresses with little support is for states and communities to assess what they have in place and plan how they go about connecting those services and providers as well as filling in gaps. Early childhood systems building work has been promoted through small pots of funding such as the Early Childhood Comprehensive Systems (ECCS) grants, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds, and the Early Learning Challenge grants, but has never been promoted as the first step in a comprehensive approach to supporting families, particularly those with the greatest risks. Through such processes, states identify gaps in services and wrestle with how to identify young children living in circumstances that place them at risk for developmental or physical harm. ZERO TO THREE has several tools to assist states and communities in this process.

   An example of coordinated planning and action is South Dakota's First 1000 Days Initiative using the collective impact approach. Funded with MIECHV and ECCS funds, the First 1000 Days Initiative works at the local level focusing on mitigating toxic stress and trauma in infancy and early childhood, but is also connected to a statewide network of early childhood and home visiting collective impact efforts.

   Action Steps:
   - ✓ *Reauthorize and expand sources of systems funding such as the Early Childhood Comprehensive Systems (ECCS) grants and the Tribal Early Learning Initiative to promote state as well as community work in creating a web of services across sectors for children and families and the means to identify and work with those most at risk.*
   - ✓ *Pool funds available for similar purposes across programs and agencies to building more robust early childhood systems that are interdisciplinary and comprehensive. States have integrated ECCS and MIECHV funds in this way.*
   - ✓ *Provide technical assistance to states and communities to help them understand the developmental needs of children, the many-faceted challenges families face, and build integrated service systems accordingly.*

2. *Include continuous program quality improvement.* States can build coordinated systems to monitor and improve the quality of parent and family support programs and to build the capacity of the workforce. For example, several states have used federal Maternal. Infant, and Early Childhood Home Visiting (MIECHV) funds to develop such systems for home visiting programs. For example:
   - Pennsylvania has developed a monitoring tool to be used across home visiting models to track compliance with state quality expectations and to identify areas where technical assistance is needed.
   - Rhode Island has created core competencies for all home visiting program staff and a coordinated professional development system for family support professionals.
   - Michigan has developed a continuous improvement model to track and improve the use of screening for depression, domestic violence, and substance abuse across home visiting program models.

B. Incorporate strategies to identify families:

- **Early, when their parenting capacities can be nurtured to become protective and prevent problems from developing;**
- **Having different levels of need, including the need for intensive support, without taking a stigmatizing approach that will drive them away; and**
- **Especially to find the babies and their families who are not necessarily part of organized programs.**

1. *Expand state and community efforts to develop universal models to reach families with infants and young children and centralized intake systems to screen and refer families to continuum of services.* Several states and communities are looking to more universal models of reaching families, especially as their children are born, and using this opportunity to offer some level of help to all, but also to assess the challenges each family faces and triage them into services at the appropriate level of intensity. Some states have used MIECHV funds as the catalyst for centralized intake systems, which extend beyond families with newborns, to screen families' needs and refer them to the most appropriate program or home visiting model. This approach ensures that families face "no wrong door" in seeking help, helps to avoid duplication and matches public resources with families most likely to benefit. Examples of these approaches include:

    - Durham Connects (now being scaled up as Family Connects), which reaches out to all families with newborns and offers home visits to support parenting and child development as well as connections to other community services. One of the keys to the latter function has been the mapping of available community services and collaboration to fill gaps identified. The project has demonstrated community-wide impacts, including reductions in emergency room visits for children.
    - New Jersey's centralized intake system for home visiting provides regional hubs and common screening and referral forms to refer families to appropriate home visiting and other family support programs.
    - The Massachusetts "Welcome Family" model uses a universal home visit as the first step in referring families to other services. Rhode Island has a similar model and allows parents to request a home visit by text message.

    Action Steps:

    ✓ Provide or expand funding sources, such as preventive health care funds, Medicaid, or integrated funding from child-serving programs such as MIECHV, which can support broad community efforts to reach parents of young children and provide both initial support and the ability to triage and connect families to the level of services they need.

2. *Integrate parent and family supports in settings such as child- and family-centered medical practices, where families already spend time and young children are most likely to be seen in the context of their families.*
    One of the major problems of identifying infants, toddlers, and families who need support is that they are less likely to be seen regularly by anyone outside the family than are older children. One of the most potent models integrates child development and family services into medical practices that focus on children and families—the one place where all infants and toddlers can be expected to be seen. Other approaches use widespread home-visiting models or co-locating and/or integrating parent support into other settings where parents are already receiving services, such as early care and education programs or WIC offices. Such an approach helps remove stigma by making parenting and family support a natural extension of these early childhood services. For example:

- Healthy Steps is an intervention that integrates child development specialists into pediatric practices to provide parent support and child guidance through an integrative care model. It eliminates stigmatizing families by being embedded within the universal experience of well-child visits. In addition to work with the child development specialist, which can occur through home visits, the specialist administers ongoing screenings to gauge child development and family risk/protective factors and connects families with community services. Evaluation found that among other positive outcomes, the approach reduced parental use of harsh punishment and identified families at risk for depression, violence, and substance abuse.
- Early care and education mental health consultation (ECMHC) teams a mental health professional with early childhood providers and parents to provide child-focused, classroom-focused, and program/community-focused consultation. Several models show positive outcomes, including Project Play in Arkansas and Maryland's Early Childhood Mental Health Consultation.

Action Steps:

- ✓ Allow and encourage Medicaid reimbursement for support for child development embedded in pediatric practices and clinics, including the medical practitioner's time spent on child/family screening and child development specialists as part of an integrated care model.
- ✓ Include infant-early childhood mental health in federal mental health reform legislation to expand the capacity to serve very young children and infuse support for mental health into all child-serving systems.
- ✓ Restore the function of developing family resource and support systems in communities and neighborhoods to the Promoting Safe and Stable Families program and Title II of the Child Abuse Prevention and Treatment Act, now called the Community-Based Child Abuse Prevention program.

C. Ensure intensive services are available and increase the capacity to provide and manage services for families so that families and young children remain visible and supported.

The move toward universal entry points must not obscure the need to undertake the most difficult task of building the system's capacity to address issues faced by families with the most complex needs—including problems most likely to contribute to harm for a child—with the thoroughness and intensity required to protect the child's wellbeing. Building this capacity means collaborating at the community level to identify gaps and streamline referral channels; making concerted efforts to build mental health, substance abuse treatment, domestic violence and other services to ensure their availability; and having a mechanism to follow and work with families as they participate in these other services.

1. *Develop community approaches to service mapping and collaboration*, as Durham Connects has done, to support broad efforts to identify and offer services to families at high risk. Below we describe the Safe Babies Court Teams approach, whose strength lies in the formation of community service providers who collaborate both at the family level to ensure the most complete picture of family functioning and craft coordinated services to meet child and family needs, and at the systems level, to improve the array of services available in the community. This approach could be adapted to community social services provision as well as child welfare.

2. *Ensure that state and community home visiting programs encompass a continuum of models to ensure the needs of the highest risk families are met.* More broadly available home visiting, including universal approaches, must have the capacity to identify families with differing levels of need, including those with serious family issues, and the capacity to either case manage with active follow up on referrals or partner with programs that have that ability. In addition, states need to have a continuum of home visiting programs that extends to models such as Child First to serve the highest risk families with the most intensive services, but also includes models capable of longer-term, but

less intensive, work with families. MIECHV needs to ensure models have a robust capacity to assess family needs and risks, particularly around domestic violence (one of the benchmark areas) and mental health (through approaches such as mental health consultation).

3. *Expand comprehensive services for pregnant women, infants, toddlers, and families through Early Head Start (EHS).* EHS provides a holistic approach to supporting early development by increasing parenting strengths and addressing both the child and parents' needs. Mental health consultation and building community partnerships are built into the program.

4. *Expand access to mental health supports for high-needs parents and families.* Given the impact of parental health on the safety and wellbeing of young children, states and communities need to put in place strategies to screen for maternal depression and to improve the availability of mental health services for those families with greater needs. For example:
    - Ohio's Maternal Depression Screening and Response System integrates screening and referral for maternal depression into the state's home visiting and early intervention program.
    - Florida allows Medicaid reimbursement for parent-child (dyadic) therapy, as well as therapy for the parent, provided that the child is a Medicaid recipient and the therapy focuses on the parent-child relationship.
    - Connecticut's Child First Model combines an intensive home visiting program with parent-child psychotherapy, an intervention model that is designed to strengthen parent-child interactions, parental capacity, and the overarching parent-child relationship.

Action steps:

- ✓ MIECHV should require states to build continuums of home visiting services and demonstrate how they are meeting the needs of the high-need families; emphasize the importance of linking with domestic violence services and mental health consultation.
- ✓ EHS funding should be expanded to reach more pregnant women and families with infants and toddlers
- ✓ The Center for Medicaid Services should strongly urge states to include reimbursement for relationship-based therapies in their Medicaid plans and to use Early, Periodic Screening, Diagnosis, and Treatment requirements to help identify and address the needs of young children in high-needs families.
- ✓ Support the inclusion of infant-early childhood mental health provisions in legislation seeking to reform federal mental health programs.

D. Invest in a well-trained workforce with knowledge of infant-toddler development and cross-disciplinary training.

The workforce involved in child and family services must have professional development and training opportunities to develop the competencies necessary to identify the sources of stress on children and families, including the possibility that they could lead to abuse or neglect. Workers must know how to access services specifically tailored to issues that most indicate potential harm to a child, especially adult mental health issues and the presence of domestic violence. MIECHV needs to emphasize both of these issues, and staff in all child and family programs must have access to mental health consultation.

Action steps:

- ✓ Make staff training and professional development in early childhood development and family issues that can lead to abuse or neglect a priority across child-serving programs.

- ✓ Professional development of the infant-toddler workforce should support practitioners in addressing the ethnic, racial, and linguistic diversity of the families they serve and prepare them for culturally competent and sensitive practice.
- ✓ Ensure funding for and availability of early childhood mental health consultation for all child-serving programs, with a special emphasis for programs such as MIECHV and Early Head Start that focus on the relationship between parents and children.
- ✓ Provide opportunities for cross-disciplinary training to ensure a common set of knowledge and competencies for adults working with infants, toddlers, and families as well as learning from each other about each other's roles and contributions in fostering young children's healthy development.

II. CHANGING POLICY AND PRACTICE IN THE CHILD WELFARE SYSTEM

ZERO TO THREE has long advocated approaches to child welfare oriented around promoting positive child development by assessing and addressing the *family's needs* in a comprehensive way. This approach, as it promotes family functioning to support the child's wellbeing, helps ensure safety by working where possible to address family issues that prevent them from caring for their children and in some cases, could create risks for physical harm through abuse or neglect.

Infants and toddlers who come to the attention of the child welfare system because of suspected maltreatment are at great risk for developmental harm. Their families face many challenges so that as the risk factors to which children are exposed increase, so do the odds of developmental delays. These children often live with chronic, unrelenting stress that causes hormone levels that can be toxic to the developing brain. The developmental risks associated with maltreatment (such as cognitive delays, attachment disorders, difficulty showing empathy, poor self-esteem, and social challenges) are exacerbated by removal from home and placement in multiple foster homes. Unfortunately, the presence of a disability also heightens the child's risk of maltreatment.

While the Commission's focus on keeping children safe from fatal or near-fatal harm must be paramount, we urge its members not to overlook the very real cognitive and social-emotional harm that threatens many young children experiencing maltreatment, with consequences lasting into adulthood. *Further, we suggest that reorienting the approach child welfare systems now take in cases involving young children—one that often is uninformed about development and the need to address parents' own trauma—to an approach that focuses on their developmental needs and their parents' own challenges in functioning as adults and parents, would help address many of the issues that lead to children experiencing fatal harm.*

Infants and toddlers account for about a quarter of substantiated cases of abuse and neglect, but almost a third of foster care placements. Once placed in foster care, they tend to stay longer and, if reunified with their birth families, have a higher incidence of returning to care. These experiences occur at a time of rapid foundational brain development on which all later learning is built. While children can be resilient and brain development continues throughout life, laying a strong foundation should be of paramount importance. Preventing removal in the first place or promoting reunification where possible helps build and maintain strong attachments to parents, important for positive development and learning, and reduces the trauma of placement changes.

To achieve this goal, however, we need to better identify and address the underlying needs (often including previous trauma) that undermine birth parents' capacity to care for their children. ZERO TO THREE's survey of state child welfare practices for infants and toddlers, undertaken with Child Trends, found that states rarely provide assessments and services to meet the needs of birth parents—an

astounding fact when we consider how central addressing these underlying problems are to ensuring parents can safely and appropriately care for their young children.

A. Change Child Welfare Policy and Practice to Better Ensure the Safety and Development of Infants and Toddlers: The Safe Babies Court Team Model

To apply research on child development to child welfare practice, ZERO TO THREE developed the Safe Babies Court Teams Project, a systems-change initiative focused on improving how the courts, child welfare agencies and related child-serving organizations work together, share information, and expedite services for very young children and families in the child welfare system. The Safe Babies Court Teams approach is designated as a promising practice by the California Evidence-Based Clearinghouse for Child Welfare.

The Court Teams are led by judges who place a strong emphasis on addressing the unique challenges facing infants and toddlers. The judges collaborate with child development specialists to create community teams of child welfare and health professionals, child advocates, and community leaders who provide comprehensive services to abused and neglected infants and toddlers and their families. The work of the Safe Babies Court Teams Project increases knowledge among all those who work with maltreated children about the developmental needs of infants and toddlers.

The Court Teams have many positive attributes, but from the Commission's perspective, one of the most important aspects is the team approach. The team ensures that the entire family is assessed and services organized from the start. It works collaboratively together to identify and fill gaps in community services, often with technical assistance provided by ZERO TO THREE and early childhood mental health experts. As such, it is a catalyst for systems change within the community. Most importantly, it insures that decision-makers—in this case, the judge and the child welfare agency—have the most complete picture possible of the families' needs, functioning, and for the Commission's purpose, the risks to the child's safety and wellbeing. In other words, instead of service providers being like spokes on a wheel, connecting individually to the hub that is the child welfare worker, the Court Team shares information among its members—functioning as the wheel's rim, connecting their collective knowledge about the family. The Safe Babies Court Teams have demonstrated that they can change practice and produce better permanency outcomes for children.

Detailed information on the Safe Babies Court Teams can be found on the ZERO TO THREE website. The ten core components from which the Teams are built include:

1. **Judicial Leadership:** Local judges in Court Team communities are the catalysts for change because of their unique position of authority in the processing of child welfare cases.

2. **Local Community Coordinator:** In each Court Team community, a local community coordinator provides child development expertise to the judge and the Court Team and acts as the Team's glue, coordinating the services and resources and ensuring that no child or family falls through the cracks.

3. **Active Court Team Focused on the Big Picture:** The Court Team is made up of key community stakeholders who commit to working to restructure the way the community responds to the needs of maltreated infants and toddlers. The Court Team meets monthly to learn about the services available in the community, to identify gaps in services, and to discuss issues raised by the cases that members of the Court Team are monitoring (See # 6 below).

4. **Targeting Infants and Toddlers in Out-of-Home Care:** The Court Team focuses on foster care cases involving children younger than 36 months. Working collaboratively with the investigators at the local child welfare agency, children are identified prior to removal. Comprehensive developmental, medical, and mental health services for the family are incorporated into the case plan document to ensure that the children's well-being is given primary consideration in the resolution of the case. The list of services is included in the family's case plan and available to the judge through inclusion in the judicial orders directly or incorporated when the judge accepts the child welfare agency's case plan.

5. **Placement and Concurrent Planning:** Every change in placement is a difficult adjustment for a young child, whose development is shaped by close relationships with trusted caregivers. Court Teams minimize changes in placement by using concurrent planning and focusing particularly on family members.

6. **Monthly Family Team Meetings to Review All Open Cases:** The community coordinator and the team of service providers, attorneys, and child welfare agency staff working with individual families meet monthly to review the family's progress. These staffings help track the referrals made, services received, and barriers encountered. *This monitoring process in and of itself can help prevent very young children from falling through the cracks and ensure that they and their families are receiving services, which in turn are addressing identified needs.*

7. **Parent-Child Contact (Visitation):** Very young children become attached to their parents whether the parents are able to provide consistent loving care or not. The goal of parent-child contact is to permit the child and parent to keep the other a living presence in their lives and to improve the parent's responsiveness to the child's needs. Research has found a correlation between the frequency of parent-child visits and the speed with which the child achieves permanency, but visit frequency is guided by knowledge about parental functioning and what is best for the child.

   One of the first and most critical steps in developing a visitation plan is assessing the parent-child relationship to determine the level of supervision and developmental guidance needed. If the parents seem unaware of what their child is capable of at a specific developmental stage or are unable to overcome their own trauma history to focus on the child, more therapeutic supervision of visits should be the norm. In some cases the parents have traumatized their children through physical or verbal abuse. In these instances, parent-child contact can further damage the children, and the family should be in the care of an experienced mental health clinician. In these cases, the relationship would be evaluated over time: the Team and the judge will receive information that will guide them in their decisions about the child's safety and the possibility of reunification.

8. **Continuum of Mental Health Services:** Children who have been traumatized by their parents' care may need mental health services. Parents who are maltreating their children need some level of intervention, for example, mental health or substance abuse treatment, to help them overcome the reasons for their neglectful or abusive behavior. The intensity of the intervention mirrors the specific characteristics of the parent and child. The continuum of mental health services includes:
   - An assessment of the parent-child relationship.
   - Parenting education programs that have been evaluated and found effective in working with maltreating parents.
   - Visit coaching: Coaches work closely with the parents to make each visit a good experience by playing an active supportive role before, during, and after visits; helping parents prepare activities for visits that will meet their children's needs; assisting parents during the visit with

reminders about what they had planned and suggestions as the parents respond to events and emotions; and helping parents recognize and cope with the emotions they are experiencing.

- Child-parent psychotherapy: In this intervention, the clinician seeks to heal the relationship between the child and the parent by helping the parent develop a realistic assessment of the child's needs and abilities. Through the course of treatment, the therapist helps the parent address the trauma in the parent's past that is clouding the parent's view of the child. CPP has been demonstrated to help maltreating parents achieve a healthy relationship with their young children while they address the underlying reasons for their parenting deficits.

9. **Training and Technical Assistance:** ZERO TO THREE staff and consultants provide training and technical assistance to the Court Team community on topics such as: infant and toddler development; parenting interventions; services available to foster children in the community; children and trauma; and parental substance abuse, domestic violence, mental illness, and poverty. Through weekly team meetings and individual supervisory calls, the director and supervising community coordinators provide support and direction to each of the community coordinators. By participating in ZERO TO THREE's Scientific Meeting and National Training Institute and in the Safe Babies Court Teams annual Cross Sites meeting, the community coordinators, judges, and key members of the Safe Babies Court Teams are integrated into the larger framework of ZERO TO THREE's efforts on behalf of infants and toddlers.

10. **Evaluation:** Each Court Team evaluates its work. Information is collected about: knowledge enhancement among professionals working in or with the child welfare system; collaboration among providers working with the child welfare system (systems change); and services for children and families.

To date, three external evaluations of the Safe Babies Court Team model have been completed: (1) Independent evaluation by James Bell Associates (JBA) funded by the U.S. Department of Justice examined the implementation of the Court Team model in four sites and indicated the teams have made significant gains on key child welfare indicators monitored by the federal government. 99.05% of the 186 infant and toddler cases examined were protected from further maltreatment while under court supervision. (2) Doctoral dissertation examined the effect of the Safe Babies Court Team approach on time to permanency. When compared with a matched sample of children included in the National Survey of Child and Adolescent Well-Being (n = 511), the children served by the Safe Babies Court Teams in the same four sites as JBA's evaluation (n = 298) reached permanency two to three times faster. Children served by the Safe Babies Court Teams exited the foster care system approximately 1 year earlier than children in the comparison. (3) Cost effectiveness study on the basis of one positive outcome—expedited permanency—found short-term savings generated by the earlier exits from foster care by Court Team children estimated that the Court Teams' reduced costs of foster care placements alone cover two thirds of the average costs per child.

Action Steps:

- ✓ Allow and specify that general child welfare funding streams (e.g., by allowing Title IV-E funds to be used for coordinated service approaches) may be used for innovative research-based approaches such as Safe Babies Court Teams that promote children's safety, permanency, and wellbeing by changing practices and ensuring family needs are addressed.
- ✓ Designate funding to expand the use of such models and provide training and technical assistance on their implementation, including increasing knowledge of applying the science of early childhood development and knowledge about parents' past trauma to child welfare practice and judicial decisions.

B. Change policy and practice at the state level to create systemic approaches to protecting the safety and wellbeing of infants and toddlers in the child welfare system

ZERO TO THREE has identified broader policy and practice issues that also impact how a system addresses the needs of infants and toddlers. The complete framework can be found in *A Call to Action on Behalf of Maltreated Infants and Toddlers* and *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.* The status of state child welfare practices and policies related to infants and toddlers are described in *Changing the Course for Infants and Toddlers: A Survey of State Child Welfare Policies and Initiatives*. Principal recommendations include:

1. Use of Evidence-Based and Evidence-Informed Practices.

We believe it is important to promote the use of interventions with the greatest likelihood of helping families be successful and ensuring the wellbeing of children. It is important to identify effective practices that are being used, while allowing for advancements in promising interventions that will expand options appropriate for the children and families in the child welfare system. All stakeholders involved with the lives of infants, toddlers, and families in the child welfare system should engage in detailed discussions to develop a decision-making framework for selecting evidence-based practices, determining the following:

- Is the selected intervention evidence-based or evidence-informed for the age group of infants, toddlers, and their families?
- Is the intervention appropriate for young children and families in the child welfare system?
- Is the intervention compatible with state policies and practices?
- Is the intervention compatible with the values and practices of the community and the clients?
- Is the population being served by the community comparable to the sample population on which the intervention has been normed?
- Are the intervention's anticipated effects aligned with the systems change that the state or community aims to achieve for the targeted population?
- Can the core intervention components—the essential principles, elements, and intervention activities that are necessary for achieving desired outcomes —be replicated in the community while still maintaining fidelity to the model?
- Can the state or community support an implementation strategy that adheres to the intervention's core components?
    - This process should be driven by a team that ensures ongoing support and monitoring of the implementation, with competencies such as: developing an understanding of the components that make the intervention successful; using data and practice experience to inform decision-making and continuous improvement; and assessing whether a state, county, or jurisdiction has the infrastructure and resources necessary to implement the intervention, including: available funding sources, available education materials, existence of trained personnel or availability of trainings for qualified personnel, and evaluation capacity.
- Is the intervention sustainable in the community and the state?

2. Promoting permanency for infants and toddlers in child welfare

We recommend that a priority be placed on implementing concurrent planning for infants and toddlers in the child welfare system. Using this tool, child welfare staff work equally diligently with birth parents and foster parents at the same time toward securing a permanent family for the very young child. 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 strong and caring relationships. Moreover, it is important to identify foster parents committed to providing for the child's emotional needs and supporting birth parents, to promote stability for the child

and ensure they remain in their first out-of-home placement throughout their tenure in foster care. While we recognize that recruiting such foster parents is not an easy task, nor is the role we ask these foster parents to play. Yet, we believe concurrent planning is a critical tool that must be used effectively to promote the healthiest development of the young child.

3. Foster homes as an intervention

Foster homes can play a critical role in a young child's permanency. If a foster home is being utilized as an intervention for consideration, a heightened focus must be placed on selection, training, and ongoing support of those families. Applicant quality is often low and the "any bed will do" attitude is often the path workers take to prevent staying with the child in a county office overnight. Also, placement in emergency shelters is frequently used due to low numbers of homes willing to accept infants. Research shows that foster parents lose their ability to closely bond after parenting multiple infants.[i] For that reason, and because infants should not have to experience multiple changes in primary caregivers, *our expectations for foster parents of infants and toddlers need to shift toward a dual role as mentors to birth parents and also the concurrent permanency plan.*

4. Training for all involved with infants and toddlers in the child welfare system

A critical focus in child welfare must be on building and maintaining a well-trained child welfare, social service, early childhood, and legal workforce educated in the science of early childhood development and informed by the most relevant and recent data. For professionals who work with infants and toddlers in the child welfare system, this must include ongoing training and continuing education. There are many levels of training that child welfare staff, foster parents, and other professionals need to understand the developmental needs of infants and toddlers, including the impact of trauma on child development and the effect of early adverse experiences. Too many professionals have limited knowledge about infant-toddler development and rely on the way they were raised to guide their practice. Among the professionals working with young children in foster care who would benefit from this training are: Physicians/Pediatricians and those in the child's medical home; Attorneys, judges, and other court staff; Family service workers and all child welfare agency staff; Service agencies such as mental health and substance abuse treatment providers; Early care and education providers; Part C Early Intervention providers; Home visiting providers; and Community advocates.

Action steps:

- ✓ Redirect child welfare spending toward efforts to prevent children from entering foster care and to address their families' needs in a purposeful way.
- ✓ Promote systemic thinking at the state and community level by repurposing the Abandoned Infants Assistance Act to provide planning grants for states to assess and create strategic plans to improve their policies and practices for young children in the child welfare system and implementation grants to build specific pieces of the system they envision.

III. RECOMMENDATIONS FOR SPECIAL POPULATIONS OF CHILDREN AND FAMILIES

A. Military Families

Military families face great stress from the prolonged wars and repeated deployments for over a decade. Infants, toddlers, and young children in these families experience this stress in ways that are not always fully understood by their parents and other adults who may be in contact with them. Yet, these children absorb the stress of the adults around them, and their development can be affected. That stress can also manifest itself in the form of increased rates of abuse and neglect in military families.

ZERO TO THREE recommends the following steps to improve the protection of young children in military families:

- *Promote standardization* (e.g. classification, units of analysis) between Family Advocacy Program data tracking systems (central registry) and civilian data tracking systems.
- *Strongly support the Department of Defense State Liaison Office initiative to promote state child welfare legislation that establishes a reciprocal requirement* for state child protective services to inform the appropriate military representative of allegations of child abuse and neglect involving active military personnel and/or their spouses.
- *Enhance communication, networking, and collaboration* between DoD's Family Advocacy Programs (FAP) and states' child protective services (CPS) through the use of Memorandums Of Understanding (MOUs), in-services, and cooperative case planning, especially when a family is involved with the court system
- *Facilitate easier interstate case transfers and temporary interstate agreements* in association with families who are relocating due to a permanent change of station (PCS), leaving the service (new vets), or temporarily returning to spouse's home state while a service member is away on deployment
- *Provide continued and enhanced funding to promote optimal staffing* for DoD family programs aimed at preventing or ameliorating child abuse (e.g. Family Advocacy Program; New Parent Support Program).
- *Provide continued and enhanced targeted training to on-installation professionals* to strengthen awareness and capacity building across disciplines (e.g. early care and education providers, teachers, home visitors, Family Advocacy professionals, pediatricians, ObGyns, chaplains, mental health professionals, child and youth program staff, health care providers, Department of Defense Education Activity (DoDEA), and other family support professionals) to prevent and respond to children and their military families at risk for, or affected by, child abuse. Training topics should include military culture and context; parental physical injury, parental trauma and psychological injury, child development, effects of abuse and trauma on children, and promotion of protective factors.
- Provide targeted training to off-installation, civilian community-based professionals to strengthen awareness and capacity building across disciplines (e.g. early care and education providers, teachers, home visitors, pediatricians, ObGyns, spiritual leaders, mental health professionals, Early Head Start providers, and other family support professionals) to prevent and respond to children and their military or Veteran families at risk for, or affected by, child abuse. Training topics should include military culture and context; parental physical injury, parental trauma and psychological injury, family stress associated with service member's transition from active duty to Veteran status, child development, effects of abuse and trauma on children, and promotion of protective factors. In addition, establish mechanisms to share existing training resources between the military and civilian communities.
- *Build on and leverage DoD's Coordinated Community Response and risk management* of child abuse by integrating a universal, medical (pediatric) home model into DoD's existing systems of care.
- *Consider using DoD's Coordinated Community Response and risk management approach as an exemplar* for state and national efforts to prevent and mitigate child abuse.
- *Formalize prevention-focused relationships* such as the inclusion of military installations in Children's Trust Funds, Prevent Child Abuse [State], etc., by specifying requirements through CAPTA and other ACF grants for outreach and inclusion of military FAP or relevant departments.

B. American Indian/Alaska Native Families with Infants and Toddlers

- *Recognize the sovereignty of tribes* and work carefully on appropriate collaboration with individual tribes to honor the various government to government relationships that exist, particularly in regards to areas of jurisdiction.

- *Provide adequate resources.* Fully fund tribes to provide culturally appropriate child welfare related services. The most successful tribal strategies provide resources of robust duration, with flexibility and appropriate technical assistance to support the development of tribal specific responses. Culturally specific responses are more likely to integrate concepts of historical trauma and cultural approaches to protection, healing and community safety.
- *Follow the tribe's lead.* Tribes and tribal entities have both responsibility and desire to address child welfare concerns within their communities regardless of jurisdictional issues. Effective strategies are developed when tribal representatives are included in the planning process both to ensure cultural fit of the intervention and appropriateness of outcome measures. A framework by which tribal communities define what constitutes success recognizes the responsibility and investment tribal organizations accept in serving their communities.
- *Start early, focus more efforts on prevention.* Fund the development of more culturally appropriate, tribally managed home visiting and early parenting programs with an emphasis on parent-child interaction, child-centered programming, mentoring and child advocacy to address risks and reduce the need for deeper child welfare system involvement.
- *Provide resources for professional development in Indian Country.* Tribal communities experience chronic workforce challenges. Supporting workforce development will lead to more trained and skilled social workers, healthcare professionals and law enforcement. Skilled workers are better able to identify and respond to at-risk families.
- There are many data needs at the tribal level, including education of tribal leaders and communities on the importance of data collection and culturally appropriate research. *Training and technical assistance and resources for data systems, evaluation and research* is needed to help tribes collect data and conduct research to better inform responsive policy recommendations for tribal nations.
- *Support collaboration and system development.* Create a multi-disciplinary and multi-jurisdictional approaches, rather than funding a "siloed" system. Provide support in all the areas listed above to leverage the development of a coordinated system of services for children and families.

Children with Special Needs

Child abuse and neglect can affect any child, but children with disabilities are at greater risk of maltreatment or of severe or repeated maltreatment than children without disabilities. There is significant overlap in the population of young children with substantiated abuse or neglect and those who experience developmental delays. A national study found that more than two-fifths (42.3 percent) of children ages 1 to 5 who were part of a maltreatment investigation had some developmental need that may have qualified them for services under Part C.[ii]

In considering how to prevent maltreatment and address the needs of young children with disabilities and their families, we must look at what puts them at risk. Several studies found children with emotional or behavioral disorders were at the greatest risk for.[iii] Another literature review concluded that children with communication or sensory impairments and learning disabilities were at increased risk for abuse (Stalker & McArthur, 2010). Two more recent studies found that children with mild impairments are at greater risk for maltreatment than those with more severe impairments (Fisher et al., 2008; Helton & Cross, 2011).[iv]

One of the most frequently cited family or parental risk factors for the maltreatment of children with disabilities is the increased stress of caring for a child with special needs and coping with challenging behaviors. Contributing factors may include

- Viewing the child as "different" or the disability as embarrassing;
- Parents who lack the skills, resources, or supports to respond to the child's special needs;

- Not understanding the greater risk of maltreatment and being unprepared to protect the child from risky situations;
- The parent of a child who exhibits challenging behaviors may be more likely to exert unnecessary control or use physical punishment;
- The parent of a child with disabilities who is unresponsive, unaffectionate, or exhibits behavior problems may have difficulty forming a strong attachment with the child;
- The cost of ongoing treatment or care for a child with disabilities may put a financial strain on the family or affect parental job stability.
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There are numerous risk factors for maltreatment that address characteristics of the child with a disability; most of them relate to the way individuals respond to or care for children with disabilities. Although children are not responsible for being victims of maltreatment, the following factors place them at greater risk:

- Boys with disabilities or children with disabilities who are in preschool or younger are more likely than children without disabilities to be.[v]
- Children who exhibit challenging behaviors or have intensive needs may overwhelm caregivers.
- Children with disabilities who rely on caregivers for their daily needs may not know when behavior is inappropriate or may have been taught to obey caregivers' demands.
- Emotional dependence on caregivers may prevent children from attempting to stop the abuse or neglect because they fear losing the relationship.[vi]
- The nature of some children's disability may prevent them defending themselves, escaping from the abusive situation, or reporting the abuse; this may cause potential perpetrators to believe they can "get away with it".[vii]

Action steps:

- ✓ Examine and improve the implementation of the CAPTA requirement for screening and referral of infants and toddlers with substantiated cases of abuse or neglect to Part C of the Individuals with Disabilities Education Act.
- ✓ Encourage better coordination between MIECHV and Part C;
- ✓ Promote interdisciplinary training on supporting parents and children where a disability is present in programs such as EHS and MIECHV.
- ✓ Promote greater attention to early childhood mental health issues within Part C and how parents may be better supported in meeting their children's needs.

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