States can improve supports for infants and toddlers who are in or at risk of entering foster care

Megan Fischer, Kristina Rosinsky, Elizabeth Jordan, Margaret Haas, Deborah Seok

February 2020

Child TRENDS

ZERO TO THREE

Table of Contents

Acknowledgments

The authors are grateful to the survey respondents who gave their time and energy to share their knowledge about state child welfare policies and practices. Child welfare agency staff have many competing demands on their time, and we appreciate the thoughtful and thorough responses we received to the survey. The states, territories, and federal districts that responded to the survey include AL, AK, AZ, AR, CO, DC, FL, GA, HI, IL, IN, KS, KY, LA, ME, MD, MO, NE, NV, NM, NC, ND, OH, OK, OR, PA, PR, RI, SC, SD, TX, UT, VT, WV, WI, and WY.

The authors also wish to thank many individuals for their contributions to this report. The survey re-fielding would not have been possible without the diligent work of Janie Huddleston and her team at ZERO TO THREE: Patricia Cole, Jamie Colvard, Jenifer Goldman Fraser, Judy Norris, Torey Silloway, and Jaclyn Szrom. The authors also thank Karin Malm from Child Trends for her thoughtful feedback on the survey instrument and this report. The instrument was improved by the careful review and expertise of Jessica Dym Bartlett at Child Trends, Larry Burd at the University of North Dakota Medical Center, Cecilia Casanueva at RTI, Alexandria Citrin at the Center for the Study of Social Policy, Marva Lewis at Tulane University, Joy Osofsky at the Louisiana State University Health Science Center, and Whitney Pesek at PL + US: Paid Leave for the United States. The instrument also benefited from the thoughtful review of the Health Resources and Services Administration team: Amanda Innes Dominguez, Dina Lieser, Kyle Peplinski, and Lynlee Tanner Stapleton. The authors also wish to recognize and thank individuals who pilot tested the survey instrument: Janice Currier Ezepchick at the Connecticut Department of Children and Families, Faye Kimura at the Hawaii Court Improvement Program, and Leigh Merritt at the Florida Office of the State Courts Administrator.

This report was made possible through the generous support of the Health and Human Resources Administration. This survey is a project of the national Infant–Toddler Court Program. This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2,986,820 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

About Us

Child Trends is a nonprofit, nonpartisan research center that studies children at all stages of development, striving to improve the lives and prospects of children and youth by conducting high-quality research and sharing the resulting knowledge with practitioners and policymakers. Child Trends worked jointly on the survey design with ZERO TO THREE, a national, nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers.

Executive Summary

To understand what policies and services are already in place for infants and toddlers in care and at risk of entering care, as well as where the child welfare field can leverage the opportunities provided by the Family First Act,[1] Child Trends fielded the 2019 *Survey of Child Welfare Agency Policies and Practices for Infants and Toddlers in, or who are Candidates for, Foster Care*. The survey, supported by ZERO TO THREE (ZTT) and the Health and Human Services Administration (HRSA), aimed to understand the current array of policies and practices intended to serve this population, and how this array may have shifted since the initial fielding of the survey in 2013. The goal of the survey and report were to identify and share innovations in policy and practice and highlight key challenges that child welfare agencies face in meeting the needs of very young children who have experienced maltreatment. By collecting and sharing such information, we hope to support agencies in strengthening their approaches to serving this population.

With the Family First Act, states have a new opportunity to use federal funds to support children who are at risk of entering foster care (also known as candidates for foster care) and their families. Healthy early development requires stable, nurturing relationships with caregivers (Center on the Developing Child, 2007). For young children who are safe and supported, staying with their families rather than entering foster care is particularly beneficial.

Although the 2019 survey was fielded early in the implementation of the Family First Act, its findings show where states have existing strengths and infrastructure to provide prevention services to families with infants and toddlers. Findings also shed light on where states need to increase their capacity to provide a robust array of services for infants and toddlers who are candidates for foster care, as well as their families.

[1] The Family First Prevention Services Act of 2018 (Family First Act, H.R. 1892)

Three overarching themes emerged from the 2019 survey.

State policies and practices for maltreated infants and toddlers and their families have not changed significantly since the 2013 survey was administered.

In 2013, we learned about many potential areas for improvement by child welfare agencies serving maltreated infants and toddlers. For example, we found that few states were implementing best practices for meeting the urgent developmental needs of infants and toddlers. These needs include greater frequency of visitation when young children are in foster care (as compared to other age groups) and the provision of training on early childhood development for adults who support young children in foster care, including agency staff, foster parents, and court personnel (Jordan, Szrom, Colvard, Cooper, & DeVooght, 2013).

In 2019, services and supports for maltreated infants and toddlers and their families remain largely the same as in 2013. For example:

- In 2019, no states reported that policies require more frequent caseworker visits for infants and toddlers in foster care, relative to children in care from other age groups. This is consistent with findings from the 2013 survey, in which just one state reported more frequent caseworker visits.

- In 2019, a little over half (57 percent) of states reported that the initial permanency hearing for infants and toddlers in foster care must occur within 12 months of initial removal; in 2013, 49 percent of states reported that the initial permanency hearing must occur within this timeframe.

- Barriers remain around the implementation of the Child Abuse Prevention and Treatment Act (CAPTA) requirement for referring maltreated infants and toddlers to Individuals with Disabilities Education Act (IDEA) Part C services. As in 2013, these barriers include parents, caregivers, and court personnel lacking familiarity with Part C, lacking the training needed to recognize the developmental needs of infants and toddlers, and/or being hesitant to use Part C services. In both 2013 and 2019, states reported using similar strategies to overcome barriers: leadership engagement and collaboration, delineation of roles and responsibilities, and formal information sharing.

Despite areas of strength, fewer states have implemented policies or practices to support candidates for foster care as compared to children in care. The Family First Act is an opportunity to expand services to candidates.

In the 2019 survey, states were consistently less likely to report that services and supports were offered to, or required for, candidates for foster care, as compared to infants and toddlers currently in foster care and their families. Even if infants and toddlers do not enter into foster care, they and their families may still benefit from the same kinds of supportive services available to children and families with child welfare system involvement. This aligns with our 2013 comparisons of services

We defined infants and toddlers "**in foster care**" as those who are in the custody of the state or local child welfare agency and in a variety of out-of-home placements.

We defined "**candidate for foster care**" as a child who is identified in a prevention plan as being at imminent risk of entering foster care, but can remain safely in the home or in a kinship placement as long as services or programs that are necessary to prevent their entry into foster care are provided. See Appendix A for the full definition of "candidate for foster care" included in the survey.

and policies for infants and toddlers in care and those with a finding of maltreatment but not removed from their home.

For example:

- Nearly all states reported that adherence to health visit and/or screening schedules for well-child visits, immunizations, and dental visits is required for infants and toddlers in foster care. However, only one quarter of states (or fewer)[2] reported that adherence to schedules for these components of health care is required for children who are candidates for care.

- Nearly two thirds of states reported that referrals are required within a specific timeframe when potential physical or developmental problems are identified for children in care, but only one third reported this requirement for infants and toddlers who are candidates for care.

- States indicated that initiatives to support children's physical and emotional health (such as care coordination and integrated behavioral health care) are required, promoted, and/or offered about half as often or less for candidates for foster care than for infants and toddlers in care.

Although we expect to see a wider range of services and requirements for children in foster care and their families due to court involvement, it is clear that there is opportunity for states to strengthen and expand policies, services, and supports to candidates for foster care and their families. The Family First Act provides new opportunities for children and their families to access mental health, substance use disorder, and parenting services that prevent entry to foster care. This is critically important: Children fare better when they can safely stay with their families, which prevents the trauma of removal and the upheaval of foster care entry and maintains children's connection to their families and caregivers (Casanueva et al., 2012).

State child welfare policies and practices could better address the unique developmental needs of infants and toddlers.

While all children in foster care may benefit from expedited or more intensive services and supports to promote healthy development, infants and toddlers are in a uniquely sensitive developmental period (Center on the Developing Child, 2007) and may especially benefit from additional supports.

We asked respondents whether some policies and practices differ for maltreated infants and toddlers and maltreated children of other age groups. We learned that states overwhelmingly do not differentiate their policies and practices by age. This finding is consistent with the 2013 findings. For example:

- Few states reported that aspects of dependency court involvement routinely occurred on an expedited basis for infants and toddlers in foster care, as compared to children of other age groups. Only three states reported that case reviews were routinely held on an expedited basis, and only four reported that permanency hearings were held more quickly for infants and toddlers. Four states reported that court review hearings were expedited.

*The **Family First Prevention Services Act** promotes keeping children with families in several ways, including opening a major federal funding source for services that prevent entry into foster care to children who are candidates for foster care and their families. While states have leeway to define the criteria for "candidates for foster care," generally candidates are children deemed at imminent risk of entering foster care.*

[2] The prevalence of states reporting adherence to schedules varies by type of health care service.

- Only two states reported that family group decision making was held on an expedited basis for infants and toddlers in foster care, as compared to children of other age groups.

- Of the nine states that reported that they require pre-removal conferences before an infant or toddler is removed from the home, none reported that the timeframe for the pre-removal conference for infants and toddlers differed from the timeframe for children of other age groups.

- Of the four states that reported requiring expedited notification of adult relatives when infants or toddlers are removed from their parents' custody (i.e., more quickly than the 30 days required by the Fostering Connections Act), none reported that the timeframe for infants and toddlers differed from that for children of other age groups.

Introduction

Nearly 132,500 children ages 0 to 3 were in foster care in fiscal year 2018, constituting around 30 percent of the total foster care population (U.S. Department of Health and Human Services, 2019). Infants and toddlers are twice as likely to enter foster care as older children (Williams & Sepulveda, 2019). In fact, in fiscal year 2017, the rate of foster care entry for infants and toddlers ages birth to 3 was 6.6 per 1,000 children, as compared to a rate of entry of 2.8 per 1,000 for children ages 4 to 17 (Williams & Sepulveda, 2019).

The earliest years of life are a uniquely sensitive developmental period of rapid brain development and growth (Center on the Developing Child, 2007). Experiences in early childhood influence children's brain development and affect their social, emotional, and physical health (Center on the Developing Child, 2007). Positive experiences promote favorable infant and early childhood mental health, and negative experiences have adverse effects on brain development (Center on the Developing Child at Harvard University, 2016).

The very young child's healthy development depends on predictable, loving, and responsive care. This early nurturing relationship with his or her caregiver(s) supports the child's health and well-being (National Scientific Council on the Developing Child, 2009). In short, a healthy relationship with a caregiver in infancy builds a strong foundation for all learning and behavior to come (Center on the Developing Child at Harvard University, 2016). By contrast, disruption or disturbance of the early attachment relationship due to neglect or abuse can lead to developmental delays or impairments (Center on the Developing Child at Harvard University, 2016). Moreover, the negative impact of maltreatment on development is exacerbated by the trauma of being removed from the home and placed in foster care, where children may experience multiple placement changes and disruptions in attachment relationships (Casanueva et al., 2012). Without timely access to appropriate supports and services, these early experiences can jeopardize children's long-term social, behavioral, mental health, and health outcomes (Child and Family Services Reviews Information Portal, n.d., b). Therefore, for infants and toddlers in foster care, an expedited timeframe for achieving permanency (through reunification, adoption, or guardianship) is crucial. It is also vital that young children receive interventions for developmental delays as soon as possible (Child Welfare Information Gateway, 2018, a).

Federal and state policies can create crucially important opportunities to support the developmental needs of infants and toddlers who have experienced maltreatment and/or are in foster care, and there are many policies and practices that states can deploy to address the urgent needs of infants, toddlers, and their families. We expect states to have a wider range of services and requirements for children in foster care and their families, given that they are under the jurisdiction of a court; moreover, the court, in its efforts to achieve permanency for children, will require a variety of services and supports. However, it is important to provide services that aim to prevent entry into care as well since the children and families on the verge of foster care involvement can have similar needs. When children can be safely supported in their homes without entering foster care, they do not face the extraordinary trauma that comes from removal (Casanueva et al., 2012).

The passage and implementation of the Family First Prevention Services Act of 2018 reflects the federal government's recognition of the essential role that child welfare systems must play in prevention. Historically, child welfare systems across the United States have lacked sufficient funding to provide robust prevention services to families with children at risk of entering foster care. The Family First Act allows states to leverage federal dollars to provide services to these children ("candidates for foster care") and their families. For children in foster care, supportive policies and practices for infants and toddlers include pre-removal conferences; expedited notification of relatives when an infant or toddler is removed from home; frequent case reviews; family team meetings that engage and support parents in the case planning process; expedited identification of needs and service referrals for both child and parent, including to IDEA Part C early intervention services; frequent, quality family time (visitation); and expedited timeframes for permanency hearings.

About the survey

The 2019 *Survey of Child Welfare Agency Policies and Practices for Infants and Toddlers in, or who are Candidates for, Foster Care* is a collaboration between Child Trends and ZERO TO THREE's national Infant-Toddler Court Program to illuminate how the urgent, unique needs of young children in the child welfare system are being addressed through current policies and practices. This is an updated re-fielding of a prior survey conducted in 2013. This report presents findings from the administration of this survey.

The most recent survey was emailed to state child welfare agency administrators in late June 2019, and responses were collected through mid-September. The survey instrument, which can be found in Appendix A of this report, had 58 questions and was divided into nine sections:

- Section I. Health Assessments and Services
- Section II. Supports for Parents
- Section III. Partnerships and Collaborations
- Section IV. The Dependency Court Process for Infants and Toddlers in Foster Care and their Families
- Section V. Promoting Stability, Attachment, and Permanency
- Section VI. Post-Permanency Services for Infants and Toddlers in Foster Care and their Families
- Section VII. Training in Early Childhood Development and Developmentally Appropriate Practice
- Section VIII. Data Collection
- Section IX. Additional Initiatives

At the beginning of the survey instrument we provided definitions for terms like "caregiver," "parent," and "routinely provided" to help ensure consistent interpretations of these terms. We encourage readers to review the survey instrument in Appendix A for the full definitions of terms used throughout this report.

This report shares findings from state responses to the second, updated fielding of the survey. Where applicable, we make comparisons to findings from a prior fielding of the survey conducted in 2013. Some of the 2013 data that are referenced here may be found in the earlier report: "Changing the Course for Infants and Toddlers: A Survey of State Child Welfare Policies and Practices" (Jordan et al., 2013). However, the two surveys were not identical; thus, for questions that were substantively changed or for new questions added in the 2019 survey, we do not provide a 2013 comparison. Additionally, the 2013 survey asked questions about infants and toddlers in foster care, as well as those with a substantiated report of abuse/neglect or a determination that the child experienced maltreatment; the 2013 survey did not specifically ask about infants and toddlers whom states define as candidates for foster care.

Among the 50 states plus DC and Puerto Rico that received the survey, 36 states completed it. The states, territories, and federal districts that responded to the survey include AL, AK, AZ, AR, CO, DC, FL, GA, HI, IL, IN, KS, KY, LA, ME, MD, MO, NE, NV, NM, NC, ND, OH, OK, OR, PA, PR, RI, SC, SD, TX, UT, VT, WV, WI, and WY. California, the state with the largest foster care population overall, did not participate in the survey and is not included in the survey findings. Further, not every state that submitted a survey responded to every question.[3] We have indicated the sample size for each question throughout the report. Since not every state responded, we are unable to make definitive statements about the national landscape. However, the diversity of states that did respond gives us a window into state practices for this population. For instance, we received responses from all 10 federal regions identified by the Child Welfare Capacity Building Collaborative (Child Welfare Capacity Building Initiative, n.d.). In addition, given that different states responded in 2013 and 2019, the comparisons we make over time are generalizations.

For state-specific information about select policies and practices, please see **Appendix B** at the end of this report.

We also note that the survey data are self-reported by state child welfare agencies and acknowledge that other stakeholders—including advocates, dependency court judges, legislators, as well as parents or other caregivers—might have responded to these questions differently.

Finally, while the data on the policies and practices contained within this report are a valuable resource for the field, we lack data on the quality of those services and whether all policies are consistently implemented in practice. These factors influence the effectiveness of the policies and practices that states report, and should be kept in mind when considering the implications throughout the report.

[3] When reporting how many of these 36 states provided a given response to a question, we use "most" to indicate 75 percent or more of states, "many" for 56 to 74 percent of states, "half" for 45 to 55 percent of states, "some" for 37 to 44 percent of states, "a third" for 30 to 36 percent of states, "a quarter" for 22 to 29 percent of states, and "few" to indicate 1 to 21 percent of states.

Summary of Results

How states define candidates for foster care

The federal Family First Act opens up a major federal funding source for child welfare services for "candidates for foster care" and their families, allowing a new infusion of federal dollars into mental health, substance use disorder, and parenting supports that can prevent children's entry into foster care. While the Family First Act provides guidelines for how a candidate for foster care should be defined, states have leeway to develop their own definitions. The way in which states define candidates will determine which families are eligible to receive services through this Act. Since the survey specifically asked states about policies and practices that are in place to support infants and toddlers in foster care and infants and toddlers who are candidates for foster care, we were interested in learning how states defined a candidate for care.

We provided the following definition of a candidate for care— largely crafted from the language of the Family First Act—and asked states whether it was consistent with their own:

> According to the Family First Prevention Services Act (Family First Act), "candidate for foster care" is defined as a child identified in a prevention plan as being at imminent risk of entering foster care but who can remain safely in the home or in a kinship placement (e.g., voluntary kinship care where a state or tribe does not have legal custody of the child [Child Welfare Information Gateway, 2018, b]) as long as services or programs that are necessary to prevent their entry into foster care are provided. This status is not dependent on whether a child would be eligible for Title IV-E foster care, adoption, or guardianship payments. The term includes a child whose adoption or guardianship arrangement is at risk of disruption or dissolution that would result in a foster care placement.

This definition can be found on page 2 of the survey in Appendix A.

Nearly half of states (42 percent) responded that their definition differed from the survey definition. Many of these states' definitions provide additional stipulations regarding children who may be considered candidates for care, such as:

- The child welfare agency must be pursuing removal of the child from the home or making reasonable efforts to prevent removal of the child.
- Imminent risk of entry into foster care includes a child who was born or will be born to a youth who is in foster care; a child who has run away from home and/or is homeless; or a child who has an emotional, behavioral, or mental health illness that is severe enough to prevent them from residing safely at home.
- Candidate status must be reviewed regularly.
- Candidates can include children who do not have an immediate or severe safety threat, but do have a safety threat that can negatively affect their long-term physical, sexual, cognitive, or psychological well-being.

One state reported that they are working on their definition.

Key findings:

- Almost all states require adherence to health visit and screening schedules for infants/toddlers in foster care, but not for candidates for care.
- Almost all states promote parent involvement in the health care of their children while in foster care.
- When physical or developmental problems are identified, many states require a referral to specialists within a specific timeframe for infants/toddlers in care; only a third of states require this for candidates.
- Supervised visitation is the most commonly reported supportive practice routinely provided for infant/toddler social/emotional well-being.
- While many states reported using a medical initiative (e.g., care coordination or integrated behavioral health in primary care) to support infants/toddlers in care, fewer states reported using these initiatives for candidates.
- The most frequently reported barriers to referring infants/toddlers to IDEA Part C were lack of familiarity with Part C and/or lack of training to identify developmental needs among parents, caregivers, and court personnel.

Health assessments and services

Identifying and addressing health concerns in a timely manner is particularly important for young children. Infants and toddlers undergo a tremendous amount of physical development, and unidentified or unaddressed health problems during this sensitive period can have a long-lasting impact on their health and development (Ullrich, Cole, Gebhard, & Schmit 2017). It is also important for all caregivers, especially parents, to be engaged in a child's health care to help infants and toddlers access services they need to be healthy.

We asked states about their policies and practices focused on health assessments and services for infants and toddlers who are in, or candidates for, foster care, and their families.

Adherence to visit/screening schedules

Most states require adherence to health visit and screening schedules for infants and toddlers in foster care. Of the 36 respondents:

- Thirty-five states (97%) require adherence to schedules for well-child visits.
- Thirty-four states (94%) require adherence to schedules for immunizations.
- Thirty-five states (97%) require adherence to schedules for preventive dental care or oral health surveillance.

States frequently reported following the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and American Academy of Pediatrics (AAP) recommended schedules.

Fewer states require adherence to visit/screening schedules for candidates for foster care. Out of 31 respondents, about a quarter require adherence to schedules for well-child visits. Out of 30 respondents, few require adherence to schedules for immunizations and one quarter require preventive dental or oral health surveillance.

See Appendix B, Table 1 for state-by-state information about visit/screening schedules.

Promoting parental involvement in the health care of their children

States were asked whether policies or practice guidelines specifically promote the involvement of parents in their children's health care while in foster care. Of the 36 states that responded to this question, 35 (97 percent) reported that they promote parent involvement, and one state (3 percent) reported that it varies by county.

Among the 36 states that reported having policies or practice guidelines that promote parents' involvement in their children's health care, the most commonly used strategies are:

- Interviewing parents about their child's health (94 percent)
- Routinely discussing the outcomes of screenings or assessments with parents (89 percent)
- Routinely inviting parents to health visits in which screenings and assessments are conducted (86 percent) and routinely including parents in health care planning discussions (83 percent)

Referral timeframes

Regarding policies for referrals when potential physical or developmental problems are identified, 21 out of 34 states (62 percent) responded that referrals to specialists are required within a specific timeframe for infants and toddlers in foster care. By contrast, only about one third of states (11 states out of 32; 34 percent) require such referrals within a specific timeframe for infants and toddlers who are candidates for foster care. Infants and toddlers need interventions as soon as possible after health issues are identified to promote healthy development (Ullrich et al., 2017); this is an area of growth states can pursue to bolster their support of maltreated infants and toddlers. See Appendix B, Table 1 for state-by-state information about referrals to specialists.

Of the states that reported a required referral timeframe, 36 percent (8 states) indicated that referrals must be made within 30 days for infants and toddlers in foster care, while 25 percent (3 states) indicated that referrals must be made within that same time period (30 days) for infants and toddlers who are candidates for foster care. About half of states also reported that the timeframe for referrals differed from the options presented on the survey, suggesting variation in state policies for referral timeframes. For example, a few states reported longer timeframes, such as Ohio (within 60 days).

These findings are consistent with responses to the 2013 survey. Just over half of the 46 states that answered this question in 2013 indicated that referrals to specialists are required when potential health or developmental concerns are identified. The distribution of responses related to timeframe was also similar.

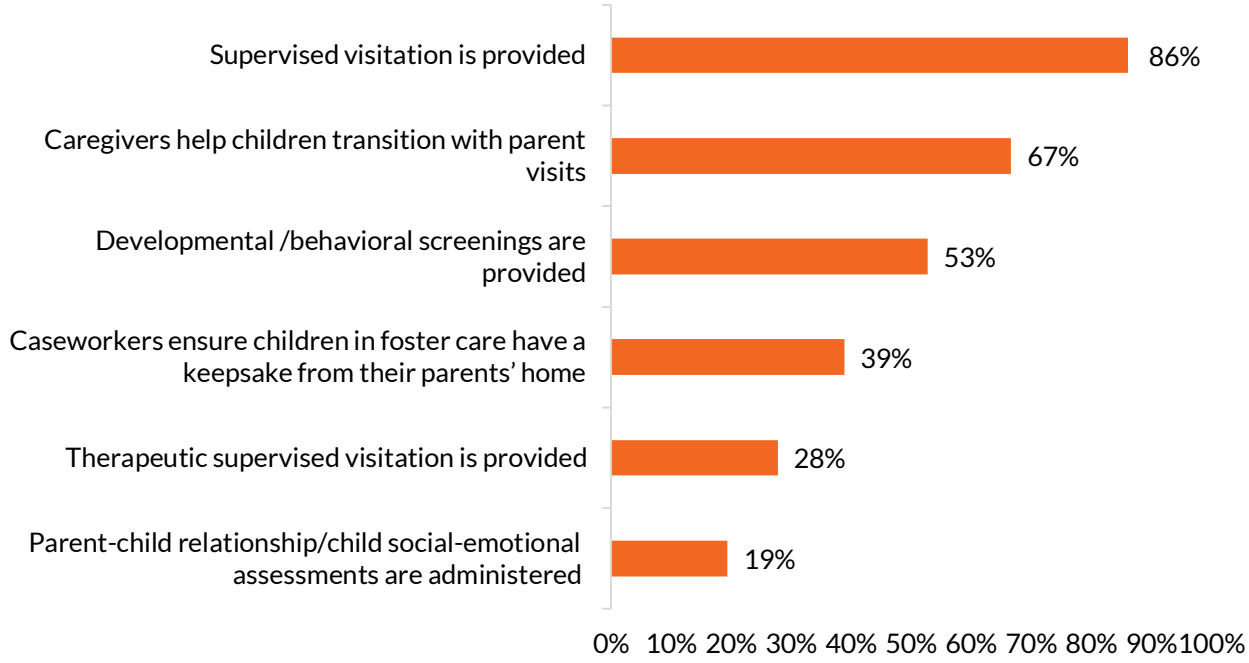
Supportive practices for infant and toddler social and emotional well-being

We asked states what supportive practices or services were routinely provided to meet the social and emotional well-being of infants and toddlers who are in foster care or are candidates for foster care, and

their families, to understand which services and supports are most commonly provided and where gaps exist. The most frequently reported support was supervised visitation (see Figure 1). While 86 percent of responding states indicated that supervised visitation is routinely provided for infants and toddlers who are in foster care or candidates for foster care, the survey does not ask about the quality of the visitation or how much mentoring or intervention support is provided during visitation to strengthen the parent-child relationship.

Assessments of the parent-child relationship and child's social-emotional well-being, as well as therapeutic supervised visitation, are services that identify and repair disruption in the attachment relationship. Yet these are among the least frequently reported provided supports. States may want to explore bolstering these supports for maltreated children and their families. These supports are important because secure attachment with a primary caregiver is essential for healthy infant-toddler development (American Academy of Pediatrics [AAP], 2000). Appropriate quality and timeliness of visitation can help facilitate a strong, secure relationship between a young child and their caregiver(s) (AAP, 2000).

Figure 1. Supportive practices/services routinely provided for infant and toddler social and emotional well-being, by percentage of states (n=36)



Medical initiatives

Infants and toddlers are in a uniquely sensitive developmental period (Center on the Developing Child, 2007), so it is important that any health-related issues that could impact their healthy development are identified early and that they receive comprehensive medical services (Cohen & Herrick, 2013). States were asked a series of questions about medical initiatives for infants and toddlers in foster care or who are candidates for foster care, including whether they:

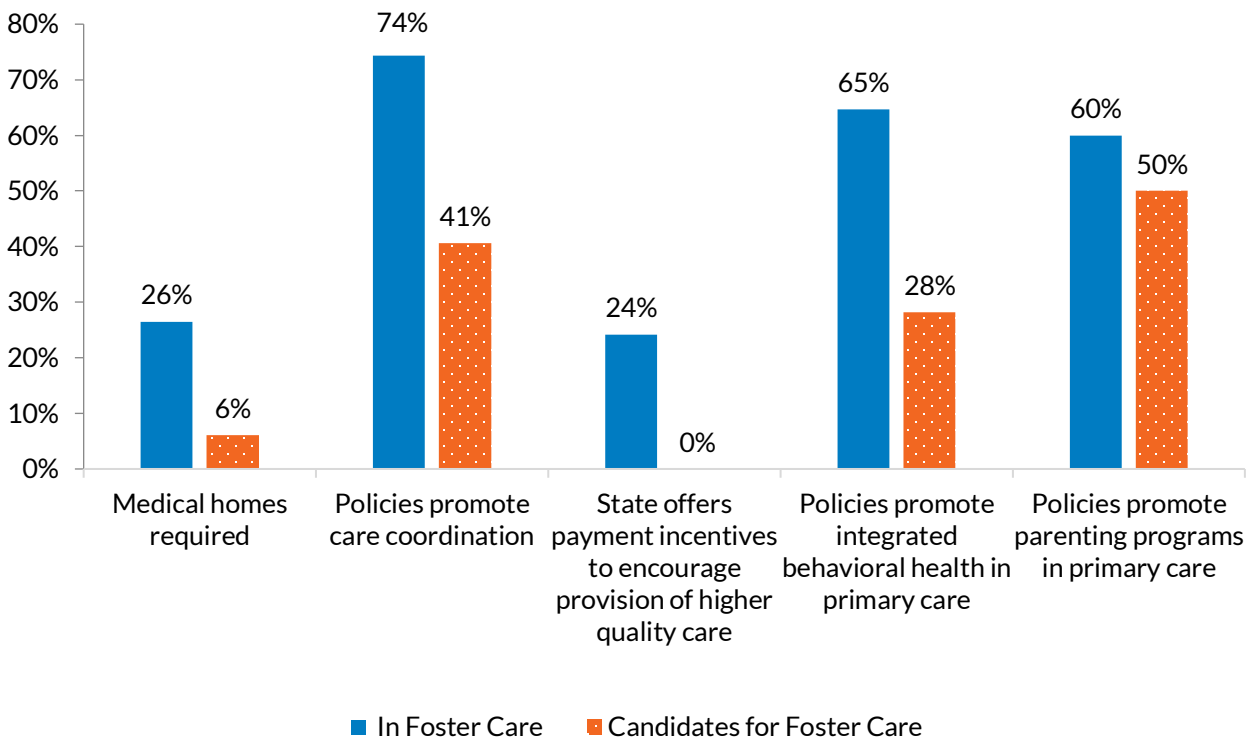
- Require medical homes (in which all aspects of pediatric care are managed by one consistent pediatrician or pediatric practice)

- Have policies that promote care coordination ("a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families"; Antonelli, McAllister, & Popp, 2009)
- Offer payment incentives to medical providers, health systems, and health plans to encourage provision of higher quality care at lower cost
- Have policies that promote integrated behavioral health in primary care ("the care a patient experiences as a result of a team of primary care and behavioral health clinicians working together with patients and families"; Korsen, Narayanan, & Mercincavage, 2013)
- Have policies that promote parenting programs in primary care

See pages 7-8 of the survey instrument in Appendix A for complete definitions of medical home, care coordination, payment incentives, and integrated behavioral health.

As Figure 2 illustrates, policies that promote care coordination were the medical initiative that states most often reported for infants and toddlers in care. For candidates for foster care, policies promoting parenting programs in primary care were the most commonly reported medical initiative.

Figure 2. Medical initiatives for maltreated infants and toddlers, by percentage of states (n=29 to 35)[4]



[4] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.

A quarter of the states reported that they offer payment incentives to encourage provision of higher quality care at lower cost for infants and toddlers in foster care (n=29). No states reported offering payment incentives to encourage higher quality care at lower cost for infants and toddlers who are candidates for foster care. Overall, fewer states reported requiring, promoting, or offering any of these medical initiatives for candidates for care than for those in care.

See Appendix B, Table 2 for state-by-state information about medical initiatives.

Barriers to referring to the Individuals with Disabilities Education Act Part C services

The Child Abuse Prevention and Treatment Act (CAPTA) requires states to refer any child under the age of 3 who is the subject of a substantiated case of child abuse or neglect to early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA). IDEA is a federal law that ensures the provision of a free and appropriate public education, including special education and related services, to children with disabilities. IDEA Part C covers early intervention services for infants and toddlers through age 2.

Over half of states (59 percent; 20 states) reported that the Part C agency is the entity that conducts early intervention screenings for infants and toddlers receiving child welfare services. This is consistent with the 2013 survey findings, in which 58 percent of respondents (26 states) reported that the Part C agency conducts these screenings.

We asked states what barriers, if any, they encountered to implementing this referral requirement. Among the 35 states that responded, the most frequently reported barriers were lack of familiarity with Part C and/or lack of training to identify developmental needs among parents, caregivers, and court personnel. These findings closely mirror those from the 2013 survey.

We also asked states what strategies, if any, they were employing to address these barriers. Out of 32 states, 63 percent (20 states) reported that leaders in child welfare and Part C agencies engaged and collaborated to implement requirements of federal, state, and local laws. Fifty-nine percent (19 states) reported trying to clearly delineate roles and responsibilities of Part C and child welfare staff, and half (53 percent; 17 states) reported implementing formal information sharing about each system's policies and procedures (i.e., between Part C and child welfare agencies). The types of strategies reported to address barriers to referring children to IDEA Part C are consistent between the 2013 and 2019 surveys.

Additional initiatives

We also learned that states are implementing additional supports and services for infants and toddlers and their families affected by substance use disorder. In fiscal year 2017, the most frequently reported reasons for child entry into foster care were neglect and parental drug abuse (Williams & Sepulveda, 2019). Specifically, the misuse of prescription opioids has been steadily increasing since the late 1990s, leading the Department of Health and Human Services to declare a national health emergency in 2017 (U.S. Department of Health and Human Services, n.d.). States reported some initiatives underway to support children and families affected by substance use disorder:

- Kentucky is implementing the START (Substance Abuse Treatment and Recovery Teams) program in some areas of the state. START provides case management and family mentors to parents with substance use disorders who have children age 5 and younger.
- Rhode Island has a Substance-Exposed Newborn Task Force with a specific focus on supporting children and families affected by the opioid crisis. The task force works to implement plans of safe care (plans to

address the needs of substance-exposed infants and their families) and ensure that all substance-exposed newborns have access to IDEA Part C services.

- In Arizona, the Substance Exposed Newborn Safe Environment (SENSE) program provides a substance-exposed newborn and their family with an intensive intervention that aims to keep the infant in the home while the family works with the SENSE team. The intervention includes case management, in-home preservation services, home visitation, substance abuse treatment, and home visits.
- North Carolina and Arkansas also reported using the ZERO TO THREE Safe Babies Court Team™ (SBCT) approach.[5] SBCTs address the urgent developmental needs of infants and toddlers under court jurisdiction (particularly the need for stable nurturing early relationships) and work intensively to strengthen families through compassionate, trauma-informed support (ZERO TO THREE, forthcoming).

Key findings:

The ***most frequently*** reported supports for parents include:

- Screening and referrals for substance use and mental health services
- Legal supports
- Housing and food supports
- Parent skills programs

The ***least frequently*** reported supports for parents include:

- Mentoring or peer support
- Information about coping strategies for managing stress
- Parent-child relationship interventions

Supports are more often required for parents of children in care than for parents of candidates.

The top challenges to providing services to parents are lack of services, finding and engaging fathers, and transportation.

Supports for parents of maltreated infants and toddlers[6]

To gather information about how states support parents of infants and toddlers, we asked states to indicate whether they require or routinely offer certain types of supports for parents of infants and toddlers who have been maltreated; we also asked whether parents routinely participate in the services when they are offered. Such supports for parents include health, substance use, and mental health-related services; parenting education and skill building; mentoring and peer support; parent-child relationship interventions; and various other supports for basic needs, such as housing and food assistance.

Offering these services and supports in a systematic and comprehensive way is crucial because many parents of young children who are involved in the child welfare system have themselves suffered histories of childhood maltreatment, traumatic experiences, and lifelong serious adversity (Hudson, Beilke, & Many, 2016). States can help prevent foster care entry and enable successful reunification by building upon parents' strengths while addressing their other needs through appropriate interventions and services.

[5] For more information, please see: https://www.zerotothree.org/
[6] In this section of the report, where applicable, we combined "Yes" and "Varies by county" responses when presenting results, as we anticipate that the supports listed on the survey may vary significantly by county.

Most frequently reported supports for parents of infants and toddlers

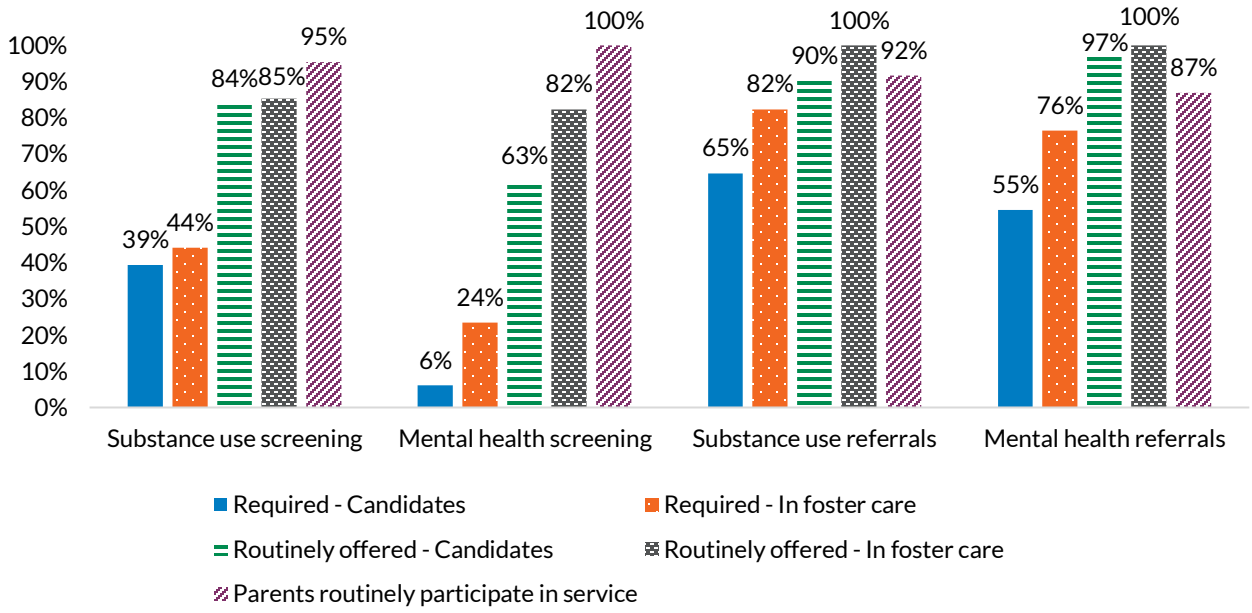
Below we describe the supports states most frequently reported requiring or routinely offering for parents of maltreated infants and toddlers.

Screening and referrals for substance use and mental health services

While not all states *require* screening for substance use and mental health needs for parents of children who are in foster care or candidates for care—a finding consistent with the 2013 survey—these screenings are routinely offered. Over three-quarters of states routinely offer substance use screening for parents.[7] Moreover, when these assessments are offered, nearly all states reported that parents routinely participate in them.

When screenings identify issues, many states require referrals to substance use and mental health treatment. Nearly two-thirds of states require these referrals for parents of candidates, and over three-quarters require these referrals for parents of children in care. Most of the responding states routinely offer these referrals, and when offered services, parents routinely participate in them. See Figure 3.

Figure 3. Screening and referrals of parents of maltreated infants and toddlers for substance use and mental health services, by percentage of states (n=18 to 34)[8]



Further, about three-quarters of the responding states indicated they have a system in place to review the effectiveness of substance use and mental health services to which parents are referred. These processes

[7] Thirty-one states responded to the question about parents of candidates for care, and 34 states responded about parents of children in care.

[8] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.

mostly include monitoring of individual parent outcomes, as opposed to more comprehensive evaluation processes occurring at an aggregate (not client-level) basis.

Legal supports for parents of children in care

Just over half of 34 responding states require legal services to be offered to parents of infants and toddlers in foster care. Most states (85 percent; 28 of 33) routinely offer these services to parents of infants and toddlers in foster care, and when they are offered, all states indicated that parents routinely participate. However, legal services are rarely required for parents of candidates for care, and are routinely offered much less often for that population.

Housing and food supports

While rarely required, housing supports are routinely offered to parents of infants and toddlers in foster care (94 percent; 31 of 33 states) and to parents of candidates for care (91 percent; 29 of 32 states). When housing supports are offered, 86 percent of 22 responding states indicated parents routinely participate.

Like housing supports, food security supports are seldom required but routinely offered to parents of infants and toddlers in foster care (97 percent; 32 of 33 states) and to parents of candidates for care (94 percent; 29 of 31 states). In all 25 of the responding states, parents routinely participate in food supports when offered.

Parent skills programs

Programs that help build parenting skills are another support that responding states infrequently require but routinely offer. These programs have a high participation rate among parents of infants and toddlers in foster care and parents of candidates for foster care.

Least frequently reported supports for parents of maltreated infants and toddlers

The findings below detail the supports states least frequently reported requiring or routinely offering for parents of maltreated infants and toddlers.

Mentoring or peer support for parents

Only a handful of states require peer support or mentors for parents of maltreated infants and toddlers to help them successfully navigate the child welfare and court systems, or require mentoring for parents by caregivers. Additionally, when these types of services are offered, only about half of 16 responding states said parents routinely participate in them. This may be because these services may be more likely to be optional, while other services (such as substance use treatment), may be required for reunification.

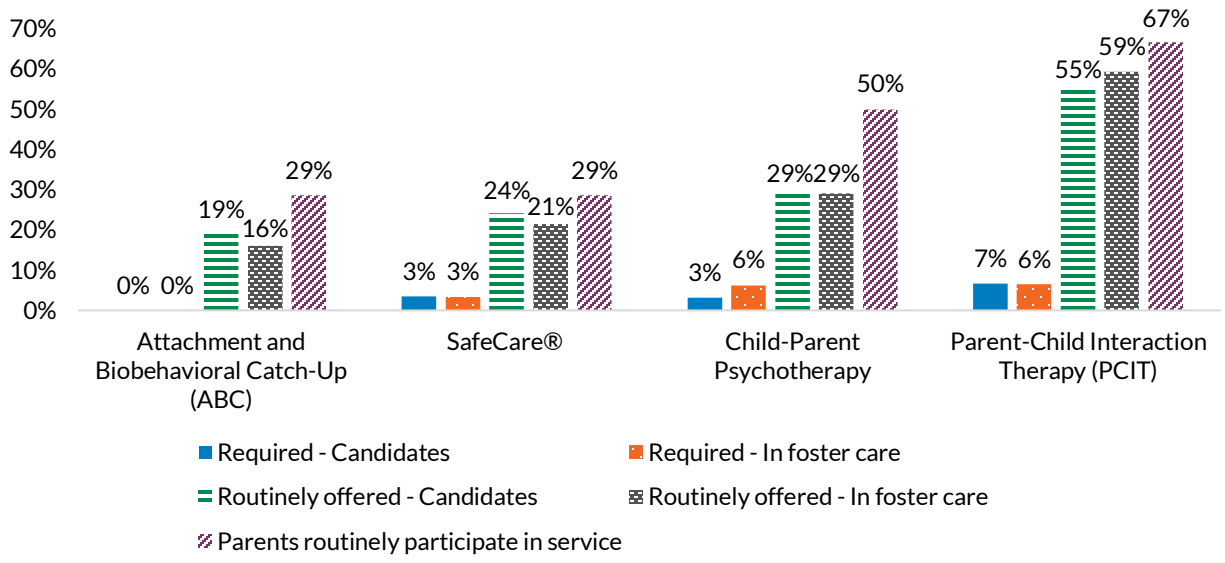
Information about coping strategies for managing stress

States rarely require that information about coping strategies for managing stress be shared with parents. Over half of responding states said this information is routinely offered to parents of infants and toddlers in foster care (62 percent; 21 of 34 states) and to parents of candidates for care (56 percent; 18 of 32 states). However, similar to mentoring and peer support, parents' participation in this supportive service is low with only 61 percent of 18 responding states saying parents routinely participate when it is offered.

Parent-child relationship interventions

We asked states which therapeutic or home visiting parent-child relationship interventions are routinely offered or required; states also reported which services parents of maltreated infants and toddlers participate in routinely. Only one state reported requiring Safe Care®, Child-Parent Psychotherapy, or Parent-Child Interaction Therapy for parents of either infants and toddlers in foster care or candidates for foster care, and a little over half or fewer of responding states said these interventions are routinely offered. While no states reported requiring Attachment and Biobehavioral Catch-up (ABC) for parents of maltreated infants and toddlers, about a quarter of states reported that parents routinely participate in this service when it is offered.

Figure 4. Parent-child relationship interventions, by percentage of states (n=14 to 32)[9]



When asked about various factors that may present barriers to parents when trying to access services, nearly all states indicated that lack of services in certain areas of the state, transportation to services, and difficulty finding, accessing, and engaging fathers were barriers. These reported barriers align with findings from the 2013 survey, suggesting ongoing challenges.

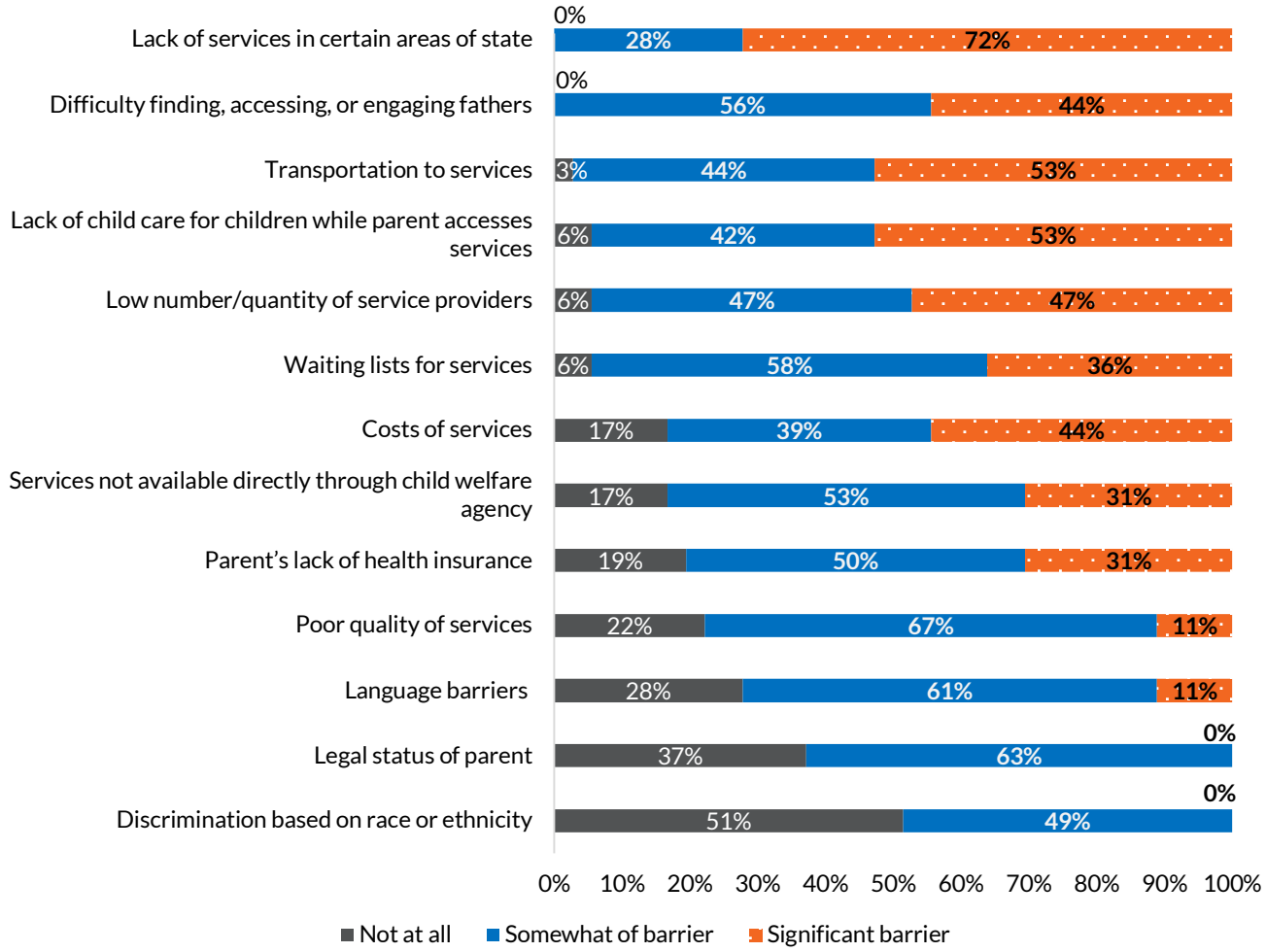
[9] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.

Barriers to providing services for parents and room for improvement

Supports are more often required for parents of children in care than for parents of candidates. In nearly all cases, a greater proportion of states require services to be offered to parents of children in care than to parents of children who are candidates for care. While this makes sense given the role of the child welfare agency and limited resources, it underscores an opportunity for expanding services to parents that could prevent a child's entry into foster care.

The top challenges for providing services to parents are lack of services, finding and engaging fathers, and transportation. See Figure 5.

Figure 5. Barriers for parents when trying to access support services, by percentage of states (n=35 to 36)[10]



[10] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.

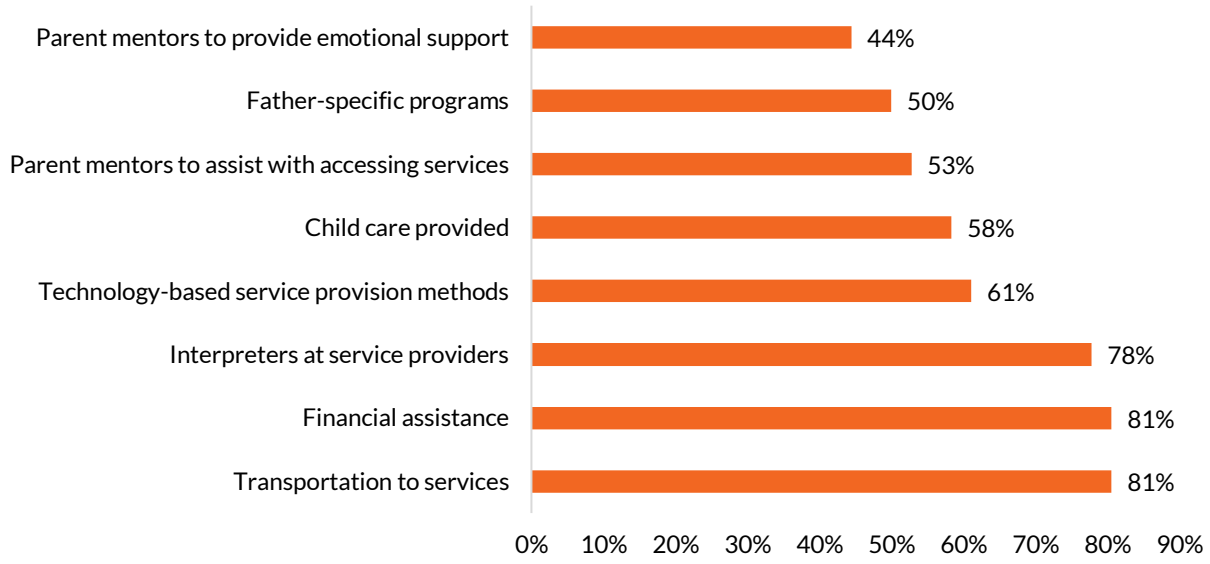
States report that discrimination, legal status, and language barriers are among the least significant challenges states face when providing services to parents. In fact:

- Eighteen out of 35 states (51 percent) said discrimination based on race or ethnicity is not a barrier.
- Thirteen out of 35 states (37 percent) said the parent's legal status is not a barrier.
- Ten out of 36 states (28 percent) said language is not a barrier.

It is important to note that survey respondents are state agency staff members; if parents were surveyed, they might give different responses to questions about barriers to support services. Given the established history of racism in the United States and in the child welfare system, it seems likely that discrimination, legal status, and language pose more significant challenges in practice (Child Welfare Information Gateway, 2016). Respondents may understand that discrimination based on race or ethnicity should not be a challenge when providing services to parents, and may be reluctant to disclose that it is a factor. Respondents may also be unaware of how racial discrimination, legal status and language barriers affect the families served.

We asked states about strategies they have undertaken to address barriers to parents accessing support services. The most frequently reported strategies were providing or reimbursing transportation to services and providing financial assistance.

Figure 6. Strategies to address barriers to parents accessing support services, by percentage of states (n=36)



In addition, over three-quarters of states said that they have tried to address barriers by providing interpreters at service providers. In the 2013 survey, only 7 percent of 46 states reported that language was not a barrier, so the efforts around providing interpreters may explain why language barriers are less of a challenge now than they were in 2013. By contrast, states cited transportation to services as a challenge, as they did in the 2013 survey. Although over three-quarters of states reported providing or reimbursing transportation to services in both the 2013 and 2019 surveys, nearly all states said transportation remains a challenge.

Finally, all states cited difficulty finding, accessing, or engaging fathers as a challenge even though half of states indicated that they have used father-specific programs to try to reduce this barrier. States reported similar challenges to involving fathers in 2013, suggesting that this challenge, like the others, poses difficult problems that states continue to struggle with.

Partnerships and collaborations

We asked states whether the child welfare agency had formal or informal linkages at the state or local level with other entities or resources to help support infants and toddlers in foster care or candidates for foster care and their families. Figure 7 shows how frequently states reported linkages between the child welfare agency and the listed entities.

States most commonly reported linkages with law enforcement agencies, Medicaid/Children's Health Insurance Program (CHIP), public assistance programs (such as the Supplemental Nutrition Assistance Program), substance use disorder treatment programs, and family court. Consistent with the 2013 survey, the least common linkage was between the child welfare agency and immigration and customs enforcement. This was the only entity for which less than half of the responding states reported a linkage.

Examples of partnerships or collaborations states reported include the following:

- The Nebraska Division of Children and Family Services reported that it facilitates weekly meetings with managed care organizations to discuss individual children's health needs in a multi-disciplinary team format. Children under the age of 5 are prioritized for these meetings.
- Louisiana reported that their child welfare department partners with the state's education department on early childhood development programs, and with the state's health department on the Early Steps program, to address the developmental needs of infants and toddlers.
- Illinois reported a strong connection with HealthWorks of Illinois (HWIL), which is a collaborative effort between the Illinois Department of Human Services (DHS) and the Illinois Department of Children and Family Services (DCFS). The main purpose of HWIL is to ensure that children in the custody of DCFS from birth to age 21 who are in substitute care receive comprehensive quality health care services. This health care service is carried out through local health departments, child welfare offices, community-based agencies, hospitals, public and private clinics, and private physicians. Illinois noted that due to HWIL's efforts, almost 100 percent of the 34,000 children in substitute care statewide have been enrolled with a primary care physician and have received comprehensive health.

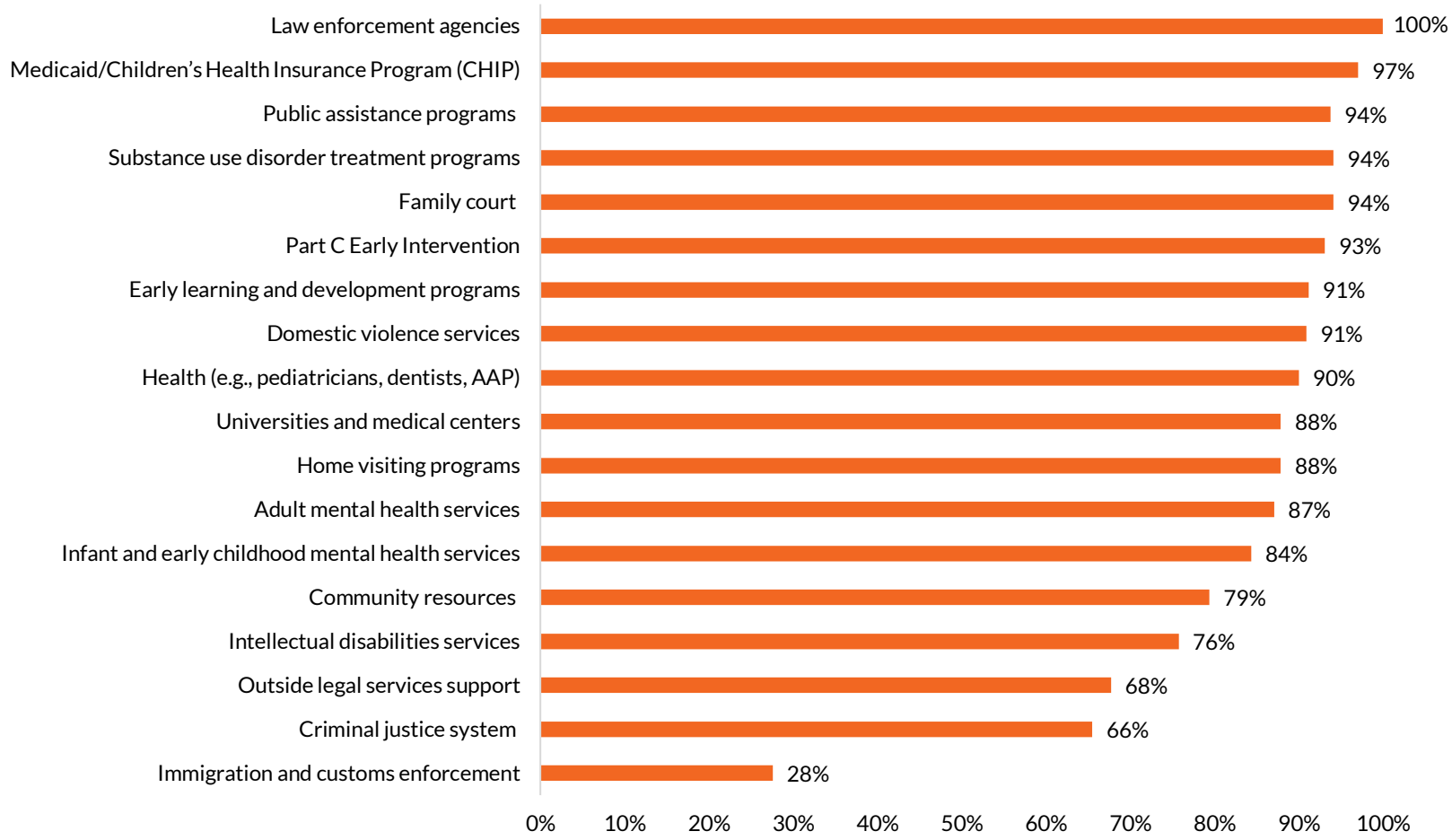
Key findings:

The most commonly reported linkages were between the child welfare agency and:

- Law enforcement agencies
- Medicaid/CHIP
- Public assistance programs (such as SNAP)
- Substance use disorder treatment programs
- Family court

The least commonly reported linkage was with immigration and customs enforcement.

Figure 7. Percentage of states reporting linkages between child welfare agency and other entities, by percentage of states (n=29 to 34)[11]



[11] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.

The dependency court process for infants and toddlers in foster care and their families

Young children and their families involved with foster care are formally connected to dependency courts to protect the children's best interests. It is important to understand the policies and practices that courts follow to ensure reasonable efforts toward reunification, protect infants and toddlers, support stable and nurturing early caregiving relationships, and promote engagement with parents. For example, by scheduling frequent case reviews, the court can provide close oversight and monitoring of whether the parents' and young children's needs are being identified and addressed in as timely and effective a way as possible to address the developmental needs of young children.

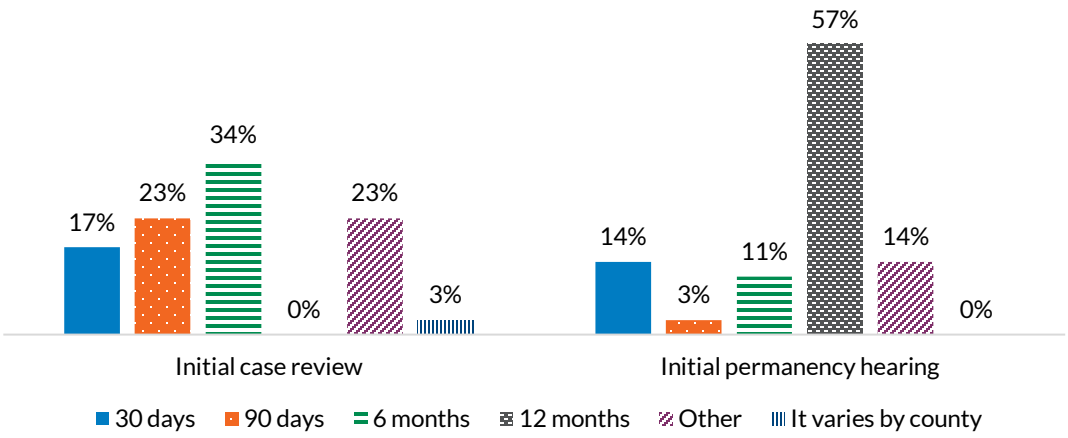
Key findings:

- Initial case reviews are most frequently held within six months of a child's removal from the home, and initial permanency hearings are most frequently held within 12 months.
- Despite the unique developmental needs of infants and toddlers, many states reported that there are no unique timeframes for ongoing case reviews, permanency hearings, other court review hearings, or family group decision making for infants and toddlers that differ from those for children of other ages.
- Some states shared policies or practices aimed at promoting parent representation in court hearings.

Timeframe for initial case review and permanency hearing

We asked states about their timeframe for holding initial case reviews and initial permanency hearings following a child's removal from the home. As shown in Figure 8 below, the most commonly reported timeframe for the initial case review is within six months, with only six states (17 percent) holding the case review within 30 days. Over half of responding states (20 of 35 responding states) hold the initial permanency hearing within 12 months of removal from the home.

Figure 8. Timeframes for initial permanency hearing and case review, by percentage of states (n=35)



This is consistent with findings from the 2013 fielding of the survey. In 2013, half of states (49 percent; 22 of 45 states) reported that the initial permanency hearing for infants and toddlers must occur within 12 months.

Frequency of court hearings, ongoing case reviews, and family group decision making

Over the life of a child welfare case, families, case workers, and courts have various opportunities to hear updates, develop plans, and make decisions. Because young children need to receive services in a timely manner and rely on a strong connection with their primary caretakers, frequent court interaction can help legal stakeholders make important decisions within the most appropriate and effective timeframe. We asked states about the frequency of some of the most common interactions for infants and toddlers in care: ongoing case reviews, permanency hearings, court review hearings, and family group decision making (such as Family Team Conferencing and Family Group Decision Making).

Responding states reported the following timeframes for infants and toddlers in care:

- Fifty-six percent (20 out of 36 states) hold case reviews every 6 months, with reviews held more frequently in 10 states (28 percent).
- Fifty-six percent (20 of 36 states) hold permanency hearings every 12 months, with 39 percent (14 states) holding them more frequently.
- Twenty-six percent (9 of 34 states) reported that there is no specified timeframe for other court review hearings, and another 21 percent (7 states) reported that the timeframe varies by county.
- Sixty-six percent (23 of 35 states) reported that the frequency of family group decision making did not fall into any of the categories provided on the survey, varied by county, or was not specified in policy.

As in the 2013 survey, we asked states whether these timeframes were unique to infants and toddlers in foster care or were applied to the entire foster care population regardless of age. Sixty-nine percent (24 states) of the responding 35 states reported that there are no unique timeframe requirements for infants and toddlers. Only 9 percent (3 states) have more frequent case reviews, 11 percent (4 states) have more frequent permanency hearings, 11 percent (4 states) have more frequent court review hearings, and 6 percent (2 states) have more frequent family group decision making for infants and toddlers as compared to other age groups. A few states (7) noted some variation by county, with specific counties working on initiatives to have more frequent court interaction with families of infants and toddlers, particularly in counties with formal specialized court programs for young children. See Appendix B, Table 3 for state-by-state information about case reviews, court hearings, and family group decision making.

Policies to support parent representation

Some states shared additional policies, programs, practices, or initiatives to promote parent representation in court hearings, or other efforts to facilitate parent engagement in court proceedings. Some federal efforts have been implemented—for example, child welfare agencies can now claim reimbursement from Title IV-E to cover the cost of legal representation for both eligible children and their parents (Family Justice Initiative, n.d.). States' efforts reported in the survey primarily fell into two categories:

- Specialized courts, such as family drug courts, or court approaches to support reunification and strengthen/maintain the bond between young children and parents
- Policies that require or encourage courts to make legal representation available for all parents, regardless of income, in the maltreatment or neglect proceeding

Additional initiatives

The ZERO TO THREE Safe Babies Court Team™ (SBCT) approach applies the science of early childhood development in meeting the urgent developmental needs of infants and toddlers under court jurisdiction and works intensively to strengthen their families (ZERO TO THREE, forthcoming). SBCTs focus on preventing removal among children at risk of entering foster care, supporting reunification and other permanency outcomes for children in foster or kinship care, and promoting the health and well-being of children and their parents. SBCTs deploy a collaborative, problem-solving teamwork structure that works at two levels: (1) a Family Team that "uses a trauma-informed lens to ensure that young children and their parents receive timely, effective services and supports" that strengthen family protective factors and "build and protect safe, stable, and nurturing relationships," and (2) and an Active Community Team that "brings stakeholders together to reduce disparities, address gaps in systems coordination, and drive improvement through new practices and policies" (ZERO TO THREE, forthcoming). The Active Community Team also advocates for "comprehensive and equitable community services to prevent both maltreatment recurrence and child abuse and neglect further upstream" (ZERO TO THREE, forthcoming). In our survey, 45 percent of states (14 out of 31) reported having policies, programs, practices, or initiatives that promote infant-toddler court teams based on the SBCT approach.

Promoting stability, secure attachment, and permanency

Policies that promote stability, attachment, and permanency benefit all children in care. However, due to their developmental needs—healthy infant development depends on a safe and stable connection with a consistent caregiver (Casanueva et al., 2012; National Scientific Council on the Developing Child, 2009)—infants and toddlers receive unique benefits from policies that support caregivers and children developing a strong and healthy attachment relationship. For example, when out-of-home placement is necessary, placement with kin helps encourage placement stability and strengthens attachment within the family.

Most states (94 percent) out of the 36 that responded reported policies requiring that preference be given to kin/relative placements (when appropriate) for infants and toddlers in foster care. Similarly, 92 percent (33 states) of

Key findings:

The most commonly reported policies and practices for infants and toddlers in foster care include:

- Requiring preference be given to kin placements (when appropriate)
- Requiring concurrent planning
- Setting the frequency of parent-child and sibling-child visitation
- Requiring that infants and toddlers be placed in care with their siblings

Less commonly reported policies and practices for infants and toddlers in foster care include:

- Requiring infants and toddlers be placed in foster-adopt homes
- Requiring pre-removal conferences before infants and toddlers are removed from home
- Requiring expedited notification of adult relatives
- Requiring expedited termination of parental rights when reunification is not possible
- Requiring more frequent caseworker visits

In most cases, these policies and practices are not differentiated for infants and toddlers as compared to children in care from other age groups.

the 36 responding states reported policies that require concurrent planning (an approach that seeks to promote timely permanence for children in foster care by considering reunification and other permanency options at the earliest possible point after a child's entry into foster care) be undertaken for infants and toddlers in foster care. These were also the most frequently reported policies for stability, attachment, and permanency in the 2013 survey.

Fifty-one percent of responding states (18 out of 35) reported having a differential response system for low- or moderate-risk abuse or neglect referrals in all areas of the state, and three additional states reported differential response in only some areas of the state. With differential response (also known as alternative response), child protective services "offer both traditional investigations and assessment alternatives to families reported for child abuse and neglect depending on the severity of the allegation and other considerations" (South Carolina Department of Social Services, 2012). Of the 21 states that reported having a differential response system in some or all areas, most (17 states; 81 percent) allow the use of differential response to respond to maltreatment referrals for infants and toddlers in all parts of the state that have differential response.

Twenty-six percent of responding states (9 states out of 35) require pre-removal conferences before an infant or toddler is removed from the home. In each of those states, pre-removal conferences are required for all children, not just infants and toddlers. Only a few states (12 percent; 4 out of 33 states) require expedited notification of adult relatives (i.e., more quickly than the 30-day timeframe required by the Fostering Connections Act) when infants or toddlers are removed from their parents' custody. In those states, expedited notification is required for all children, not just infants and toddlers.

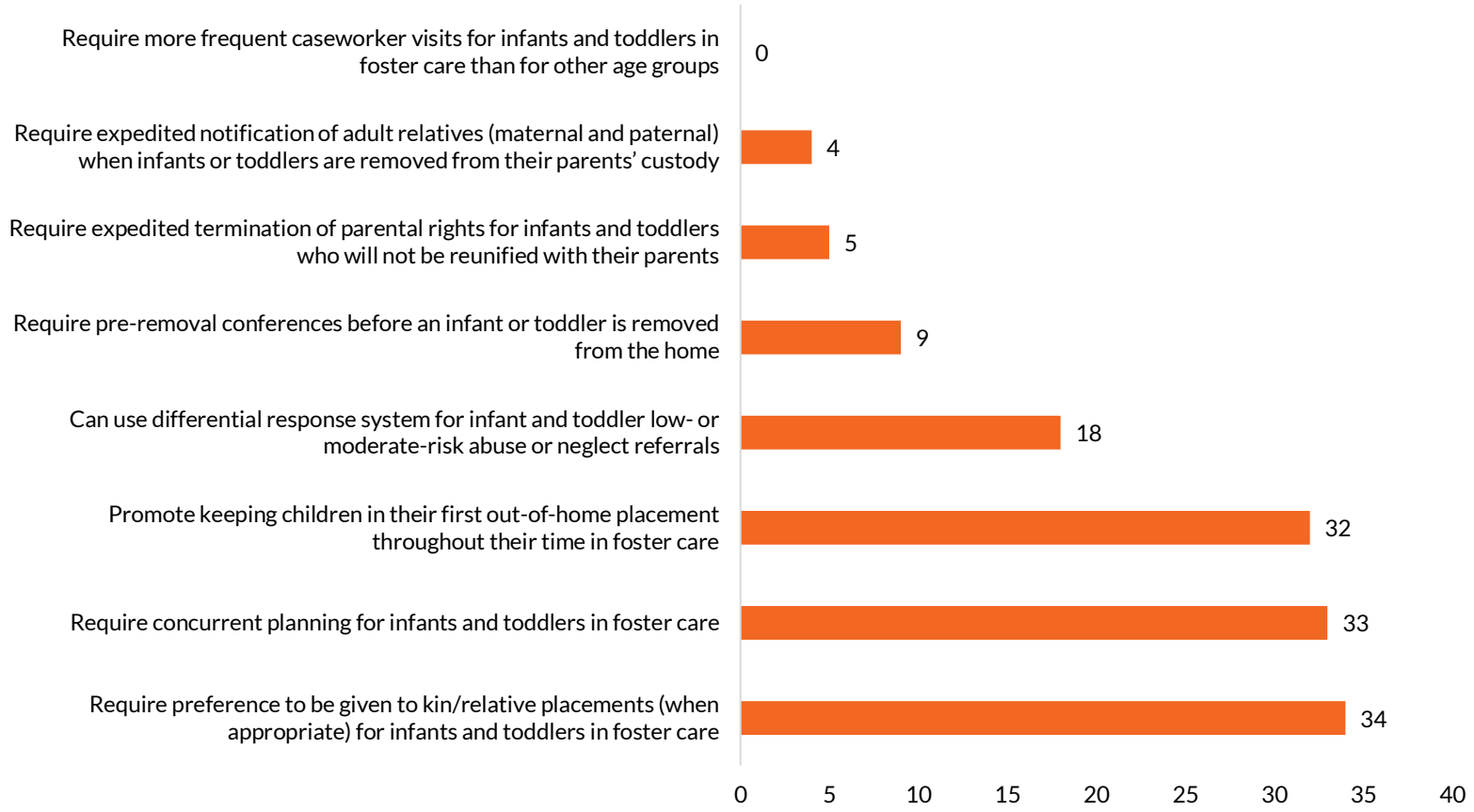
A few (14 percent; 5 states out of 36) reported that they have expedited termination of parental rights (i.e., within a shorter timeframe than is typically required for other age groups) for infants and toddlers for whom reunification is not possible.

No states report policies requiring more frequent caseworker visits for infants and toddlers in foster care than for children of other ages.

A third of states (36 percent; 13 states of 36) specifically promote placing children in foster-adopt homes so that if reunification is not possible, a child can be adopted by their foster family. One state reported that they specifically promote placing infants and toddlers in foster-adopt homes.

Figure 9 summarizes the number of responding states that reported having the policies to promote stability, attachment, and permanency detailed above.

Figure 9. State policies to promote stability, attachment, and permanency, by number of states (n=21 to 36)[12]



[12] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.

Parent and sibling visitation

Maintaining a strong relationship with a safe and stable caregiver is critical to the healthy development of young children. This is a significant challenge for infants and toddlers placed in foster care. Frequent visitation with parents and siblings is one strategy for supporting these important relationships. Most of the 36 responding states have policies that set the frequency of parent-child visitation (29 of 36 states). Forty-six percent of states (13 of 28 states) reported that visitation happens once a week. States generally have the same visitation policies for infants and toddlers as for all children in foster care. Only 19 percent of states (6 of 32) have policies that require a different frequency of parent-child visits for infants/toddlers than for children of other ages in foster care. In Georgia, children ages 0 to 2 have visits twice per week, while children ages 3 to 5 have visits once per week. In Nebraska, infant and toddler visitation with parents occurs minimally three times per week, while older youth visitation occurs twice a week.

These findings mirror those from the 2013 survey, in which most states (38 of 46) responded that they have policies that set the frequency of parent-child visitation. In 2013, about a quarter of states (24 percent; 9 of 38 states) reported that parent-child visitation frequency is differentiated for infants and toddlers in foster care versus other age groups.

In the 2019 survey, about three-quarters of responding states (26 of 36 states) reported having policies that dictate how often sibling-child visitation should occur. Just over one third (9 of 24 states) require sibling-child visits at least monthly. One state responded that sibling-child visitation occurs at a different frequency for infants and toddlers than for children of other age groups but did not specify how frequently.

Other policies promoting early relationships

There are additional policies and practices in some states that can help support strong relationships between infants and toddlers and their parents or siblings when a child has to enter foster care.

- Eighty-nine percent of states (32 of 36 states) routinely place infants and toddlers who enter foster care with their siblings who are also in foster care.
- Eighty-six percent of states (31 of 36 states) have policies requiring that parents (when appropriate) be invited/encouraged to participate in routine activities (e.g., doctor's appointments, birthday celebrations) for children in foster care. Generally, these policies are for all children in foster care, not just infants and toddlers in foster care.
- Only 28 percent of states (10 of 36 states) routinely provide visit coaches or use other relationship-supporting approaches for visits between parents and their children in foster care. Generally, these supports are available for all children in care and are not specific to infants and toddlers.

See Appendix B, Table 4 for state-by-state information about policies and practices related to stability, attachment, and permanency.

Post-permanency services for infants and toddlers and their families

When children achieve permanency and exit the foster care system, the need for services to ensure their healthy development does not end. Infants and toddlers, as well as their caregivers, often continue to need services to help maintain permanency and promote healthy infant/toddler development. Nearly 20 percent of all children in foster care have been in foster care before (Casey Family Programs, 2017).

One way to ensure that families receive post-permanency services is to develop post-permanency plans. We asked states whether post-permanency plans were required for reunifications, adoptions, and guardianships. Of the 34 states that responded to the question:

- Sixty-five percent (22 states) indicated they require post-permanency plans for reunifications.
- Fifty percent (17 states) indicated they require post-permanency plans for adoptions.
- Forty-one percent (14 states) indicated they require post-permanency plans for guardianships.
- An additional 29 percent of states (10 states) responded that they do not require permanency plans for reunifications, adoptions, or guardianships.
- Two states responded that requirements for permanency plans vary by county.

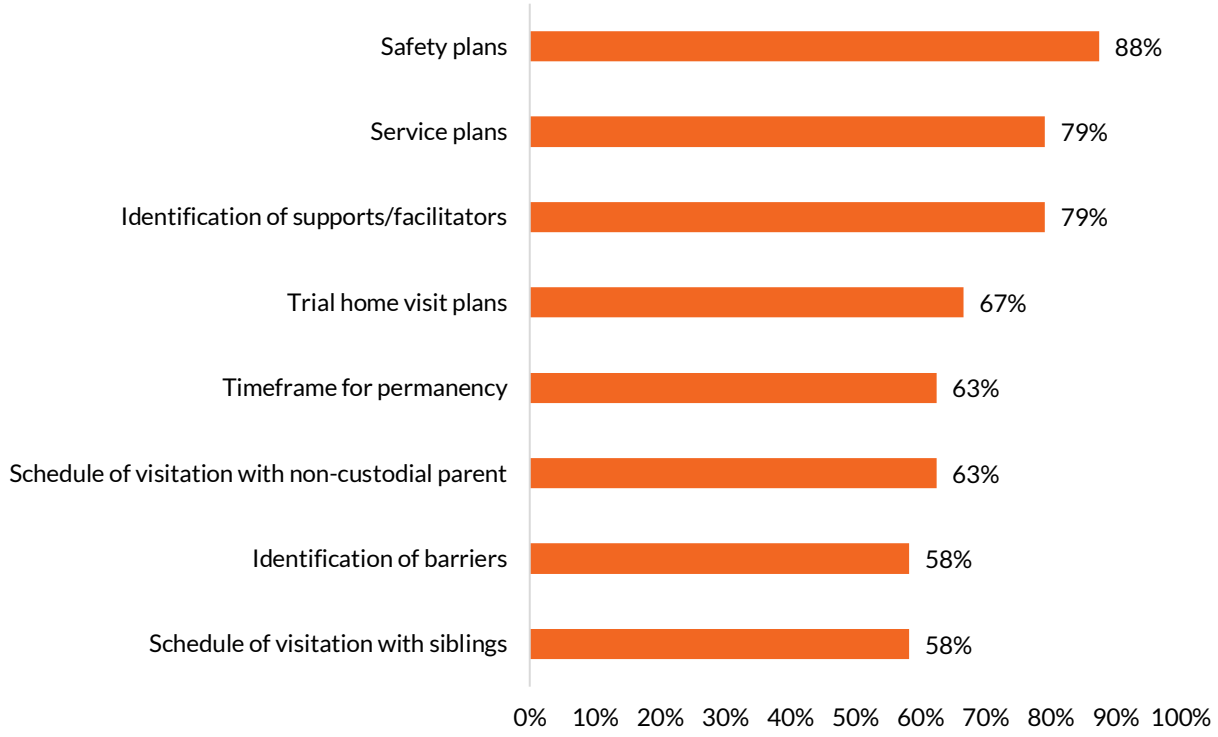
The percentage of states that reported requiring post-permanency plans for reunifications, adoptions, and guardianships is consistent with findings from the 2013 survey.

We asked states to indicate what their post-permanency plans must entail; of the 24 states that responded, 88 percent (21 states) reported that a safety plan (an agreement between the parents and case worker to ensure a child is safe in the home [Child and Family Services Reviews Information Portal, n.d., a]) must be included. The least frequently reported components of post-permanency plans are (1) identification of barriers to successful adoption, reunification, or guardianship; and (2) a schedule of visitation with siblings. Still, over half of states indicated that these components must be included (see Figure 10).

Key findings:

- States most commonly require post-permanency plans for reunifications, as opposed to adoptions and guardianships.
- The most common element of post-permanency plans is a safety plan; the least common elements are identification of barriers to successful permanency and a schedule of visitation with siblings.
- Only one state reported that post-permanency plans are required specifically for infants and toddlers in foster care.
- The most frequently offered post-permanency supports for parents/caregivers are information and referrals, and linkages with community-based services.

Figure 10. Components of post-permanency plans, by percentage of states (n=24)



We asked states whether post-permanency plans were required specifically for infants and toddlers in foster care or were required for children of all ages. Only one state reported that post-permanency plans were required specifically for infants and toddlers.

We provided states with a list of post-permanency services and supports and asked them to indicate which ones are routinely offered for parents reunified with their infants or toddlers, or for caregivers who adopt or take guardianship of infants or toddlers. See Figure 11. The most frequently offered post-permanency supports are information and referrals, and linkages with community-based services. The least frequently reported support is written agreements for open relationships between parents and caregivers. These findings closely mirror those reported in the 2013 survey.

Figure 11. Post-permanency supports for parents, by number of states (n=33 to 36)[13]

Services	Post-reunification	Post-adoption	Post-guardianship
Respite care	3	17	6
Support groups	6	22	12
Linkages with community-based services	27	30	28
Information and referrals	29	33	29
Educational support/advocacy	18	26	19
Mental health services	20	23	19
Material supports	19	22	21
Follow-up visits/communication with child welfare staff	21	14	12
Written agreements for open relationships	3	11	4
Assistance with residential treatment for parents	10	4	4
Recovery support services for parents	18	4	5

We also asked states which post-permanency services and supports are routinely offered to infants and toddlers who are reunified with their parents, who are adopted, or who have a finalized legal guardianship. As illustrated in Figure 12, infants and toddlers tend to be routinely offered the same sorts of services/supports regardless of permanency outcome.

Figure 12. Post-permanency supports routinely offered to infants and toddlers, by number of states (n=33-35)

Services	Post-reunification	Post-adoption	Post-guardianship
Well-child visits	20	22	22
Preventive dental health care/oral health surveillance	19	22	21
Early learning and development programs	20	20	19
Part C early intervention services	22	21	21

[13] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.

Professional training in early childhood development and developmentally appropriate practice

Training in developmentally appropriate practices for individuals who regularly come into contact with infants and toddlers is important for supporting young children's healthy development. Therefore, we asked states about their policies related to providing professional training on these practices for groups whose work involves regular contact with infants and toddlers in foster care or candidates for foster care. These groups are listed in Figure 13. Seventy-four percent (25 out of 34 states) reported that professional training in early childhood development is required for front-line child welfare agency staff regardless of the age of children on their caseload; an additional 26 percent (9 out of 34 states) reported that training was offered to (but not required for) this group. On the other end of the spectrum, training in developmentally appropriate practices is not frequently required for nor offered to mental health and substance use disorder professionals —only 26 percent (5 of 19) states reported that it is required, and an additional 53 percent (10 of 19) reported that it is offered. This training is also not frequently offered to nor required for kinship navigators and health care providers.

Key findings:

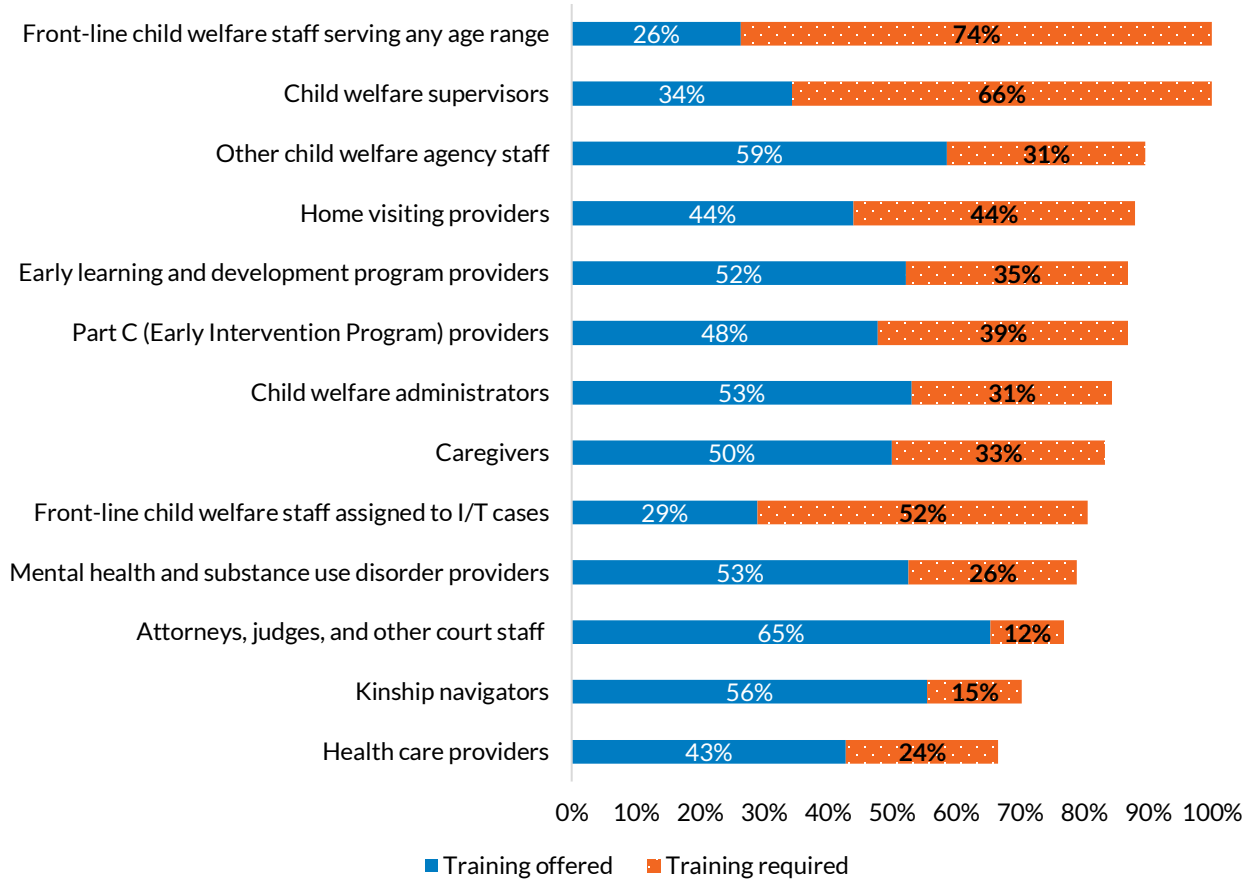
Training in developmentally appropriate practices is ***most frequently required or offered*** for:

- Front-line child welfare staff (regardless of the age of children on their caseload)
- Child welfare supervisors
- Other child welfare agency staff

This training is ***least frequently required or offered*** for:

- Health care providers
- Kinship navigators
- Attorneys, judges, and other court staff

Figure 13. Training for professionals in developmentally appropriate practices for infants and toddlers in foster care or candidates for foster care, by percentage of states (n=19 to 34)[14]



We also asked states which types of trainings on infants/toddlers in care or candidates were offered to professionals. Out of 33 respondents:

- Ninety-one percent of states (30) reported that training is provided on infant/toddler development.
- Seventy-six percent of states (25) reported that training is provided on cultural competence.
- Fifty-eight percent of states (19) reported that training is provided on racial/ethnic disparities and disproportionality.
- Eight-eight percent of states (29) reported that training is provided on trauma-informed care.

[14] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.

Data collected on maltreated infants and toddlers

States collect a variety of data on infants and toddlers who are in foster care or candidates for care. Nearly neglect, and those entering foster care (e.g., age, sex, time in care, placement setting). States also collect data on the race, ethnicity, and geographic location of infants and toddlers affected by maltreatment.

Gaps exist in data collected about the referrals and services received by infants and toddlers, as well as data about training for professionals and caregivers who work with maltreated infants and toddlers. Thirty-one percent (10 of 32 states) reported that they do not collect data on services received by infants and toddlers, and 24 percent (8 of 34 states) reported that they do not collect data on referrals made to services for infants and toddlers. These types and frequency of data states collected are consistent with those reported in the 2013 survey.

Given the disproportionate representation of children from racial and ethnic minority groups in the child welfare system as compared to the general population (Child Welfare Information Gateway, 2016), we asked states to report disparities in outcomes for the infant and toddler population by race and ethnicity. A notable number of states were not able to provide responses to questions about disparities, which is noteworthy given the significance of this issue. Among states that did respond, slightly more than three-quarters (77 percent; 17 of 22) reported disparities in removal rates for infants and toddlers, and approximately two-thirds (67 percent; 12 of 18) reported disparities in reunification rates. Just shy of two-thirds (63 percent; 12 of 19) reported disparities in length of stay in foster care. Only 15 percent (2 of 13) reported disparities in the timeliness of developmental screenings.

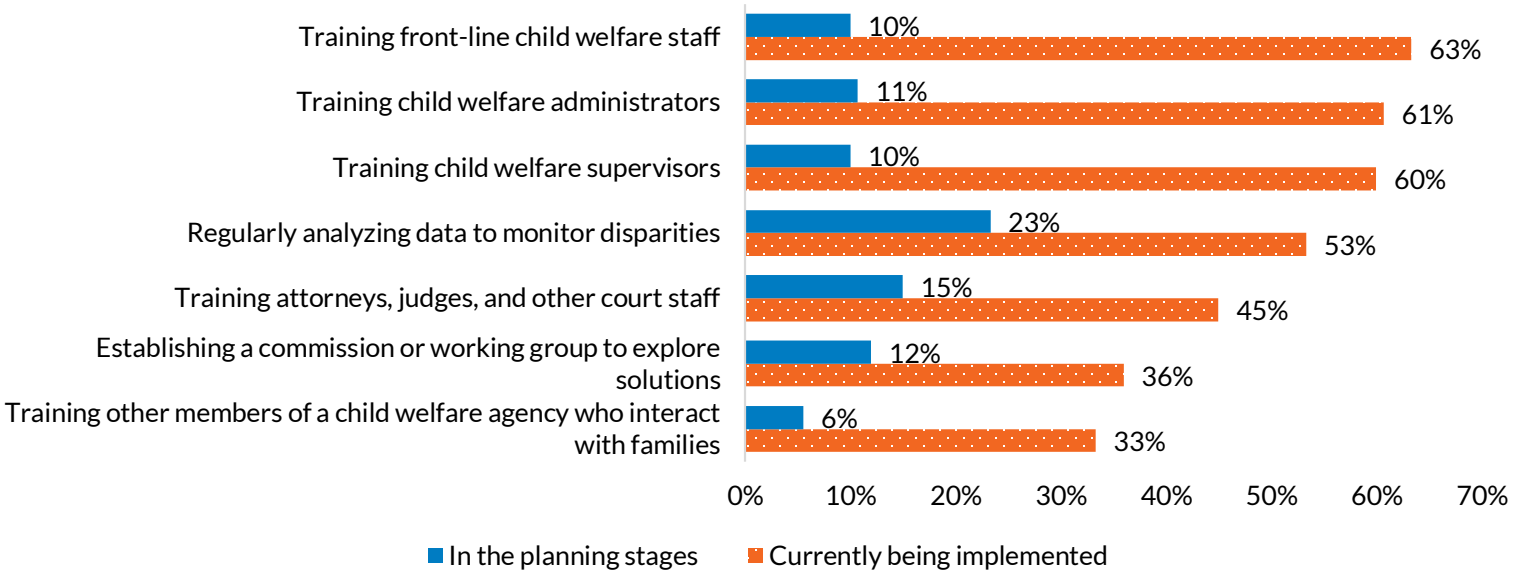
Key findings:

- Nearly all states collect basic demographic data on infants and toddlers affected by maltreatment
- However, there are gaps in data about referrals to services and services received, as well as training for professionals and caregivers who work with maltreated infants and toddlers.
- A notable number of states were not able to provide a response to questions about disparities, which is notable given the significance of this issue.
- The most frequently reported strategies for understanding and addressing disparities included training for front-line child welfare staff, child welfare administrators, and child welfare supervisors.

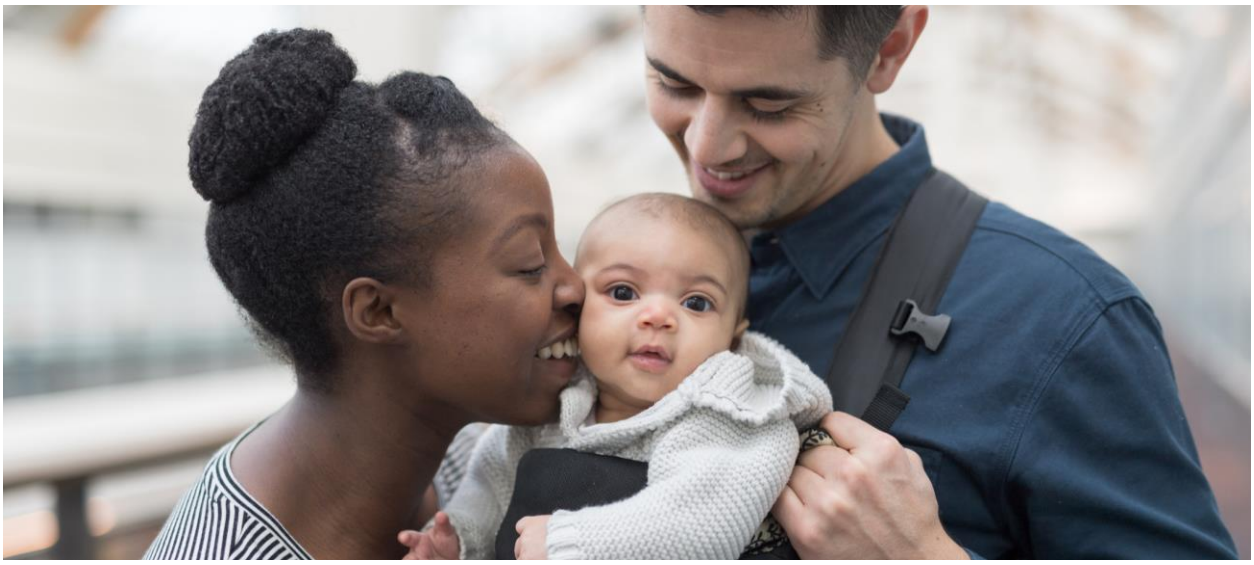
In addition, we asked states to indicate whether there were disparities in outcomes for infants and toddlers across geographic locations in their state. Sixty percent (9 of 15 states) of states that responded reported disparities in reunification rates, length of foster care stays, and removal rates for infants and toddlers. Only 22 percent (2 of 9 states) of states that responded reported a disparity in timeliness of developmental screenings. Again, respondents are state agency staff members, and the results of these questions about disparities may have been different if parents, caregivers, advocates, legislators, or other parties were asked.

We also asked states which strategies, if any, were being implemented to understand and address disparities across race, ethnicity, and geographic location. As shown in Figure 14, the most frequently reported strategies included training for front-line child welfare staff, child welfare administrators, and child welfare supervisors.

Figure 14. Strategies to understand and address disparities across race, ethnicity, and geographic location, by percentage of states (n=18 to 30)[15]



[15] This figure displays responses to multiple questions that had differing numbers of total responses, so we have provided a range for the number of respondents.



Discussion

The survey data on state child welfare policies and practices help bring into focus the array of services and policies that may be used to support infants and toddlers and their families across the country. Based on our analysis of the data, we share several areas of strength and highlight areas where sizeable gaps and challenges exist.

Areas of strength

The 2019 survey shows several ways in which states are strongly supporting the healthy growth and development of infants and toddlers who are in foster care or candidates for foster care.

Health visit and screening schedules

Most states require adherence to health visit and screening schedules for infants and toddlers in foster care; moreover, when potential physical or developmental problems are identified, nearly two-thirds of states require referrals within a specific timeframe for children in foster care. Early identification of health and developmental challenges and referrals to appropriate services are important for young children's healthy development, and states clearly recognize and facilitate these services for infants and toddlers in foster care.

Referrals to substance use and mental health services for parents

States are providing referrals to substance use and mental health services to parents when issues are identified. These services are particularly important for parents of young children: Infants and toddlers are more likely to enter foster care due to parental substance use than their older peers (Williams & Sepulveda, 2019). Referrals to high-quality, effective substance abuse services are essential for reunification with parents. We see a clear opportunity for states to build on this strength by accessing additional federal funding for such services to parents of candidates for care via the Family First Act. With more federal funds for services that prevent entry to care, states can build off existing infrastructure and expand services for young children who are not yet in foster care.

Stability and supporting early attachment relationships

States are engaging in policies and practices to promote stability and early attachment relationships between infants and toddlers and their parents or caregivers. Nearly all states reported policies or practice guidelines that give preference to kin/relative placements (when appropriate) for infants and toddlers in foster care. Nearly two-thirds of states also reported having a differential response system for low- or moderate-risk abuse or neglect referrals. These policies reflect states' understanding that all children benefit from placement stability, ongoing connections to family, and avoiding the trauma associated with entry into foster care when possible.

Collaboration

States universally reported many connections between child welfare agencies and other entities. This indicates that the agencies, systems, and community resources that have an impact on the lives of families involved with the child welfare system are communicating and connecting. Young children and their families may interact with several key public programs—such as publicly subsidized child care, food assistance, Medicaid or special education services. Effective linkages between these entities help states coordinate service delivery and ensure that children and families are connected to the services they need.

Challenges and areas for growth

Through the 2019 survey, we learned that some promising policies and practices are less common across states, and that barriers exist to accessing services, creating potential challenges for young children and their families.

Most states reported that policies and practices are available to all children and not specifically designed or implemented to support infants and toddlers.

Consistent with the 2013 survey, we found that while states have policies and engage in practices to promote stability and attachment for children in foster care, including infants and toddlers, most states did not report differentiation between policies and practices for infants and toddlers in foster care and those for children of all ages in foster care. Policies that promote stability and attachment benefit all children in care; however, it is important to recognize that infants and toddlers have a unique set of developmental needs and opportunities and may particularly benefit from policies that ensure more frequent visits with parents, more frequent caseworker visits, and placement in foster-adopt homes to support placement stability and attachment with a consistent caregiver when reunification is not possible. States can explore how differentiation in their policies can better meet the unique developmental needs of infants and toddlers.

Action steps for states:

- When developing policies and practice guidelines, consider how they will support the unique developmental needs of infants and toddlers
- Support infants and toddlers by supporting their parents and caregivers—before entry into foster care, while in foster care, and after exit from foster care
- Support parents and caregivers who have experienced trauma
- Leverage federal opportunities—such as the Family First Act—to help young children stay with their families
- Explore child welfare data to understand and remedy racial and ethnic disparities
- Help connect infants and toddlers to kin caregivers

Candidates for foster care do not have the same supports as children in foster care

Across all policies and practice areas, infants and toddlers who are candidates for foster care and their families are not offered as many supports as infants and toddlers in foster care and their families. This is an expected finding: There are more policy requirements for and services available to children who are in foster care and under the jurisdiction of a child welfare agency and court. For example, 65 percent of states reported policies that promote integrated behavioral health for infants and toddlers in foster care and only 28 percent reported these policies for infants and toddlers who are candidates.

Through the Family First Act, states have an opportunity to expand supportive services to candidates for foster care and their families. These children and families would benefit from supportive services that child welfare agencies may be able to provide with appropriate levels of funding. Such prevention services can help prevent entry into foster care. As states begin to implement the Family First Act, we encourage them to learn from states that already have services and policies in place for candidates for foster care, and to explore which services, available now, can be expanded for candidates for foster care.

Post-permanency supports are limited

Although nearly every state routinely offers at least one of the post-permanency supports listed in the survey, many states lack a robust array of services. Offering more post-permanency supports and services to promote placement stability for infants and toddlers can help ensure that children are not retraumatized by another removal or changed placement. The need for supportive services does not decline, and may even increase, after an adoption finalizes or a child reunifies with their parents. Providing more post-permanency supports for families may help prevent re-entry of children into foster care. Infants and toddlers need to maintain their connections to a consistent caregiver to thrive, and policies that promote consistency can play a large role in keeping those connections strong.

There is a major gap in our understanding of how states are responding to child welfare disparities based on race and ethnicity

A notable number of states did not respond to the survey question about whether they were experiencing disparities in child welfare outcomes for infants and toddlers based on race/ethnicity and geographic location. This signals that states may not know whether they are experiencing disparities or that they are unwilling to report that information publicly, both of which are problematic given the over-representation of children from racial and ethnic minority groups in foster care and the established history of racism in the United States. Reporting and examining data on disparities is critical for understanding disparities in outcomes and determining actionable steps child welfare agencies can take to promote equitable outcomes for all children in care.

Efforts to connect infants and toddlers with potential kin caregivers are underutilized

Nearly all states reported policies or practice guidelines that give preference to kin/relative placements (when appropriate) for infants and toddlers in foster care. However, only a quarter of responding states reported that they require pre-removal conferences before infants and toddlers are removed from the home, and only 12 percent reported that they employ expedited notification of adult relatives for infants and toddlers when they are removed from their home. Pre-removal conferences and expedited notification of adult relatives are practices that create a critical opportunity for infants and toddlers to go directly into the care of a relative or kinship caregiver when removed from the home. These practices help promote

stability and secure attachment for infants and toddlers in foster care, which we know is crucial for healthy development and well-being.

Conclusion

The findings from the 2019 *Survey of Child Welfare Agency Policies and Practices for Infants and Toddlers in, or who are Candidates for, Foster Care* offer the field important information about the array of policies, practices, and supports available for maltreated infants and toddlers and their families. Because we developed and fielded this survey at the initial stages of states' implementation of the Family First Act, its findings offer insights about state policy and practice at a unique time of assessment and change. We hope that the data presented in this report—such as those on states' candidacy definitions and their existing mental health and substance abuse services—will be helpful to states and stakeholders as they grapple with how to leverage the new opportunities available to states through this federal law. More broadly, to improve the lives of children and families, we encourage state and federal leaders, advocates, and other stakeholders to use this information to build upon areas of strength and seek ways to address opportunities for growth.

References

American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. (2000). Developmental Issues for Young Children in Foster Care. ***Pediatrics***, **106**(5), 1145-1150. DOI: https://doi.org/10.1542/peds.106.5.1145

Antonelli, R. C., McAllister, J. W., & Popp, J. (2009). ***Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework***. New York, NY: The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2009_may_making_care_coordination_a_critical_component_1277_antonelli_making_care_coordination_critical_final.pdf

Casanueva, C., Dozier, M., Tueller, S., Jones Harden, B., Dolan, M., & Smith, K. (2012). ***Instability and Early Life Changes Among Children in the Child Welfare System. OPRE Report #2012-44***. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/early_life.pdf

Casey Family Programs. (2017). ***Supporting Lifelong Families***. Retrieved from https://caseyfamilypro-wpengine.netdna-ssl.com/media/supporting-lifelong-families-action-plan.pdf

Center on the Developing Child. (2007). **InBrief: *The Impact of Early Adversity on Child Development***. Harvard University. Retrieved from https://developingchild.harvard.edu/resources/inbrief-the-impact-of-early-adversity-on-childrens-development/

Center on the Developing Child at Harvard University. (2016). ***Applying the Science of Child Development in Child Welfare Systems***. Retrieved from https://developingchild.harvard.edu/resources/child-welfare-systems/

Child and Family Services Reviews Information Portal. (n.d., a). Safety plans**.** Retrieved from: https://training.cfsrportal.acf.hhs.gov/section-2-understanding-child-welfare-system/3016

Child and Family Services Reviews Information Portal. (n.d., b). Section 4: Trauma in the child welfare system**.** Retrieved from https://training.cfsrportal.acf.hhs.gov/section-4

Child Welfare Capacity Building Collaborative. (n.d.). Child welfare capacity building collaborative liaisons**.** Retrieved from https://capacity.childwelfare.gov/map/

Child Welfare Information Gateway. (2016). ***Racial Disproportionality and Disparity in Child Welfare***. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway. (2018, a). ***Addressing the needs of young children in child welfare: Part C – Early intervention services***. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/partc.pdf

Child Welfare Information Gateway. (2018, b). ***Working with Kinship Caregivers***. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubs/kinship/

Family Justice Initiative. (n.d.). Federal funding. Retrieved from https://familyjusticeinitiative.org/iv-e-funding/

Hudson, L., Beilke, S., Many, M. (2016). If You Brave Enough to Live it, the Least I Can Do is Listen: Overcoming the Consequences of Complex Trauma. ***ZERO TO THREE Journal, 36***(5).

Jordan, E., Szrom, J., Colvard, J., Cooper, H., & DeVooght, K. (2013). ***Changing the Course for Infants and Toddlers: A Survey of State Child Welfare Policies and Initiatives***. Washington, DC: Child Trends and ZERO TO THREE. Retrieved from https://www.zerotothree.org/resources/218-changing-the-course-for-infants-and-toddlers

Cohen, J. & Herrick, K. (2013). ***Securing a Bright Future***. (2nd ed.) ZERO TO THREE. Retrieved from https://www.zerotothree.org/resources/725-securing-a-bright-future-maltreated-infants-and-toddlers

Korsen N., Narayanan V., Mercincavage L., et al. (2013). ***Atlas of integrated behavioral health care quality measures.*** AHRQ Publication No. 13-IP002-EF. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from https://integrationacademy.ahrq.gov/products/ibhc-measures-atlas

National Scientific Council on the Developing Child. (2009). ***Young Children Develop in an Environment of Relationships***. (2nd ed.) Working Paper No. 1. Retrieved from http://www.developingchild.net

South Carolina Department of Social Services. (2012). ***South Carolina Annual Progress and Services Report FFY 2012***. Retrieved from https://dss.sc.gov/resource-library/statistics/APSR/files/h_SCAPSR_FY12.pdf

Ullrich, R., Cole, P., Gebhard, B., and Schmit, S. (2017). ***Building Strong Foundations: Advancing Comprehensive Policies for Infants, Toddlers, and Families***. CLASP and ZERO TO THREE. Retrieved from https://www.clasp.org/sites/default/files/publications/2017/10/Health%20Services%20FINAL%2010-17-17%20%282%29.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). ***The AFCARS Report: Preliminary FY2018 Estimates as of August 22, 2019 – No. 26***. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport26.pdf

U.S. Department of Health and Human Services. (n.d.). What is the U.S. opioid epidemic?. Retrieved from https://www.hhs.gov/opioids/about-the-epidemic/index.html

Williams, S.C., & Sepulveda, K. (2019). Infants and toddlers are more likely than older children to enter foster care because of neglect and parental drug abuse. Bethesda, MD: Child Trends. Retrieved from https://www.childtrends.org/infants-and-toddlers-are-more-likely-than-older-children-to-enter-foster-care-because-of-neglect-and-parental-drug-abuse

ZERO TO THREE. (forthcoming). Safe Babies Court Team approach: Core components and key activities. Washington, DC: ZERO TO THREE.

Appendix A

Survey of Child Welfare Agency Policies and Practices for Infants and Toddlers in, or who are Candidates for, Foster Care

Survey of Child Welfare Agency Policies and Practices for Infants and Toddlers in, or who are Candidates for, Foster Care

Thank you for participating in this national survey, which aims to gather information about policies and practices that guide child welfare agencies' work in addressing the needs of (1) infants and toddlers in foster care, and their families, and (2) infants and toddlers who are at risk of entering foster care, and their families. The survey is being conducted by ZERO TO THREE, a national nonprofit organization that works to ensure that all infants and toddlers have a strong start in life by transforming the science of early childhood into resources, tools, and policies for professionals and policymakers. ZERO TO THREE is administering this survey in partnership with Child Trends, a nonprofit, nonpartisan research center that seeks to improve the lives and prospects of children and youth by conducting high-quality research and sharing knowledge with practitioners and policymakers.

We sincerely appreciate the time you devote to completing the survey. While the survey is long, you may save your responses and have multiple staff contribute to the survey. Further, depending on your responses, not all questions will be applicable. The information you provide will help fill in critical knowledge gaps and will be an important tool for policymakers, practitioners, advocates, and others helping children and families.

When answering questions, please consider current practices and policies at the time you are completing the survey. **For the purposes of this survey, we ask states to consider children in foster care and children who are "candidates for foster care" using the definition of "children at risk of entering foster care" outlined in the Family First Prevention Services Act (see Definitions section below)**.

The survey is organized into nine sections:

Section I. **Health Assessments and Services**
Section II. **Supports for Parents**
Section III. **Partnerships and Collaborations**
Section IV. **The Dependency Court Process for Infants and Toddlers in Foster Care and their Families**
Section V. **Promoting Stability, Attachment, and Permanency**
Section VI. **Post-Permanency Services for Infants and Toddlers in Foster Care and their Families**
Section VII. **Training in Early Childhood Development and Developmentally-Appropriate Practice**
Section VIII. **Data Collection**
Section IX. **Additional Initiatives**

Completing and Submitting the Survey: The survey can be completed electronically by providing responses directly in this document. Throughout the survey, there are options for you to indicate you do not know the answer to the question. Please only use this option when it is infeasible to obtain a response as many "don't know" responses will reduce the usefulness of this survey for the child welfare field. Please send the completed survey as an email attachment to Megan Fischer at mfischer@childtrends.org.

Survey Results: The information you provide may be reported in a product that is made publicly available.

Questions? Please do not hesitate to contact Megan Fischer at mfischer@childtrends.org or (240) 223-9284.

This survey is a project of the national Infant-Toddler Court Program. This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $3,000,000 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Key Definitions and Terms

Below, we provide definitions of terms that appear throughout this survey. In addition, we have included definitions or descriptions of other important terms in textboxes. These descriptions will assist you in responding accurately to the questions and will enhance comparability of responses across states. Defined terms are presented in purple text throughout the survey.

DEFINITION: "PROMOTED"
Something is **"promoted"** in your state when policy or guidance language clearly states that the activity should be prioritized or attempted.

DEFINITION: "ROUTINELY"
Something "**routinely**" occurs when the activity or procedure is the norm; that is, if it occurs more than 80% of the time.

DEFINITION: "POLICIES"
"**Policies**" include laws, agency regulations, and other written guidance.

DEFINITION: "INFANTS AND TODDLERS"
"**Infants and toddlers**" are defined as children ages birth to 3 years.

DEFINITION: "CANDIDATE FOR FOSTER CARE"
According to the Family First Prevention Services Act (Family First Act), **"candidate for foster care"** is defined as a child identified in a prevention plan as being at imminent risk of entering foster care but who can remain safely in the home or in a kinship placement (e.g. voluntary kinship care where a state or tribe does not have legal custody of the child [Child Welfare Information Gateway, 2018]) as long as services or programs that are necessary to prevent their entry into foster care are provided. This status is not dependent on whether a child would be eligible for Title IV-E foster care, adoption, or guardianship payments. The term includes a child whose adoption or guardianship arrangement is at risk of disruption or dissolution that would result in a foster care placement. For the purposes of this survey, if your state has a different definition of "candidate for foster care," please provide it in question 2, and use that definition throughout the survey. If your state does not have a different definition, use the definition provided here.

DEFINITION: "FOSTER CARE"
Infants and toddlers in **"foster care"** are those who are in the custody of the state or local child welfare agency and may be in a variety of out-of-home placements (e.g. non-relative or relative/kin foster homes, shelter care homes, group homes, institutions, hospitals).

DEFINITION: "PARENT"
"**Parents**" of infants and toddlers are birth parents, adoptive parents, or guardians (formal or informal) who primarily cared for a child before coming to the attention of the child welfare agency.

DEFINITION: "CAREGIVER"
"**Caregivers**" are any primary caregiver of a child who is already in foster care (e.g. resource parent, kinship caregiver).

1. **Please provide the contact information for the individual primarily responsible for completing this survey or the individual we should contact if we have any questions.**

Name:	
Job Title:	
Agency:	
Number of years employed at agency:	
Email address:	
Phone number:	

2. **Does your state currently have a different definition for the term "candidate for foster care" than the one specified in the Definitions section, above?**

☐ Yes
☐ No

2a. If yes, what is the definition? *Please include what specific criteria are used to identify infants/toddlers at imminent risk of entering foster care.*

I. Health Assessments and Services

3. **The table below gathers information about medical or dental visit/screening schedules that are used in your state to track the health of infants and toddlers who are in foster care or are candidates for foster care.** *Examples of schedules include the American Academy of Pediatrics (AAP) or American Academy of Pediatric Dentistry's recommended schedules; the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) framework; Bright Futures recommended schedule; or a state- or county-developed schedule.*

   We understand that your policies around health visit/screening schedules may vary depending on a child's status with the child welfare agency (e.g., in foster care versus remaining at home in the parents' custody). Therefore, we have provided a distinction between the groups in the table.

   Please select the boxes in each row to indicate whether policies require adherence to any health visit/screening schedules for maltreated infants and toddlers.

	Adherence to visit/screening schedule required for infants and toddlers who are:		If yes, please name (e.g., AAP, EPSDT) or describe the type of schedule(s) used (e.g., annually, bi-annually, monthly)
	Candidates for foster care	In foster care	
a. Well-child visits (including developmental screenings)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	
b. Immunizations	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	
c. Preventive dental health care/oral health surveillance (e.g., oral health examinations, screening, fluoride treatment)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	

4. **For infants and toddlers in foster care, do policies or practice guidelines in your state specifically promote the involvement of parents in the health care of their children?**

   ☐ Yes
   ☐ No
   ☐ It varies by county *(please describe the variation in the text box below)*

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

4a. If yes, how do your policies or practice guidelines specifically promote parents' involvement? *(Select all that apply)*

- ☐ Parents are interviewed about their child's health (i.e., physical, dental, and social/emotional well-being)
- ☐ Parents are routinely invited to health visits where screenings and assessments are conducted
- ☐ Parents' attendance and participation in health visits is facilitated (e.g., providing transportation)
- ☐ Outcomes of screenings or assessments (e.g., doctor recommendations or screening/assessment results) are routinely discussed with parents
- ☐ Developmental milestones are reviewed with parents
- ☐ Parents are routinely included in health care planning discussions
- ☐ Child welfare workers are trained in how to promote parent involvement in the health care of their children
- ☐ Other (*please specify*): ☐

5. Do policies in your state require that referrals to specialists be made within a specific timeframe when potential physical or developmental problems are identified? Please answer for each group of children specified in the table below.

	Yes	No	It varies by county	Don't know	If yes, within what timeframe must referrals be made?
a. Infants and toddlers in foster care	☐	☐	☐ If checked, please describe variation: ☐	☐	☐ Within 1 week ☐ Within 2 weeks ☐ Within 30 days ☐ Other (please specify): ☐
b. Infants and toddlers who are candidates for foster care	☐	☐	☐ If checked, please describe variation: ☐	☐	☐ Within 1 week ☐ Within 2 weeks ☐ Within 30 days ☐ Other (please specify): ☐

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

6. **What supportive practices or services are routinely provided in your state to meet the social and emotional well-being of infants and toddlers who are in foster care or are candidates for foster care and their families? Please only select practices or services that are routinely provided, not those that are routinely offered but are rarely accessed or received by families.** *(Select all that apply)*

☐ Caseworkers ensure children in foster care have a keepsake from their parents' home (e.g., a stuffed animal, recording of their parent singing or reading aloud, a comforter or item of clothing with the parent's scent on it)

☐ Caregivers help children make the transition before and after visits with parents

☐ Developmental and behavioral health screening is conducted (e.g., Ages & Stages Questionnaire® [ASQ]; ASQ-Social Emotional®)

☐ Parent-child relationship/child social-emotional assessments are administered (e.g., Parenting Interactions with Children: Checklist of Observations Linked to Outcomes [PICCOLO™], Infant Toddler Social & Emotional Assessment [ITSEA])

☐ Therapeutic supervised visitation is provided (visitation between a parent and child supervised by a licensed mental health professional)

☐ Supervised visitation is provided (visitation between a parent and child supervised by a qualified person)

☐ *Other (please specify):* _____

☐ It varies by county *(please describe the variation in the text box below)*

_____

☐ No supportive practices or services are routinely provided

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

7. Are medical homes required for the children specified in the table below? *Please check the appropriate response for each row in the table below*.

	Yes	No	Varies by county	Don't know
a. Infants and toddlers in foster care	☐	☐	☐	☐
b. Infants and toddlers who are candidates for foster care	☐	☐	☐	☐

When children have a "**medical home,**" all aspects of pediatric care are managed by one consistent pediatrician who knows a child's family and medical history. Pediatric care includes well-child visits to monitor health and development with regular screenings and assessments; immunizations; making timely referrals to needed services including early intervention; and, for parents of young children, counseling about health, nutrition, safety, and social and emotional well-being [Infant and Early and Childhood Mental Health (IECMH)]. When a child has special health care needs, the pediatrician coordinates specialized health care with other programs and services. The American Academy of Pediatrics (AAP) has identified seven desirable characteristics of a medical home: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective (AAP, 2018). Please see www.medicalhomeinfo.org for more information.

8. Do your state's policies promote care coordination for the children specified in the table below? *Please check the appropriate response for each row in the table below***.**

	Yes	No	Varies by county	Don't know
a. Infants and toddlers in foster care	☐	☐	☐	☐
b. Infants and toddlers who are candidates for foster care	☐	☐	☐	☐

"**Care coordination**" is "a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes. […] Care coordination is integrated within or strongly linked to a community-based primary care medical home setting, which has the resources and trained staff required to serve as a central hub for communication and information exchange among specialists and community partners across the continuum of care." (Antonelli, McAllister & Popp, 2009).

9. **Does your state offer payment incentives to encourage the provision of higher quality care at a lower cost for the children specified in the table below?** *Please check the appropriate response for each row in the table below*.

	Yes	No	Varies by county	Don't know
a. Infants and toddlers in foster care	☐	☐	☐	☐
b. Infants and toddlers who are candidates for foster care	☐	☐	☐	☐

"**Payment incentives**" are fiscal incentives to medical providers, health systems, and health plans to provide higher quality care at a lower cost.

10. **Do your state's policies promote integrated behavioral health in primary care for the children specified in the table below?** *Please check the appropriate response for each row in the table below*.

	Yes	No	Varies by county	Don't know
a. Infants and toddlers in foster care	☐	☐	☐	☐
b. Infants and toddlers who are candidates for foster care	☐	☐	☐	☐

"**Integrated behavioral health"** refers to "the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization" (Korsen et al, 2013).

11. **Do your state's policies promote parenting programs in primary care for the children specified in the table below?** *Please check the appropriate response for each row in the table below*.

	Yes	No	Varies by county	Don't know
a. Infants and toddlers in foster care	☐	☐	☐	☐
b. Infants and toddlers who are candidates for foster care	☐	☐	☐	☐

12. **How is the Child Abuse Prevention and Treatment Act (CAPTA) screening requirement for referral of maltreated infants and toddlers to Individuals with Disabilities and Education Act (IDEA) Part C implemented in your state?** *(Select one)*

☐ Child welfare agency conducts screenings
☐ Part C agency conducts screenings
☐ Contracted agency or another organization conducts screenings
☐ Other (*please specify*):
☐ We have not yet implemented this requirement
☐ It varies by county (*please describe the variation in the text box below*)

☐ Don't know

The "**Child Abuse Prevention and Treatment Act (CAPTA)**" is federal legislation that provides federal funding to states for prevention, assessment, investigation, prosecution, and treatment activities.

The "**Individuals with Disabilities and Education Act (IDEA)**" is federal legislation that ensures a free and public education, including special education and related services, is available to children with disabilities. IDEA Part C covers early intervention services for infants and toddlers through age 2.

13. **Please indicate how much of a barrier each item presents to implementing the CAPTA requirement for referring maltreated infants and toddlers to Part C in your state.** *Please respond to each row in the table below.*

	Not at all a barrier	Somewhat of a barrier	Significant barrier
a. Part C staff lack familiarity with child welfare populations, policies, and/or procedures or lack training to identify developmental needs	☐	☐	☐
b. Child welfare staff lack familiarity with Part C services, policies, and/or procedures or lack training to identify developmental needs	☐	☐	☐
c. Parents lack familiarity with Part C services, policies, and/or procedures; lack training to identify developmental needs; or are hesitant to utilize Part C services	☐	☐	☐
d. Caregivers lack familiarity with Part C services, policies, and/or procedures; lack training to identify developmental needs; or are hesitant to utilize Part C services	☐	☐	☐
e. Court personnel lack familiarity with Part C services, policies, and/or procedures or lack training to identify developmental needs	☐	☐	☐
f. Children lack access to primary health care or have limited contact with health care professionals (who may otherwise identify developmental needs)	☐	☐	☐

	Not at all a barrier	Somewhat of a barrier	Significant barrier
g. Part C program has limited capacity to process referrals	☐	☐	☐
h. Referral requirement is implemented inconsistently across state	☐	☐	☐
i. Children lack access to health insurance in the community or timely insurance once placed in foster care	☐	☐	☐
j. Other *(please specify):*	☐	☐	☐

14. Which of the following, if any, has your state undertaken (at any time) to address barriers identified above? *(Select all that apply)*

☐ Required training for child welfare staff on the Part C referral requirement
☐ Required training for child welfare staff on the supports and services available through Part C
☐ Required training for Part C agency staff on the developmental needs of infants and toddlers in the child welfare system
☐ Implemented formal information sharing about each system's policies/procedures (i.e., between Part C and child welfare agencies)
☐ Implemented data sharing/service plan sharing or Memoranda of Understanding (MOU) between Part C and child welfare agencies
☐ Had leaders in child welfare and Part C agencies engage and collaborate to implement requirements of federal/state/local laws
☐ Clearly delineated roles/responsibilities of Part C and child welfare staff
☐ Included the parent/family from assessment through the development of the service plan
☐ Required training for parents on how and when to seek services for young children under Part C
☐ Required training for caregivers on how and when to seek services for young children under Part C
☐ Required training for court personnel on Part C requirements and developmental delays
☐ Other (*please specify*):
☐ My state has not made efforts to address the barriers identified above

The following questions are related to substance-exposed infants.

15. Are newborns with positive tests for drugs automatically removed from their parent's custody in your state? *(Select one)*

☐ Yes
☐ No
☐ It varies by county (*please describe the variation*):
☐ Don't know

16. Are medication assisted treatment (MAT) and/or prescription drugs that treat opioid addiction made available to pregnant women in your state?

☐ Yes
☐ No
☐ It varies by county (*please describe the variation*):
☐ Don't know

17. What entity(ies) in your state is/are responsible for developing a Plan of Safe Care for infants as required under CAPTA/Comprehensive Addiction and Recovery Act (CARA)?

The "**Comprehensive Addiction and Recovery Act (CARA)**" authorizes federal dollars to fund programs centered around substance use-related prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal. CARA affected CAPTA by removing the word "illegal" in reference to substance use and established that Plans of Safe Care must address both the needs of affected infants and their families.

"Plans of Safe Care" are required of any state that receives CAPTA funding. These plans must address the needs of both substance-exposed infants and their families and must specify how the services that the infant and family receive will be monitored.

18. Are there current practices for identification, screening, assessment, or referral of pregnant women/parents with substance use disorders and infants affected by prenatal substance exposure in your state?

- ☐ Yes, at birth (*please describe the practices*):
- ☐ Yes, but not at birth (*please describe the practices*):
- ☐ No
- ☐ It varies by county (*please describe the variation*):
- ☐ Don't know

19. Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, to assess and address the health of infants and toddlers in foster care or who are candidates for foster care.

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

II. Supports for Parents

20. The following table requests information about supports that may be offered to parents of infants and toddlers in your state. The first column asks if policies require the support to be offered, while the second column asks about which supports are routinely offered (regardless of whether they are required to be offered or not).

We understand that your policies may vary based on factors such as a child's status with the child welfare agency (e.g., in foster care versus remaining at home in the parent's custody). Therefore, we have provided this distinction between groups in the table.

	***Required* to be offered to *parents* of *infants/toddlers* who are:**		***Routinely* offered to *parents* of *infants/toddlers* who are:**		***Do parents routinely participate in service when offered?***	***Additional information***
	Candidates for foster care	***In foster care***	***Candidates for foster care***	***In foster care***		
a. Preventive health visits (primary health care to detect any underlying issues)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
b. A neuropsychological assessment to assess the parent's cognitive capabilities and capacities (including for fetal-alcohol syndrome and resulting impairments)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
c. Domestic violence screening	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
d. Substance use disorder screenings	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	

	***Required* to be offered to *parents* of *infants/toddlers* who are:**		***Routinely* offered to *parents* of *infants/toddlers* who are:**		***Do parents routinely participate in service when offered?***	***Additional information***
	Candidates for foster care	***In foster care***	***Candidates for foster care***	***In foster care***		
e. *If substance use disorder identified:* Referral to substance use disorder treatment programs	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
f. *If substance use disorder identified:* Parents of maltreated children are given priority for substance use disorder treatment services	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know		
g. A psychological assessment to assess any mental health issues (including for post-partum and maternal depression)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
h. *If mental health issues identified:* Referral to mental health services	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
i. Trauma screening (trauma exposure and/or trauma symptoms)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
j. *If trauma issues identified:* Referral to trauma-specific or trauma-focused treatment	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	

	***Required* to be offered to *parents* of *infants/toddlers* who are:**		***Routinely* offered to *parents* of *infants/toddlers* who are:**		***Do parents routinely participate in service when offered?***	***Additional information***
	Candidates for foster care	***In foster care***	***Candidates for foster care***	***In foster care***		
k. Parenting education that includes resources on child development and the impact of trauma on children's development and well-being	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	Please specify types of programs: ☐
l. Parent skills programs	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	Please specify types of programs: ☐
m. Peer support/mentors for successfully navigating the child welfare and court systems	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
n. Mentoring for parents by caregivers	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
o. Information about coping strategies for managing stress	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
p. Home visiting programs	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	

	***Required* to be offered to *parents* of *infants/toddlers* who are:**		***Routinely* offered to *parents* of *infants/toddlers* who are:**		***Do parents routinely participate in service when offered?***	***Additional information***
	Candidates for foster care	***In foster care***	***Candidates for foster care***	***In foster care***		
Parent-child relationship interventions, such as:						
q. Attachment and Biobehavioral Catch-Up (ABC)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
r. SafeCare®	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
s. Child-Parent Psychotherapy (CPP)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
t. Parent-Child Interaction Therapy (PCIT)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
u. Other parent-child relationship interventions	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	Please specify types of programs:
Social Determinants of Health:						
v. Housing supports	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	

	***Required* to be offered to *parents* of *infants/toddlers* who are:**		***Routinely* offered to *parents* of *infants/toddlers* who are:**		***Do parents routinely participate in service when offered?***	***Additional information***
	Candidates for foster care	***In foster care***	***Candidates for foster care***	***In foster care***		
w. Food security supports	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
x. Education and employment supports	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
y. Social supports	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
z. Legal services	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
aa. Other economic supports (such as cash assistance)	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	
Other:						
bb. Other	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Varies by county ☐ Don't know	☐ Yes ☐ No ☐ Don't know	Please specify:

20cc. If referrals are made to mental health, substance use, and/or trauma services (indicated above), is there an established process to review the effectiveness of the services to which parents are referred? If so, please describe.

	Yes, there is a process	No, there is no process	Don't know	N/A (referrals to these services are not offered)
i. Mental health	☐ *If checked, please describe:*	☐	☐	☐
ii. Substance use	☐ *If checked, please describe:*	☐	☐	☐
iii. Trauma services	☐ *If checked, please describe:*	☐	☐	☐

21. Please indicate how much of a barrier each item presents to parents of infants and toddlers in foster care or who are candidates for foster care when trying to access support services in your state. *(Please respond to each row in the table below)*

	Not at all a barrier	Somewhat of a barrier	Significant barrier
a. Lack of services in certain areas of state/unequal geographical distribution of services	☐	☐	☐
b. Low number/quantity of service providers	☐	☐	☐
c. Waiting lists for services	☐	☐	☐
d. Poor quality of services	☐	☐	☐
e. Services not available directly through child welfare agency (e.g., referrals to outside agencies needed)	☐	☐	☐
f. Language barriers (i.e., service providers do not speak the parent's native language)	☐	☐	☐
g. Transportation to services	☐	☐	☐
h. Difficulty finding, accessing, or engaging fathers	☐	☐	☐
i. Lack of child care for children while parent accesses services	☐	☐	☐
j. Costs of services	☐	☐	☐
k. Parent's lack of health insurance	☐	☐	☐
l. Legal status of parent	☐	☐	☐
m. Discrimination based on race or ethnicity	☐	☐	☐
n. Other *(please specify):*	☐	☐	☐

22. Which of the following, if any, has your state undertaken (at any time) to reduce the barriers identified above? *(Select all that apply)*

☐ Transportation to services provided or reimbursed
☐ Financial assistance for services provided
☐ Interpreters made available at service providers
☐ Technology-based service provision methods (e.g., "virtual"/on-line or telephone consultations)
☐ Peer support including parent mentors/navigators to assist with accessing services
☐ Peer support including parent mentors/navigators to provide emotional support
☐ Child care provided for children while parent receives services
☐ Father-specific programs
☐ Other *(please specify)*:

☐ My state has not made efforts to address the barriers identified above

23. Please describe any initiatives in your state that are specifically focused on outreach to youth in foster care who are pregnant or parenting to assess and address their needs.

24. Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, to support parents of infants and toddlers who are in foster care or candidates for foster care.

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

III. Partnerships and Collaborations

25. Does the child welfare agency have linkages (either formal or informal) at the state or local levels with any of the following entities or resources to help support infants and toddlers in foster care or who are candidates for foster care and their families? *(Select all that apply)*

Entity/Resource	Linkage?	If yes, please describe, including the nature of the linkage (e.g., How do the agencies partner or collaborate? What is the quality of the relationship? Frequency of contact? Do they share data? Is there an MOU in place?)	Is this a formal or informal collaboration?
a. Health (e.g., pediatricians, dentists, AAP)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
b. Medicaid/Children's Health Insurance Program (CHIP)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
c. Adult mental health services	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
d. Infant and early childhood mental health services	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
e. Public assistance programs (e.g., Supplemental Nutrition Assistance Program [SNAP], Special Supplemental Nutrition Program for Women, Infants and Children [WIC], Low Income Home Energy Assistance Program [LIHEAP], and housing assistance)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
f. Part C Early Intervention	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
g. Home visiting programs	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
h. Early learning and development programs (e.g., Early Head Start)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
i. Substance use disorder treatment programs	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
j. Domestic violence services	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

Entity/Resource	Linkage?	If yes, please describe, including the nature of the linkage (e.g., How do the agencies partner or collaborate? What is the quality of the relationship? Frequency of contact? Do they share data? Is there an MOU in place?)	Is this a formal or informal collaboration?
k. Family court (court with jurisdiction over child abuse and neglect cases)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
l. Community resources that help families build informal supports systems (e.g. the Parent Partners Organization, church groups)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
m. Immigration and customs enforcement (in cases of detained parents)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
n. Criminal justice system (in cases of incarcerated parents)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
o. Intellectual disabilities services (for parents)	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
p. Law enforcement agencies	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
q. Outside legal services support	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
r. Universities and medical centers	☐ Yes ☐ No ☐ Don't know		☐ Formal ☐ Informal ☐ Don't know
s. Other *(please specify):*	☐ Yes		☐ Formal ☐ Informal ☐ Don't know

IV. The Dependency Court Process for Infants and Toddlers in Foster Care and their Families

26. According to policies in your state, how soon must the initial permanency hearing for infants and toddlers in foster care occur after initial removal?

☐ Within 30 days
☐ Within 90 days
☐ Within 6 months
☐ Within 12 months
☐ Other (*please specify*): _____

☐ It varies by county *(please explain the variation in the text box below)*

_____

☐ Don't know

In a **"permanency hearing,"** the court reviews whether the child should continue to be in foster care and the nature of the child's permanency plan, and determines whether reasonable efforts are being made by the child welfare agency on the child's behalf to achieve this permanency plan.

27. According to policies in your state, how soon must the initial case review for infants and toddlers in foster care occur after initial removal?

☐ Within 30 days
☐ Within 90 days
☐ Within 6 months
☐ Within 12 months
☐ Other *(please specify):* _____

☐ It varies by county *(Please explain the variation in the text box below)*

_____

☐ Don't know

"**Case reviews**" are the process through which a comprehensive and thorough examination of a child's current status, plans, and case goals are discussed. Case reviews may entail an administrative, judicial, or citizen review model.

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

28. How frequently do policies require that the following take place for infants and toddlers in foster care? *(Select one response for each row)*

	More than once a month	Monthly	Quarterly	Every 6 months	Every 12 months	Other *(please specify in box provided)*	Varies by county	Frequency not specified in policy	Don't know
a. Case reviews (after the initial case review upon entry into care)	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Permanency hearings (after the initial hearing upon entry into care)	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Other court review hearings	☐	☐	☐	☐	☐	☐	☐	☐	☐
d. Family group decision-making (or similar approach)	☐	☐	☐	☐	☐	☐	☐	☐	☐

"Court review hearings" typically include a court review of whether the child's case plan, services, and placement meet the special needs and best interests of the child. They may be held as frequently as the judge orders them. Similar to a "case review," a court review hearing typically includes a comprehensive and thorough examination of the child's current status, plans, and case goals, and the progress the parents are making toward completion of their goals (as long as reunification is one of the concurrent permanency plans).

"Family group decision-making refers to a collection of family intervention approaches in which family members come together to make decisions about caring for their children and to develop a plan for services. This type of intervention also is referred to as family team conferencing, family team meetings, family group conferencing, family team decision-making, family unity meetings, and team decision-making." (Child Welfare Information Gateway, n.d.)

29. **Are case reviews, permanency hearings, court review hearings, or family group decision-making for infants and toddlers in foster care routinely held on a more frequent/expedited basis than those for other age groups?** *(Select all that apply)*

☐ Yes, for case reviews
☐ Yes, for permanency hearings
☐ Yes, for court review hearings
☐ Yes, for family group decision-making
☐ No
☐ It varies by county *(Please explain the variation in the text box below)*

☐ Don't know

29a. If yes, please describe how the frequency differs.

30. **Please describe any policies, programs, practices, or initiatives in your state to promote parent representation in court hearings, or other efforts to facilitate parent involvement in court proceedings for infants/toddlers who have been maltreated.**

31. **Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, to promote frequent case reviews, court hearings, family group decision-making, or other efforts to more closely monitor infant and toddler foster care cases.**

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

V. Promoting Stability, Attachment, and Permanency

32. Does your state have a differential response system for low- or moderate-risk abuse or neglect referrals?

☐ Yes, in all parts of the state
☐ Yes, but only in some parts of the state
☐ No
☐ Don't know

With **"differential response"** (also known as "alternative response"), child protective services "offer both traditional investigations and assessment alternatives to families reported for child abuse and neglect depending on the severity of the allegation and other considerations" (South Carolina Department of Social Services, 2012).

32a. If yes, can your state use differential response to respond to maltreatment referrals for infants and toddlers?

☐ Yes, in all parts of the state that have differential response
☐ Yes, but only in some parts of the state that have differential response
☐ No
☐ Don't know

33. Do policies in your state require pre-removal conferences before an infant or toddler is removed from the home?

☐ Yes
☐ No
☐ Varies by county
☐ Don't know

"**Pre-removal conferences**" are conferences where the parents have a voice about the best placement for their child should they have to be removed. Pre-removal conferences may be referred to by a variety of names, including "family group decision-making" or "family placement meetings."

If yes:

33a. In what timeframe must the pre-removal conference take place?

33b. How does the timeframe for pre-removal conferences for infants/toddlers differ (if at all) from the timeframe for other age groups?

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

34. Do policies in your state require expedited notification (i.e., more quickly than the 30 days required by the Fostering Connections Act) of adult relatives (maternal and paternal) when infants or toddlers are removed from their parents' custody?

☐ Yes
☐ No
☐ Varies by county
☐ Don't know

If yes:

34a. How soon after removal do policies require notification of adult relatives of infants or toddlers take place?

34b. How does the timeframe for notification for infants/toddlers differ (if at all) from the timeframe for other age groups?

35. Do policies in your state require preference be given to kin/relative placements (when appropriate) for infants and toddlers in foster care?

☐ Yes
☐ No
☐ Varies by county
☐ Don't know

36. Do policies in your state require concurrent planning be undertaken for infants and toddlers in foster care?

☐ Yes
☐ No
☐ Varies by county
☐ Don't know

"Concurrent planning" seeks to promote timely permanence for children in foster care by considering reunification and other permanency options at the earliest possible point after a child's entry into foster care.

If yes:

36a. What does concurrent planning for infants and toddlers entail (including when does it begin)?

37. Do policies in your state require expedited termination of parental rights (i.e., a shorter timeframe than would typically be the case for other age groups) for infants and toddlers who will not be reunified with their parents?

☐ Yes
☐ No
☐ Varies by county
☐ Don't know

If yes:

37a. What is the required timeframe for the termination of parental rights process for infants and toddlers?

37b. How does this timeframe for infants/toddlers differ from the timeframe for other age groups?

38. Do policies in your state require more frequent caseworker visits for infants and toddlers in foster care than for other age groups?

☐ Yes
☐ No
☐ Varies by county
☐ Don't know

If yes:

38a. What is the required timeframe for caseworker visits for infants and toddlers?

38b. How does the timeframe for infants/toddlers differ from the timeframe for other age groups?

39. Do policies or practice guidelines in your state promote keeping children in their first out-of-home placement throughout their time in foster care?

☐ Yes
☐ No
☐ It varies by county *(Please explain the variation in the text box below)*
☐ Don't know

39a. If yes, do policies/practices specifically promote placement stability for infants and toddlers?

☐ Yes, guidelines specifically promote placement stability for infants and toddlers
☐ No, guidelines promote placement stability for all children in foster care regardless of age
☐ Don't know

39a1. If yes, please describe how policies or practice guidelines specifically promote placement stability for infants and toddlers.

40. Do policies or practice guidelines in your state specifically promote placing children with foster-adopt families?

☐ Yes
☐ No
☐ It varies by county *(Please explain the variation in the text box below)*

☐ Don't know

"When a child is placed with a "**foster-adopt family,**" typically the child's permanency options are being evaluated through concurrent planning in two directions: adoption and family reunification. The child is placed in the home of a specially trained prospective adoptive family, who will work with the child during family reunification efforts but will adopt the child in the event family reunification is not successful" (Colvard & Szrom, 2012).

40a. If yes, do policies/practices specifically promote this placement type for infants and toddlers?

☐ Yes, guidelines specifically promote this placement type for infants and toddlers
☐ No, guidelines promote this placement type for all children in foster care regardless of age
☐ Don't know

40a1. If yes, please describe how policies or practice guidelines specifically promote this placement type for infants and toddlers.

41. Which of the following foster parenting models have been implemented in your state?

☐ "Shared family care" (i.e., the child and parent are placed together in a foster or kin home)
☐ Resource parents mentor parents
☐ Resource parents maintain contact with parents after reunification or adoption
☐ Other *(please specify):*

☐ No foster parenting models have been implemented in my state

42. Do policies require how often face-to-face visitation between infants and toddlers in foster care and their parents and siblings should occur?

	Yes	No	It varies by county	Don't know	If yes: how frequently must visitation occur?
a. Parents	☐	☐	☐ If checked: *Please describe the variation*	☐	☐ Daily ☐ At least once a week ☐ At least every two weeks ☐ At least monthly ☐ Other *(please specify)*:
b. Siblings	☐	☐	☐ If checked: *Please describe the variation*	☐	☐ Daily ☐ At least once a week ☐ At least every two weeks ☐ At least monthly ☐ Other *(please specify)*:

42c. Is required parent-child and sibling-child visitation frequency different for infants and toddlers in foster care versus other age groups?

	Yes	No	Don't know
i. Parent-child	☐ If checked: *Please describe how required visitation frequency for infants and toddlers in foster care differs from other age groups*	☐	☐
ii. Sibling-child	☐ If checked: *Please describe how required visitation frequency for infants and toddlers in foster care differs from other age groups*	☐	☐

43. Are visit coaches or other relationship-supporting approaches routinely provided for visits between parents and their children in foster care?

☐ Yes
☐ No
☐ It varies by county *(Please explain the variation in the text box below)*

☐ Don't know

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

A "**visit coach**" guides parents through phases of a visit or family time: planning, spending time with the children, and debriefing afterwards. The visit coach supports parents in spending focused nurturing time with their infants and toddlers in foster care. Visit coaches can come from a range of professions including child welfare caseworkers, in-home service providers, and Court Appointed Special Advocate (CASA) volunteers.

43a. If yes, do policies/practice guidelines specifically promote visit coaches for infants and toddlers?

☐ Yes, guidelines specifically promote visit coaches for infants and toddlers
☐ No, guidelines promote visit coaches for all children in foster care, regardless of age
☐ Don't know

43a1. If yes, please describe how policies or practice guidelines specifically promote visit coaches for infants and toddlers.

44. Do policies require that parents (when appropriate) are invited/encouraged to participate in routine activities (e.g., doctor's appointments, birthday celebrations) for children in foster care?

☐ Yes
☐ No
☐ It varies by county *(Please explain the variation in the text box below)*

☐ Don't know

44a. If yes, do policies specifically require parents be invited/encouraged to participate in routine activities for infants and toddlers?

☐ Yes, policies specifically require parents be invited/encouraged to participate in routine activities for infants and toddlers
☐ No, policies require parents be invited/encouraged to participate in routine activities for all children in foster care, regardless of age
☐ Don't know

44a1. If yes, please describe how policies specifically require parents be invited/encouraged to participate in routine activities for infants and toddlers in foster care.

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

45. Are infants and toddlers in foster care routinely placed with their siblings who are also in foster care?

☐ Yes
☐ No
☐ It varies by county *(Please explain the variation in the text box below)*

☐ Don't know

46. Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, to promote stability, attachment, and permanency for infants and toddlers in foster care.

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

VI. Post-Permanency Services for Infants and Toddlers in Foster Care and their Families

47. According to policies in your state, are post-permanency plans required to be developed before an infant or toddler is reunified, adopted, or placed with a legal guardian? *(Select all that apply)*

☐ Yes, for reunification
☐ Yes, for adoption
☐ Yes, for guardianship
☐ No
☐ It varies by county *(Please explain the variation in the text box below)*

☐ Don't know

If yes:

47a. What must these plans entail? *(Select all that apply)*

☐ Identification of barriers to successful reunification or adoption/guardianship
☐ Identification of supports/facilitators for successful reunification or adoption/guardianship
☐ Schedule of visitation with siblings (if applicable)
☐ Schedule of visitation with non-custodial parent (if applicable)
☐ Trial home visit plans
☐ Timeframe for permanency
☐ Service plans
☐ Safety plans
☐ Other (*please specify*):

☐ There are no rules dictating what these plans must entail

47b. Are policies requiring permanency plans specific to infants and toddlers in foster care?

☐ Yes, policies requiring permanency plans are specific to infants and toddlers
☐ No, policies requiring permanency plans are for all children in foster care, regardless of age
☐ Don't know

47b1. If yes, in what cases do policies specifically require permanency plans for infants and toddlers as opposed to children of other ages?

☐ Reunification
☐ Adoption
☐ Guardianship

48. In the table below, please indicate all post-permanency services and supports that are routinely offered in your state for parents who are reunified with their infant or toddler, or caregivers who adopt or take guardianship of an infant or toddler. *Select all boxes that apply.*

	Offered post-reunification	Offered post-adoption	Offered post-guardianship	Not offered	Varies by county	Don't know
a. Respite care	☐	☐	☐	☐	☐	☐
b. Support groups	☐	☐	☐	☐	☐	☐
c. Linkages with community-based services	☐	☐	☐	☐	☐	☐
d. Information and referrals	☐	☐	☐	☐	☐	☐
e. Educational support/advocacy	☐	☐	☐	☐	☐	☐
f. Mental health services	☐	☐	☐	☐	☐	☐
g. Material supports (e.g., income support, health insurance, housing assistance)	☐	☐	☐	☐	☐	☐
h. Follow-up visits/communication with child welfare staff (e.g., home visits or mentors)	☐	☐	☐	☐	☐	☐
i. Written agreements for open relationships between parents/caregivers	☐	☐	☐	☐	☐	☐
j. Assistance with locating/paying for residential treatment for parents in recovery	☐	☐	☐	☐	☐	☐
k. Recovery support services for parents with a substance use disorder	☐	☐	☐	☐	☐	☐
l. Other *(please specify)*:	☐	☐	☐	☐	☐	☐

49. In the table below, please indicate all post-permanency services and supports that are routinely offered in your state for infants and toddlers who are reunified with their parents, who are adopted, or who have a finalized legal guardianship. *Select all boxes that apply.*

	Offered post-reunification	Offered post-adoption	Offered post-guardianship	Not offered	Varies by county	Don't know
a. Well-child visits (including developmental screenings)	☐	☐	☐	☐	☐	☐
b. Preventive dental health care/oral health surveillance (e.g., oral health examinations, screening, fluoride treatment)	☐	☐	☐	☐	☐	☐
c. Early learning and development programs (such as Early Head Start)	☐	☐	☐	☐	☐	☐
d. Part C Early Intervention services	☐	☐	☐	☐	☐	☐
e. Other *(please specify)*:	☐	☐	☐	☐	☐	☐

50. Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, for post-permanency services for infants and toddlers in foster care and/or their families.

VII. Training in Early Childhood Development and Developmentally-Appropriate Practice

51. Do your child welfare agencies employ front-line staff (e.g., caseworkers) dedicated to working with (or specifically assigned to work with) infants/toddlers in foster care or who are candidates for foster care?

☐ Yes, in all areas of the state
☐ Yes, but only in some areas of the state
☐ No
☐ Don't know

52. The table below asks about your state's policies related to professional training on developmentally-appropriate practices for infants and toddlers in foster care or who are candidates for foster care. Please indicate whether training on developmentally-appropriate practice is "offered" or "required" for the each of the groups listed below.

	Training offered	Training required	Training is neither offered nor required	Don't know
a. Front-line child welfare staff (e.g., caseworkers) – only for those assigned to infant/toddler cases	☐	☐	☐	☐
b. Front-line child welfare staff (e.g., caseworkers) – regardless of the age of children on their caseload	☐	☐	☐	☐
c. Child welfare supervisors	☐	☐	☐	☐
d. Child welfare administrators	☐	☐	☐	☐
e. Other child welfare agency staff	☐	☐	☐	☐
f. Caregivers	☐	☐	☐	☐
g. Kinship navigators	☐	☐	☐	☐
h. Attorneys, judges, and other court staff (including Guardians ad Litem, Court Appointed Special Advocates)	☐	☐	☐	☐
i. Early learning and development program providers	☐	☐	☐	☐
j. Part C (Early Intervention Program) providers	☐	☐	☐	☐
k. Home visiting providers	☐	☐	☐	☐
l. Health care providers (including pediatricians, occupational therapists, etc.)	☐	☐	☐	☐
m. Mental health and substance use disorder providers	☐	☐	☐	☐
n. Other *(please specify):*		☐	☐	☐	☐

53. What trainings are offered or required for any of the groups in the table above on infants and toddlers in foster care or who are candidates for foster care?

☐ Infant/toddler development
☐ Cultural competence
☐ Racial/ethnic disparities and disproportionality
☐ Trauma-informed care
☐ Other *(please specify)*:

VIII. Data Collection

54. The following table requests information about whether data are collected in your state on various items or indicators related to infants and toddlers in foster care or who are candidates for foster care. We understand that data may not be collected consistently across your state or in all circumstances, and therefore have provided response options for this distinction in the table. *Please respond to each row in the table below.*

	Data collected	Data not collected	It varies	If it varies, how does it vary?	Don't know
a. Basic characteristics of infants and toddlers who have substantiated cases of abuse and/or neglect (e.g., age, sex, maltreatment type experienced)	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify*:	☐
b. Basic characteristics of infants and toddlers entering foster care (e.g., age, sex, time in care, episodes in care, placement settings, siblings in care, reason for entering care)	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
c. Race of infants/toddlers affected by maltreatment	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
d. Ethnicity of infants/toddlers affected by maltreatment	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
e. Geographic location of infants/toddlers affected by maltreatment	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
f. Health characteristics of infants and toddlers in foster care (e.g., physical disability, autism)	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

	Data collected	Data not collected	It varies	If it varies, how does it vary?	Don't know
g. Frequency of contact between infants and toddlers in foster care and **their parents** (e.g., face-to-face visits, phone calls, overnight or weekend visits)	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
h. Frequency of contact between infants and toddlers in foster care and **their siblings** (e.g., face-to-face visits, phone calls, overnight or weekend visits)	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
i. Frequency of **case reviews** for infants and toddlers in foster care	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
j. Frequency of **permanency hearings** for infants and toddlers in foster care	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
k. Timeliness of the initial permanency hearing for infants and toddlers in foster care	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
l. **Referrals made to services** for infants and toddlers who have experienced abuse and/or neglect	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
m. **Services received** by infants and toddlers who have experienced abuse and/or neglect	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
n. Infants and toddlers referred to Part C, including how many are eligible and how many receive services	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐

	Data collected	Data not collected	It varies	If it varies, how does it vary?	Don't know
o. Training for professionals and caregivers working with maltreated infants and toddlers	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
p. Characteristics of permanent placements of infants and toddlers who were in foster care by race, sex, and age (including reunifications with parents, relative guardianships, adoption)	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
q. Services received by infants and toddlers in foster care with special health care needs (e.g., cerebral palsy, asthma, diabetes, sickle cell anemia, physical disabilities, autism)	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐
r. Other data specific to infants and toddlers affected by maltreatment (*please specify*):	☐	☐	☐	☐ Data collected only in certain areas of state ☐ Data collected only in certain circumstances. *Please specify:*	☐

54s. Is your state experiencing a racial or ethnic disparity in the categories described below for infants and toddlers of different racial/ethnic groups?:

	Yes	No	Don't know
i. Length of foster care stays	☐	☐	☐
ii. Timeliness of developmental screenings	☐	☐	☐
iii. Removal rates	☐	☐	☐
iv. Reunification rates	☐	☐	☐

"**Disparities**" are "the unequal outcomes of one [group] as compared to outcomes for another [group]." For example, data show that African American and American Indian/Alaskan Native children experience higher rates of foster care placement than White children (CWIG, 2016).

54t. Is your state experiencing a disparity in the categories described below for infants and toddlers from different geographic locations (e.g. urban vs. rural)?:

	Yes	No	Don't know
i. Length of foster care stays	☐	☐	☐
ii. Timeliness of developmental screenings	☐	☐	☐
iii. Removal rates	☐	☐	☐
iv. Reunification rates	☐	☐	☐

55. Are the following strategies being implemented in your state to understand and address disparities across race, ethnicity, and geographic location?

	Yes	No	Don't know	In the planning stages	Varies by county
a. Regularly analyzing data to monitor disparities	☐	☐	☐	☐	☐
b. Training front-line child welfare staff	☐	☐	☐	☐	☐
c. Training child welfare supervisors	☐	☐	☐	☐	☐
d. Training child welfare administrators	☐	☐	☐	☐	☐
e. Training attorneys, judges, and other court staff	☐	☐	☐	☐	☐
f. Training other members of a child welfare agency who interact with families (e.g., security guards, administrative staff)	☐	☐	☐	☐	☐
g. Establishing a commission or working group to explore solutions	☐	☐	☐	☐	☐
h. Other (*please specify*):	☐	☐	☐	☐	☐

Questions? Please contact Megan Fischer at Child Trends: mfischer@childtrends.org

IX. Additional Initiatives

56. Are there policies, programs, practices, or initiatives in your state to promote infant-toddler court teams based on the Safe Baby Court Team ™ approach?

☐ Yes (*please specify*): _____

☐ No

☐ Don't know

The **Safe Babies Court Team™** approach focuses on system and capacity building to improve outcomes for very young children and families involved with dependency court. The approach relies on leadership from judicial and child welfare partners that fosters a climate of collaboration, trust, and shared vision for improving outcomes. Frontline professionals (the *Family Team*) supporting the child and family meet regularly to identify and address child and parent needs and promote reunification for children in foster/kinship care. At the organizational level, service providers and advocates come together as a *Community Stakeholder Team* to address gaps and disparities via system improvements. A *Community Coordinator* plays a pivotal role identifying and galvanizing stakeholders and coordinating local services and resources to ensure that children's and families' needs are met. For more information visit: https://www.zerotothree.org/resources/services/safe-babies-court-team

57. Are there any other policies, programs, practices, or initiatives in your state specifically addressing the needs of infants and toddlers who are in foster care or who are candidates for foster care and their families, other than those reflected in the questions above? If so, please briefly describe them in the box below.

58. Please use this space to share any descriptions of policies, programs, practices, or initiatives targeting either specific age groups within the larger birth to age 3 group (e.g., a program specifically for birth to 1-year-olds), or a broader early childhood age group (e.g., a program for children birth to 4, or specifically for 3-4 year olds).

THANK YOU FOR COMPLETING THE SURVEY!

References

American Academy of Pediatrics (2018). *What is a Medical Home?* Retrieved from https://medicalhomeinfo.aap.org/overview/Pages/Whatisthemedicalhome.aspx

Antonelli, R. C., McAllister, J. W., & Popp, J. (2009). *Making care coordination a critical component of the pediatric health system: a multidisciplinary framework*. New York, NY: The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2009_may_making_care_coordination_a_critical_component_1277_antonelli_making_care_coordination_critical_final.pdf

Child Welfare Information Gateway (2016). *Racial Disproportionality and Disparity in Child Welfare*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway (2018). *Working with kinship caregivers*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway (n.d.). *Family Group Decision-Making*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

Colvard, J. & Szrom, J. (2012). *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*. Washington, DC: Zero To Three.

Korsen N., Narayanan V., Mercincavage L., et al (2013). *Atlas of Integrated Behavioral Health Care Quality Measures*. Rockville, MD: Agency for Healthcare Research and Quality. AHRQ Publication No. 13-IP002-EF.

South Carolina Department of Social Services (2012). *South Carolina Annual Progress and Services Report FFY 2012*. Retrieved from https://dss.sc.gov/resource-library/statistics/APSR/files/h_SCAPSR_FY12.pdf

Appendix B

Tables of State Policies

Table 1. Screening schedules and referrals

	Policy requires adherence to visit/screening schedules for well-child visits for Infants/Toddlers (I/T)		Policy requires adherence to visit/screening schedules for immunizations for I/T		Policy requires adherence to visit/screening schedules for preventive dental health care/oral health surveillance for I/T		Policy requires referral to specialists within specific timeframe when physical or developmental problems are identified for I/T	
State	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates
AL	Yes	Don't know	Yes	Don't know	Yes	Don't know	Yes	
AK	Yes	No	Yes	No	Yes	No	Yes	No
AZ	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
AR	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
CO	Yes	No	Yes	No	Yes	No	Yes	No
DC	Yes	No	Yes	No	Yes	No	Yes	Don't know
FL	Yes	No	Yes	No	Yes	No	Yes	Yes
GA	Yes	No	Yes	No	Yes	No	Yes	No
HI	Yes	No	Yes	No	Yes	No	No	No
IL	Yes	No	Yes	No	Yes	No	Yes	Yes
IN	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
KS	Yes	Don't know	Yes	Don't know	Yes	Don't know	No	No
KY	Yes	No	Yes	No	Yes	No	No	No
LA	Yes	No	Yes	No	Yes	No	No	No
ME	Yes	Yes	Varies by county	No	Yes	No	Yes	Yes
MD	Yes	No	Yes	No	Yes	No	No	No
MO	Yes	No	Yes	No	Yes	No	Yes	Yes
NE	Yes	Yes	Yes	No	Yes	No	No	No
NV	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
NM	Yes	No	Yes	No	Yes	No	No	No
NC	Yes	Yes	Yes	Yes	Yes	Yes	No	No
ND	No	No	No	No	No	No	No	No
OH	Yes	Varies by county	Yes	Varies by county	Yes	Varies by county	Yes	No
OK	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

	Policy requires adherence to visit/screening schedules for well-child visits for Infants/Toddlers (I/T)		Policy requires adherence to visit/screening schedules for immunizations for I/T		Policy requires adherence to visit/screening schedules for preventive dental health care/oral health surveillance for I/T		Policy requires referral to specialists within specific timeframe when physical or developmental problems are identified for I/T	
State	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates
OR	Yes	Don't know	Yes	Don't know	Yes	Don't know	Yes	Don't know
PA	Yes	No	Yes	No	Yes	No	Yes	Yes
PR	Yes		Yes		Yes			Yes
RI	Yes	Yes	Yes	Yes	Yes	Yes	No	No
SC	Yes	No	Yes		Yes		Yes	Yes
SD	Yes	No	Yes	No	Yes	No	No	No
TX	Yes	No	Yes	No	Yes	No	No	No
UT	Yes	No	Yes	No	Yes	No	Yes	No
VT	Yes	No	Yes	No	Yes	No		
WV	Yes	Don't know	Yes	Don't know	Yes	Don't know	Yes	Yes
WI	Yes	No	Yes	No	Yes	No	Yes	No
WY	Yes	No	Yes	No	Yes	No	No	No

Table 2. Medical initiatives

	Policies promote care coordination for I/T		State offers payment incentives for high quality health care for I/T		Policies promote integrated behavioral health in primary care for I/T		Policies promote parenting programs in primary care for I/T		Medical homes required for I/T	
State	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates
AL	Yes	Don't know	Don't know	Don't know	Yes		Yes	Don't know	Don't know	Don't know
AK	No	No	No	No	No	No	No	No	No	No
AZ	No	No	No	No	Yes	Yes	Yes	Yes	No	No
AR	Yes	Yes	No	No	No	No	Yes	Yes	No	No
CO	Yes	Don't know	No	No	No	No	Yes	Yes	Varies by county	No
DC	Yes	No	No	No	Yes	Yes	No	No	No	No
FL	Yes	No	No	No	Yes	No	Yes	Yes	Yes	No
GA	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
HI	Yes	No	Don't know	No	Yes	No	Yes	No	Yes	No

	Policies promote care coordination for I/T		State offers payment incentives for high quality health care for I/T		Policies promote integrated behavioral health in primary care for I/T		Policies promote parenting programs in primary care for I/T		Medical homes required for I/T	
State	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates
IL	Yes	Yes	Yes	No	Yes	Varies by county	Yes	Yes	Yes	Varies by county
IN	No	No	Don't know	Don't know	Don't know	Don't know	Yes	Yes	No	No
KS	No	No	No	No	No	No	Yes	Yes	No	No
KY	Yes	Yes	No	No	No	No	Yes	Yes	No	No
LA	Yes	No	No	No	Yes	No	No	No	Yes	No
ME	No	No	No	No	No	No	Yes	Yes	No	Yes
MD	Yes	No	No	No	Yes	No	No	No	No	No
MO	Yes	No	Don't know	Don't know	Yes	Yes	Yes	Yes	No	No
NE	Varies by county	Varies by county	No	No	Varies by county	Varies by county	No	No	Varies by county	Varies by county
NV	Varies by county	No	No	No	Yes	Yes	Varies by county	Varies by county	Varies by county	No
NM	Yes	Yes	Yes	No	Yes	No	No	No	No	No
NC	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Varies by county	Varies by county
ND	Yes	Yes	No	No	No	No	No	No	No	No
OH	Yes	Yes	Yes	No	Yes	Yes	Yes	Varies by county	Varies by county	No
OK	Yes	Yes	Don't know	Don't know	Yes	Yes	Yes	Yes	No	No
OR	Yes	Yes	No	No	Varies by county	Varies by county	No	No	Varies by county	Varies by county
PA	Yes	Yes	No	No	Yes	Yes	Don't know	Don't know	No	No
PR	No		Yes	No	Yes	Don't know	Yes	Yes	No	
RI	Yes	Yes	Don't know	Don't know	Varies by county	Varies by county	Varies by county	Varies by county	Yes	Yes
SC	Yes	No	No	No	No	No	No	No	No	No
SD	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No
TX	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No

	Policies promote care coordination for I/T		State offers payment incentives for high quality health care for I/T		Policies promote integrated behavioral health in primary care for I/T		Policies promote parenting programs in primary care for I/T		Medical homes required for I/T	
State	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates	In foster care	Candidates
UT	Don't know	Don't know	No	No	Don't know	Don't know	Yes	Yes	Don't know	Don't know
VT	Yes	No	No	No	Yes	No	No	No	Yes	No
WV	Yes	No	Don't know	Don't know	Yes	No	Yes	Yes	Yes	No
WI	Varies by county	No	No	No	Varies by county	Varies by county	No	No	Varies by county	No
WY	Yes	No	Yes	No	Yes	No	Varies by county	No	No	No

Table 3. Case reviews, court hearings, and family group decision making[16]

State	More frequent case reviews are routinely held for I/T in foster care than children of other ages	More frequent permanency hearings are routinely held for I/T in foster care than children of other ages	More frequent court review hearings are routinely held for I/T in foster care than children of other ages	More frequent family group decision making is routinely held for I/T in foster care than children of other ages
Alabama				
Alaska				
Arizona		Yes	Yes	
Arkansas				
Colorado	Yes	Yes		
District of Columbia				
Florida				
Georgia		Yes		
Hawaii				
Illinois				
Indiana				
Kansas				
Kentucky				
Louisiana				
Maine				
Maryland				
Missouri				
Nebraska				
Nevada				
New Mexico				
North Carolina				
North Dakota				
Ohio				
Oklahoma	Yes	Yes	Yes	Yes
Oregon				
Pennsylvania				
Puerto Rico				
Rhode Island	Yes		Yes	Yes
South Carolina				
South Dakota				
Texas				
Utah				
Vermont			Yes	
West Virginia				
Wisconsin				
Wyoming				

[16] Table displays "Yes" responses from states.

Table 4. Stability, attachment, and permanency for infants and toddlers in foster care

State	Policy specifically promotes keeping I/T in first out-of-home placement	Policy requires concurrent planning for I/T in foster care	Visit coaches or other relationship-supporting approaches routinely provided for visits between parents and their I/T in foster care	Mentoring for parents by caregivers routinely offered to parents of I/T		Policy requirement for how often visitation between parents and I/T in foster care should occur	Training on developmentally appropriate practices for maltreated I/T required for all front-line child welfare agency staff
				In foster care	Candidates		
AL	Yes	No	Yes	Yes	Don't know	Other	Don't know
AK	No	Yes	No	No	No	Other	Training required
AZ	Yes	Yes	Yes	No	No	At least once a week	Training required
AR	Yes	Yes	No	Yes	No	Other	Training offered
CO	Yes	Yes	Yes	Varies by county	Varies by county	At least once a week	Training required
DC	Yes	Yes	No	No	No	At least once a week	Training required
FL	Yes	No	No	No	No	At least once a week	Training required
GA	Yes	Yes	Yes	No	No	Other	Training offered
HI	Yes	Yes	No	Yes	No	Other	Training offered
IL	Yes	Yes	No	No	No	At least once a week	Training required
IN	Yes	Yes	Yes	Varies by county	Varies by county	At least once a week	Training required
KS	Yes	No	No	Yes	Yes	At least once a week	Training required
KY	Yes	Yes	No	Varies by county	Varies by county	At least every two weeks	Training required
LA	Yes	Yes	No	Yes	No	At least every two weeks	Training offered
ME	Yes	Yes	Varies by county	No	No	Other	Training required
MD	Yes	Yes	No	No	No	At least once a week	Training offered
MO	Yes	Yes	Yes	No	No	At least monthly	Training required
NE	Yes	Yes	Yes	No	No	Other	Training required
NV	Yes	Yes	Varies by county	Varies by county	Varies by county		Training required
NM	Yes	Yes	No	No	No		Training offered
NC	Yes	Yes	No	Yes	No		Training required
ND	No	Yes	No	Yes	Yes		Training required
OH	Yes	Yes	Varies by county	Varies by county	Varies by county	Other	Training required
OK	Yes	Yes	No			At least once a week	Training required
OR	Yes	Yes	Varies by county	Varies by county	Varies by county		Training required

State	Policy specifically promotes keeping I/T in first out-of-home placement	Policy requires concurrent planning for I/T in foster care	Visit coaches or other relationship-supporting approaches routinely provided for visits between parents and their I/T in foster care	Mentoring for parents by caregivers routinely offered to parents of I/T		Policy requirement for how often visitation between parents and I/T in foster care should occur	Training on developmentally appropriate practices for maltreated I/T required for all front-line child welfare agency staff
				In foster care	Candidates		
PA	Yes	Yes	Varies by county	No	No	At least once a week	Training required
PR	Yes	Yes	No	No			
RI	Varies by county	Yes	Yes	Varies by county	Varies by county		Training required
SC	No	Yes	No	No	No	Other	Training offered
SD	Yes	Yes	No	Yes	Yes	At least monthly	Training required
TX	Yes	Yes	No			At least every two weeks	Training offered
UT	Yes	Yes	No	Varies by county	Varies by county	At least once a week	Training required
VT	Yes	Yes	Yes	No	No		Training required
WV	Yes	Yes	Yes	Varies by county	No	Other	Training required
WI	Yes	Yes	Varies by county	No	No	At least once a week	Training offered
WY	Yes	Yes	No	Varies by county	Varies by county	At least once a week	Training required