



Strengthening Families with Infants and Toddlers:
A Policy Framework for States
National Infant-Toddler Court Program

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ABOUT THIS REPORT

Strengthening Families with Infants and Toddlers: A Policy Framework for States, is a new report from ZERO TO THREE designed to reframe the role of child welfare from preventing harm to children toward strengthening families and the communities where they live. The policy framework includes 11 recommendations for states and communities that aim to advance equitable outcomes supporting the health and well-being of very young children and their families, including those who are in or are at risk of entering the child welfare system. The report provides state and local policymakers with a roadmap to develop and advance policies that will drastically improve the systems and supports families with young children need to thrive and create protective factors that promote resilience. Promising examples from states and communities where ZERO TO THREE has effectively implemented the National Infant-Toddler Court Program based on the Safe Babies Court Team approach are also included in the report, highlighting strategies on how to infuse family strengthening, child development and parent voice into child welfare systems.

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ABOUT ZERO TO THREE

The policy recommendations provided in this report draw from more than 40 years of work at [ZERO TO THREE](#) translating the science of early childhood development for parents, practitioners, and policymakers using an interdisciplinary approach. This includes leading the field in identifying and developing the implementation of evidence-based child development, teaching, and learning practices; transforming the promise of pediatric primary care through a unique approach that integrates a HealthySteps Specialist into primary care practice to meet families' individual needs; expertise on the broad policy areas affecting infants, toddlers, and families at the state and federal level; and an intense focus at both the policy and practice level on meeting the needs of infants, toddlers, and families in or at the risk of entering the child welfare system.

ABOUT THE NATIONAL INFANT-TODDLER COURT PROGRAM

The [National Infant-Toddler Court Program](#), directed by ZERO TO THREE, has worked throughout the country in local communities and states over the past 16 years to implement the [Safe Babies Court Team™ \(SBCT\) approach](#). This evidence-based approach—targeted to families with children from birth to 3 years of age who are in foster care or at risk of removal—applies the science of early childhood development in meeting the urgent needs of infants and toddlers and strengthening their families so they can flourish. There are currently more than 100 sites implementing the SBCT approach across the country. Our reach covers 31 states, including eight that are implementing a statewide approach at multiple sites.



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INTRODUCTION

Overview

The greatest opportunity to influence a child's success is from the very start. Every baby has enormous potential, and every family wants to help their child reach this potential. All families need support from their community of family, friends, caregivers, and educators. We all have a shared responsibility to nurture and protect each child and to support communities and families in creating the safe, stable, nurturing environment children need.

Yet, families with young children continue to face challenges, often stemming from economic insecurity, material hardship, and stressful experiences that can undermine healthy development. Due to the intergenerational effects of and lived experiences with institutional and interpersonal racism, Black, Hispanic, and American Indian/Alaska Native (AI/AN) families disproportionately face these challenges, leading to inequities in opportunities for their young children.ⁱ These challenges translate into an array of needs, some of which are addressed through national and state policies. However, one persistent gap remains: there are few policies that address how families navigate and access the array of supports they need to be strong nurturers of their children, especially as their challenges multiply, as well as how communities can support these efforts. Using a public health approach, states can implement a continuum of formal and informal community-based prevention and intervention strategies to reach all children and families that need support, buffering the effects of environmental conditions.

Tragically, these critical strategies—which include access to health care, concrete supports for basic needs such as food and housing, high-quality childcare, and other behavioral health services—are often only made available to a family after they are in crisis or are reported for child abuse or neglect.ⁱⁱ The inequities experienced by Black and Brown families are further compounded within the child welfare system, where policy decisions and structural and systemic racism have led to

disproportionate involvement of child protective services and overrepresentation of children of color in foster care.ⁱⁱⁱ

The conversation about how best to support families is often framed as one of prevention of families entering the child welfare system. We must reorient our thinking away from preventing harm to children toward strengthening families and the communities where they live. By providing supports from the start, communities can enable families to nurture their children and promote positive outcomes for the entire family.

This report lays out a framework for state and local policymakers to develop policies that meet the basic components of what it takes for young children and families to thrive, by helping families create protective factors that promote resilience and building the community systems needed to support these efforts. It also envisions a child welfare system transformed by the same principles of family strengthening and child development for what ideally will be a much smaller group of children and families in need of intensive interventions to provide permanency and stability.





Structural Racism in the United States and Racial Inequity in the Child Welfare System

Historical and current federal and state legislation and public policies have contributed to systematic disadvantages and inequities for families of color. Structural racism in the United States has led to deeply rooted societal inequities and injustice resulting in generations of families living in poverty. This institutionalized racism has shaped and perpetuates social and environmental conditions that undermine access to safe and stable housing, good-paying and stable jobs, healthy food, health care, and other services and supports that promote well-being—conditions that are disproportionately experienced by children and families of color as starkly illuminated by the COVID-19 pandemic.^{iv}

For many families of color in the United States, the compounding impact of policy decisions and systemic racism are drivers of disproportionate involvement with child protective services and over-representation of children of color, particularly African American children, in foster care. Numerous studies have shown that racial bias and racial inequities occur at various decision points in the child welfare continuum. Although race and ethnicity do not strongly correlate with rates at which maltreatment is substantiated, systemic racism drives reports of maltreatment of African American children being investigated at higher rates than those for White children.^v

Background

From the prenatal period to age 3, the brain undergoes its most dramatic development as children acquire the ability to think, speak, learn, reason, and relate to others. The healthy development of this brain architecture equips a child to succeed in all areas of life and to contribute to society.^{vi} Science has significantly enhanced what we know about the needs of infants and toddlers, underscoring the importance of early relationships. In short, a safe, stable, and nurturing relationship with a caregiver in infancy—i.e., a family—builds a strong foundation for all learning and behavior to come.

Critical to development is a child and family's environment, including the conditions in which they live, learn, work, and play that affect a wide range of health risks and outcomes.¹ Every family wants to give its children a strong start in life and often needs support at different times from family, friends, neighbors, caregivers, educators, or their community. Some families may live in environments where providing safety and stability is a challenge, making it more difficult to support their children's healthy development. Parents may lack steady financial resources, paid leave, childcare, a stable living situation, or access to health insurance. For some families, life conditions such as community violence, trauma, physical or mental health issues, substance use disorders, or racism can magnify the normal stresses of raising children.

State and local policies can play a positive role in ensuring children thrive and reach their full potential. States can leverage a broad range of prevention supports to help keep families together, support family protective factors,^{vii} and work with communities to strengthen the conditions where families live. This can be done through creating a coordinated system of formal and informal supports to help strengthen families before a crisis occurs—described in this brief as a child and family well-being system (See Section 1: Create a child and family well-being system that helps all families thrive on [page 15](#)).



To be effective, child and family well-being systems must have the capacity to nurture the social and emotional development of young children, empower parents and communities, and build protective factors that can set children on the right track developmentally. While each community is unique, an effective child and family well-being system shares key attributes: they are community-based, responsive to local needs and cultural differences, accessible, and easy to navigate, as well as have identifiable entry points.

Approaching systems from a family-strengthening standpoint rather than one of prevention requires reorienting systems so that they are led by agencies and organizations outside of the child welfare system. There is widespread agreement that the traditional approach of child abuse prevention—overseen by child protective services—has resulted in many families being brought into the child welfare system who could have been supported through other systems within the community. Moreover, those families whose children do need protection often do not receive adequate community support. For example, Black, American Indian, and—in some states—Latinx infants and toddlers are significantly overrepresented in the child welfare population.^{viii}

¹ These conditions are encompassed within the social determinants of health (SDOH) as defined in Healthy People 2030, U.S. Department of Health and Human Services: <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>.

Poverty, which also is disproportionately common in communities of color, carries further implications for families' involvement in the child welfare system. Poverty is often mistaken for neglect, which results in increased reports of child maltreatment and out-of-home placements. Low-income families are more likely to be investigated for child maltreatment and to have substantiated findings of child abuse and neglect than families with higher incomes—despite a lack of evidence that maltreatment itself is more prevalent. These factors often lead to unnecessary removals from families without addressing the underlying unmet needs that negatively affect child and family health. Research shows that cases of neglect are frequently the result of lack of access to treatment for mental health and substance use disorders, as well as lack of concrete supports.^{ix} Another common reason for removal due to a case of neglect is simply the struggle to cope with the logistics of life with a young child when economic security is precarious and neighborhoods lack supports such as childcare programs or safe, affordable housing.

Recent efforts to reform the child welfare system have focused primarily on what can be done to prevent families from entering the system. Yet, strong families produce positive outcomes well beyond simply preventing abuse or neglect, as important as that is. Ensuring that child development is on track, improving mental health for both parents and children, reducing stress, and increasing economic security are also important outcomes that a child and family well-being system can help promote. The reality is that the birth or adoption of a baby is a moment of great opportunity to proactively support families and continue that support throughout the child's early years.

While focused efforts to strengthen families can reduce the number of those who enter the child welfare system, some families have complex needs that are unable to be addressed or supported in the community. For children in these families, it may be necessary to provide in-home supervision or even temporarily remove the child from the family and bring them into out-of-home or foster care. Children under age 3 are particularly vulnerable. With limited verbal abilities and unique stressors potentially compounded by parental poverty, infants and toddlers at this developmental stage experience the highest rate of abuse and neglect and the highest rate of foster care entry of any age group.^x While we believe that adequate prevention supports and a focus on equitable treatment of families can help significantly reduce the number of infants and toddlers being reported to and entering foster care, it remains critical that states improve the way they support families who do come into the system. In such cases, a family-centered child welfare system must be implemented (See Section 2: Infuse family strengthening, child development, and parent voice into child welfare systems on [page 42](#)).

States have an opportunity to transform their child welfare systems to be more responsive to the physical and mental health and developmental needs of infants and toddlers and the complex needs of their parents. Advancing the recommendations proposed in this report will require support and shared investment from a wide range of state and local leaders, including those leading child welfare, public health, early care and education, mental health, behavioral health, and basic needs agencies, as well as advocates, policymakers, community members, and, most importantly, families.





Opportunity for Reform

This report was researched and written almost entirely after the COVID-19 pandemic began in early 2020, a period during which families with young children have faced unprecedented challenges, including economic fallout and its impact on jobs and businesses, disruption to childcare and access to critical services, and social isolation. These impacts have been exacerbated for families involved in the child welfare system. Courts were closed for long periods of time, resulting in such challenges as less frequent contact between parents and their children, while fewer court hearings caused delays in families seeking reunification. Additionally, many families were unable to access critical health services, including mental health and substance use treatment, potentially prolonging the time their children spend in out-of-home care or resulting in fewer families being able to receive preventive services to help maintain their children in the home. Further, many experts fear that the closure of childcare providers has led to undetected reports of child abuse and neglect due to the social isolation of many young children. Child welfare workers, health care workers, early childhood providers, and others who make up the larger social safety net of this country have also faced unparalleled challenges in their efforts to reach families and help provide needed services and supports.

Despite these unprecedented challenges, however, many leaders involved in child welfare, public health, and early childhood have identified this time as an opportunity to make significant, long-needed structural changes to the child welfare system. While there are many different opinions among experts and leaders on what this reform should look like, there are also many shared principals that can help lead the way. Key among these is the importance of involving parents with lived experience in designing policies and systems so they are easier to use and reflect the knowledge that parents have in navigating systems that should be designed to support them. Also, any system reform effort should aim to provide all families with the services and supports they need to help their children thrive without ever having to encounter the child welfare system. Additionally, we must not only recognize the intergenerational effects of and lived experiences with institutional and interpersonal racism, as well as disparities that are pervasive throughout child and family systems, but actively work to expel these injustices throughout systems.

POLICY RECOMMENDATIONS

This policy framework includes 11 recommendations for states and communities that aim to advance equitable outcomes supporting the health and well-being of very young children and their families, including those who are in, or are at risk of entering, the child welfare system. The framework outlines a collaborative approach to family strengthening and child welfare prevention in which communities work with public health and other early childhood leaders to promote the healthy development and well-being of children and families. Rather than waiting until a family crisis occurs, a public health approach uses a continuum of community-based prevention and intervention strategies to reach all children and families who need support.

Each of the 11 recommendations provides information on:

- The size and scope of the challenge;
- The opportunity for change;
- A range of policy options for states and communities to consider;
- Promising examples from states and communities; and
- Key data that should be collected and examined at the state and county levels to measure and track progress of the policy impact on families.

The policies highlighted in this document are based on research and best practices in working with young children and their parents. [The Appendix of State and Local Examples](#) provides resources and contact information for each of the state and community examples included in the recommendations.

The policy framework is divided into two areas:

Section 1 Create a child and family well-being system that helps all families thrive

This section of policy recommendations focuses on providing a continuum of services and supports to all families who need assistance, including primary and secondary prevention services, that can support the healthy development and well-being of all infants and toddlers—and their families.

POLICY #1 Provide a continuum of services to all children and families to support good health, including affordable health care, comprehensive health and well-being assessments, and nutritious food

POLICY #2 Ensure families have access to affordable, high-quality services and supports to meet their basic needs, including safe and stable housing and economic supports

POLICY #3 Strengthen early learning experiences, including access to high-quality childcare

POLICY #4 Build community-level systems that provide a comprehensive continuum of supports to families through enhanced coordination and access to resources and services for families

Section 2 Infuse family strengthening, child development, and parent voice into child welfare systems

This section of policy recommendations focuses on tertiary prevention and includes services and supports for families with infants and toddlers with an open child welfare case,² placed in out-of-home care, or remaining at home.

POLICY #5 Adopt early childhood development principles into all child welfare and dependency court and family treatment court practices

POLICY #6 Provide infants and toddlers with an open child welfare case and their parents with regular screenings, comprehensive assessments of need, and timely referrals and connections to appropriate services

POLICY #7 Provide high-quality legal representation as early as possible and throughout the entire legal process

POLICY #8 Require early and more frequent court hearings and case reviews for infants and toddlers involved in the child welfare system

POLICY #9 Ensure the use of frequent family team meetings or other family teaming models

POLICY #10 Require frequent, high-quality family time (visitation) between infants and toddlers in out-of-home care and their parents and siblings

POLICY #11 Create a network of family support partners and mentors to help parents successfully navigate the child welfare and court processes

² Throughout this document, an open child welfare case refers to any families that have been “screened in,” meaning a case was accepted for investigation or assessment for abuse and neglect.



GUIDING PRINCIPLES

In addition to the recommended policies, there is a set of guiding principles that should be considered when developing and implementing policies to support infants, toddlers, and families. To achieve the best outcomes for families, these principles should not be implemented through a single policy but rather be reflected across all state and community policies and practices. The principles include:

- **PRIORITIZING FAMILY WELL-BEING.** Lessons learned over decades of research have demonstrated that children need families. The most effective family well-being system is one that is preventative; supports parents and caregivers; promotes safe, positive, and nurturing relationships; and provides families with comprehensive, high-quality supports. A coordinated, effective prevention system provides programs and services that address the social determinants of health—including environmental factors; education and employment pathways; social supports and social cohesion; health services including physical and mental health; a safe home and neighborhood; and other basic needs—to help families thrive.
- **EMPOWERING FAMILIES AND ELEVATING THE PARENT VOICE.** A key element in supporting a family well-being system is listening to families who have lived experience navigating child welfare and other systems—integrating their voices into all aspects of planning and improvement, at both the individual level and the systems level. This includes parents (both mothers and fathers), grandparents, kin, fictive kin,³ and other extended family. This approach empowers parents and families in goal setting and decision-making and is critical to achieving the best outcomes for children, by creating opportunities to increase parents’ capacity for self-advocacy, confidence, and motivation. Parent–peer mentor and parent advocacy organizations and programs can also play a key role in directly supporting families as they navigate child welfare investigations and cases. Diversity and representation of the community should be a goal in terms of race, language, age, SOGIE (sexual orientation, gender identity, and gender expression), and other key areas. These same groups can also be strategic partners in creating a family well-being system and championing cross-system collaboration to improve services and systems for infants, toddlers, and their families.
- **REMOVING BARRIERS TO RACIAL EQUITY, HEALTH EQUITY, AND SOCIAL JUSTICE.** Advancing the health and well-being of very young children and their families requires an awareness of the intergenerational effects of and lived experiences with institutional and interpersonal racism, as well as disparities that are pervasive throughout child and family systems, including health, early care and education, and child welfare. To begin to achieve equity and social justice for all children and families who live with historical trauma, a guiding tenet of the restoration of dignity must be woven throughout all programs. All states and communities should strive for a commitment to building systems that welcome and affirm all people and parents in honoring their lived experiences. This tenet should focus on health equity—the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Blacks, Latinos, Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.^{xi}

³ A fictive kin relationship is one that a child has with “an individual who is not related by birth, adoption, or marriage to a child, but who has an emotionally significant relationship with the child.” Source: Eger, J. J. (2022). “Legally Recognizing Fictive Kin Relationships: A Call for Action.” American Bar Association. https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january-december2022/fictivekin/.

- INFUSING A TRAUMA-RESPONSIVE APPROACH THAT SUPPORTS YOUNG CHILDREN AND FAMILIES.** An effective public health approach to family strengthening requires addressing the factors and conditions that affect families. For many families in or at risk of entering the child welfare system, this includes a parent’s own trauma history, substance use or mental health disorder, or intellectual disabilities. To create an equitable system, we must look to strategies that help build strong state and community systems oriented around positive early childhood development and strengthening parents’ ability to address their trauma and embark on a healing-centered path. By building strong and collaborative partnerships with child welfare, physical health and mental health providers, providers of substance use disorder treatment, early care and education, home visiting, attorneys, judges, families, caregivers, peer mentors, parent advocacy groups, and others, states can build a system that addresses complex trauma and healing.
- SUPPORTING EFFORTS TO BUILD AND STRENGTHEN SYSTEMS AND FOCUSING ON CROSS-SECTOR ALIGNMENT AND COLLABORATION.** A critical element of a public health approach is a continuum of services that starts with broadly based preventive interventions with an emphasis on infants and toddlers. This maximizes upstream impact and minimizes the number of families that require more intensive care and supports, with collaboration occurring within communities and states. Such system integration can enhance how families are supported before problems occur or escalate, with readily available resources being invested in needed areas and the adoption of strategies that build protective factors across the community and state.^{xii}
- ENSURING SYSTEM COMMITMENT TO CONTINUOUS QUALITY IMPROVEMENT (CQI).** Collecting, examining, and disaggregating statewide and county-level data on infant and toddler health, development, and well-being is a key first step in a system that strives for comprehensive and equitable services for all families. This commitment should extend to prioritizing regular review and discussion of policy and practice areas for their impact on disparities in child welfare. States and communities should convene stakeholders that represent the diversity of their population and develop commonly agreed upon performance measures across the state and across child- and family-serving systems. These discussions should include CQI efforts that are centered around the collection of data on infants, toddlers, and their families. Whenever possible, data should be disaggregated by key subgroups at the federal, state, and local levels. This integration of data collection and ongoing CQI must maintain a focus on equity at the core, with data interpretation occurring in partnership with those most impacted by the systems and programs being analyzed. Equally important as the accurate and consistent collection of data is a deep understanding and ongoing analysis of what the numbers reveal.^{xiii} Moreover, it is important to develop a collaborative data agenda or shared measures that link data systems and drive collaboration and partnership.^{xiv}

SECTION 1.

CREATE A CHILD AND FAMILY WELL-BEING SYSTEM THAT HELPS ALL FAMILIES THRIVE



Because the earliest years of life are a period of incredible growth, they present an opportunity to shape strong and positive development. Good health, secure and stable families, and positive early learning environments are necessary to support children’s physical, intellectual, and social–emotional development during this significant period.^{xv} When infants, toddlers, and parents have the supports and skills they need to succeed, families are stronger and more stable. This not only creates stronger and more productive communities, but also helps build the nation’s economy by empowering our future workforce.

Such a child and family well-being system exists on a continuum with different levels of need for support. The array of services and level of intensity should match the needs of the family. States and communities can identify and prioritize services for families with more significant needs based on comprehensive family screening and assessment made available to all families prenatally and to those with young children either during pediatric visits or through other community-based access points such as family resource centers. More intensive services may include mental health and substance use disorder treatment; parenting supports; maternal health; women’s health needs; and other supports that address the social determinants of health.

Policies that provide easier access to these services, including expanding eligibility and increasing outreach to populations facing multiple stressors such as food insecurity, unstable housing, and violence, can help ensure that those families with the greatest needs are identified early and supported before a crisis occurs. The service continuum should be designed by local communities and informed by families who have experience in the challenges of navigating such systems to ensure the programs and services are responsive to community needs and culturally relevant.

Building a continuum of services is an important first step, but to be effective, communities must have a structure in place to coordinate the supports and services that families need. This coordinating entity, which may look different across communities, can provide navigation services and/or case management to connect families to the relevant services and supports they need and increase their engagement in those services. Such an approach will require collaborative partnerships across child- and family-serving systems, including early care and education, infant and early childhood mental health, behavioral health, maternal and child health, housing, economic security, and child welfare.

The programs, policies, and supports discussed in this section should be made available through a two-generation approach—to all children and their parents and caregivers who can benefit from them—to support good health, secure and stable families, and positive early learning experiences. Families should have access to this continuum of services without ever having to encounter the child welfare system unless there are significant safety concerns for the child. Rather than lead these efforts,

the child welfare system can be an important partner, providing insights into the services that families may need to be successful and providing funding to build capacity outside of the child welfare system to help strengthen families and help prevent child abuse and neglect.

Research shows that increasing access to programs and supports, particularly for families facing significant stressors and adversity such as poverty, unsafe or unstable housing, or mental health problems, can provide significant benefits by reducing the need for more costly interventions in the future. These programs and supports also help families build resilience, including the capacities, resources, or skills to respond to adversity in a healthy, adaptive manner.^{xvi}

The policy recommendations included in this section highlight a subset of the most critical policies that can support the healthy development of young children and their families. For a more comprehensive list of recommended state strategies from ZERO TO THREE, see [Building for the Future: Strong Policies for Babies and Families After Covid-19](#).

The Challenge

Good health—including physical and mental health—provides the foundation for babies to develop physically, cognitively, emotionally, and socially. Access to good nutrition, affordable maternal health care, and pediatric care is essential to ensure that babies have a strong start in life. In addition, parental health is important in enabling families to provide safe, stable, nurturing environments. This includes access to care and equitable treatment from providers. Yet, in 2018, more than 1 million children under age 6 were uninsured, putting them at risk of missing out on the routine screening, growth and developmental milestone monitoring, health guidance, and immunizations they need in the early years. Furthermore, food insecurity is one of the strongest drivers of caregiver anxiety, depression, and stress in lower-income households, which presents a concern for babies and toddlers in these households.

Data from ZERO TO THREE'S State of Babies Yearbook reveals areas of concern such as the proportion of infants and toddlers in low-income families who are not insured, incidence of low birthweight, preterm births, high maternal and infant mortality rates, and the need for greater attention to the social-emotional health of both mothers and babies. Moreover, the impact of systemic racism can be seen throughout health systems: maternal mortality among Black women is more than two times higher than among White women. Babies of color are much less likely to have well-child visits than White infants and toddlers, while Black women are more than twice as likely as White women to receive late or no prenatal care.^{xvii}

Another challenge is the prevalence of substance use disorders in parents of young children. Of children under age 3 in U.S. households, 12.8 percent—or 1.5 million—had a parent with a substance use disorder, and 7.5 million lived in households with at least one parent who had an alcohol use disorder.^{xviii} Disparities in access to services to address mental health and substance use disorders and disparate treatment across maternal and pediatric care point to the health inequities that exist in the United States among mothers and babies of different races and ethnicities, geographic location, and socioeconomic status.

The infant and toddler years present a critical opportunity to promote emotional health, to prevent emotional disturbances from taking root, and to treat mental health problems before they can manifest into more severe problems later in life. While mental health has received increased attention in recent years across states, the services provided across mental health systems are mainly designed for older children. It is critical that infant and early childhood mental health (IECMH)—a key foundation of all future development—is understood across systems in the context of family, community, and culture. While social and emotional well-being can be promoted across all systems that touch the lives of families with young children, many states lack the capacity to identify and diagnose early mental health issues, which is compounded by the lack of clinical workforce capacity to diagnose and treat infants, toddlers, and their families.

The Opportunity

Pediatric primary care provides an opportunity to reach almost every baby, toddler, and young child in the nation. Strategies such as adding a child development specialist to the primary care team and ensuring that children have access to a medical home are other cost-effective approaches to improving the overall health of children and their families. The opportunity exists for states to establish comprehensive and coordinated service systems that are developmentally

focused, trauma-informed, culturally relevant, and family-oriented. This service system should focus first and foremost on preventive care. The cost to care for children is very small compared with the financial and societal costs of forgoing prevention, which may expose children to serious health, mental health, and behavioral health issues down the road. To promote optimal health, a two-generation approach recognizes and addresses the needs of a family holistically, supporting young children and their parents and caregivers. This includes areas that have largely been overlooked but impact families and communities, such as screening for interpersonal violence and paternal postpartum depression.

Medicaid, together with the Children’s Health Insurance Program (CHIP), covers about 45 percent of children under 6 years old and almost three-quarters of young children living in or near poverty.^{xix} While the federal government sets a basic floor for Medicaid coverage, states play a critical role in determining whom they will cover and the types of services that may be reimbursed. States that have adopted Medicaid expansion have seen a greater decline in uninsured low-income children. Insured parents, particularly those now covered by Medicaid, have access to much-needed health care, including medical services, substance use disorder treatment services, and mental health services, which help provide a safe and nurturing home for their children. Even states that have not adopted Medicaid expansion can still expand eligibility for families and access to services, including extending coverage past the required 60 days postpartum, ideally up to 12 months.

Good nutrition is an important part of a healthy lifestyle for both children and parents because it improves the ability to grow and develop, as well as to achieve and maintain a healthy weight. Eating nutritious foods provides pregnant women and children the nutrients they need to stay healthy, active, and strong. Increasing participation of eligible families in federal nutrition programs including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)^{xx} and the Supplemental Nutrition Assistance Program (SNAP)^{xxi} can reduce food insecurity and ensure that babies receive the nourishment and care they need for a strong start in life. Nutrition assistance programs like SNAP and WIC can make a significant impact in reducing food insecurity; increasing access to and availability of these programs helps people purchase healthy food they might not otherwise be able to afford, thereby increasing healthy eating. Beyond the ability to purchase food, WIC also provides nutrition education, breastfeeding support, and referrals to health care and social services for millions of families—playing a crucial role in improving the lifetime health of women and young children.

American Rescue Plan Act, passed in March 2021, provided one-time funding and other opportunities to support the health and well-being of infants, toddlers, and their families. One important provision in the law is the option for states to extend Medicaid and CHIP postpartum coverage to 12 months, while states that have not adopted Medicaid expansion can now receive incentives to do so. States can also specify in their Medicaid plans that multigenerational mental health therapies for babies and caregivers are covered based on the children’s eligibility.^{xxii}

Research and Best Practice

Research finds that infants and toddlers with access to health coverage are more likely than their uninsured peers to see a doctor regularly and receive preventive health care and treatments. Studies show that Medicaid enrollment during childhood is associated with better health in adulthood.^{xxiii} Healthy parents are more likely to have healthy children, underscoring the need for parents to have access to affordable health care. Medicaid pays for nearly one-half of all births in the country, covering a full range of services for children after birth—from essential screenings to critical treatment—and is critical in helping to identify and provide treatment for developmen-

tal disabilities in children.^{xxiv} Nearly one-half of children under age 3 receive medical coverage through Medicaid, and those covered have better long-term health, educational, and employment outcomes than those who are uninsured. Medicaid expansion has improved parents' access to care, and it has been associated with lower rates of infant mortality in states that adopted the policy.^{xxv}

Studies have also found that pregnant women with Medicaid are more likely to report a substance use disorder (SUD), as well as more likely to receive SUD treatment than women with other forms of coverage.^{xxvi} Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program can be used in some states to cover maternal depression screening and substance use disorder treatment for qualifying pregnant women. Medicaid expansion has been shown to improve preconception and prenatal care, including increased use of folic acid supplements, critical health screenings, and mental health services.^{xxvii}

Access to IECMH services, including maternal depression screening and interventions such as dyadic therapy like Child-Parent Psychotherapy, which involves treatment delivered to a parent and child simultaneously to support the parent-child relationship, can detect mental health problems, or prevent them from taking root. Across the U.S., 37 states require, recommend, or allow maternal depression screening during well-child visits. Medicaid covers social-emotional screening for babies in 43 states, as well as IECMH services at home in 49 states, in medical settings in 46 states, and in early childhood education settings in 34 states.^{xxviii}

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Provide health insurance for all families by adopting Medicaid expansion under the Affordable Care Act.** Children's health and well-being relies on having healthy caregivers, and research shows that insurance coverage improves access to health care while also improving the financial stability of the entire family. To date, 39 states have adopted Medicaid expansion under the Affordable Care Act.^{xxix}
- **Extend Medicaid coverage to 12 months postpartum for mothers and provide continuous enrollment for all children until 3 years old.** This would ensure that parents receive coverage for a minimum of one year after giving birth. State Medicaid infrastructure and delivery systems, in close partnership with public health agencies, are well-positioned to encourage promising, innovative practices while monitoring quality and specifying the qualifications and requirements necessary for providers.
- **Provide a comprehensive array of screening, diagnostic, treatment, and support services to families with very young children who are covered by Medicaid.** Medicaid coverage of dyadic treatment, in which the infant or young child and parent are treated together, can also help improve parenting and the parent-child relationship.
- **Provide a central medical home for all infants and toddlers to connect families with an expanded care team that can identify and address areas outside of the traditional pediatric scope.** Providing a central medical home can help ensure children receive coordinated health care that encompasses the entire family. Research shows that children with special health care needs in particular receive more timely and thorough care when they are connected to a medical home.^{xxx}

- **Promote continuous and coordinated preventive primary health care for infants and toddlers following the American Academy of Pediatrics Bright Futures guidelines for universal screening.** Bright Futures guidelines can be incorporated into many public health programs, including home visiting, childcare, and child welfare systems. States can implement models such as ZERO TO THREE'S HealthySteps program, which incorporates a child development specialist in pediatric primary care into their maternal and child health approaches, using financing strategies such as Medicaid to sustain the approach.^{xxxii}
- **Strengthen integration of community services so families can receive screenings, assessments, and referrals to appropriate services when needed,** including for perinatal depression, perinatal mood and anxiety disorders, behavioral health, interpersonal violence, and the social determinants of health.
- **Increase availability of family-based substance use disorder treatment services for mothers and fathers of infants and toddlers, including residential family-centered SUD treatment settings.** A family-centered approach to SUD treatment provides a comprehensive array of clinical treatment and related support services that meet the needs of each member in the family, not just of the individual requesting care. While the length of services, type of setting (e.g., residential or outpatient), and program size may vary, it is critical to have a consistent process in place for assessment and referral so that parents are fully supported in their parenting roles and that children receive the necessary services and supports to remain with their parent(s) during the treatment and recovery process.^{xxxiii} Options may include intensive home-based SUD treatment, which can provide the long-term stabilization and support necessary for families based on lengths of time needed for the brain to heal from more chronic substance use.
- **Expand Medicaid coverage to include substance use disorder treatment as a required benefit for Medicaid-eligible adults.** States should develop policies to ensure that service-level medical necessity criteria for mental health are aligned with the DC:0-5™ manual^{xxxiii} and the needs of very young children. Young children and their families should have access to behavioral health screening, diagnostic assessment, and parent–child dyadic treatment, as these services align with the intent of EPSDT.
- **Expand the state definition of “medically necessary service” under Medicaid to cover the provision of mental health preventive and early intervention services to infants, toddlers, and their families, including services that strengthen parent–child relationships.** When revising or expanding their parameters for medical necessity under EPSDT, states should consider including critical services that are currently state options and not federal requirements, such as behavioral health screening, diagnostic assessment, and parent–child dyadic treatment.
- **Strengthen mental health services for babies and their families by building a workforce that understands IECMH and is prepared to identify situations that threaten children’s healthy emotional development and by increasing access to IECMH and perinatal mental health services.** States can adopt policies through Medicaid, such as covering maternal depression screening in well-child visits, social–emotional screening of infants and toddlers, and delivery of IECMH services in various settings (e.g., early intervention, childcare, child welfare, primary care, and home visiting).
- **Increase participation in nutrition programs, including WIC and SNAP, by increasing outreach to eligible families, facilitating enrollment through efforts such as streamlined enrollment forms and online enrollment, and expanding eligibility.** The American Rescue Plan Act provides additional funding to states to administer the SNAP and WIC programs, while the U.S. Department of Agriculture has provided additional guidance for states to make investments in their business processes and improve their technology to increase access for families of both SNAP and WIC.^{xxxiv}

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on [page 72](#).

- The role that Medicaid can play in reducing racial disparities in maternal and infant health is demonstrated in initiatives such as [North Carolina's Pregnancy Medical Home Program](#), a partnership between state Medicaid, Community Care of North Carolina, and the state Division of Public Health. This program provides participating health care providers with incentives to complete a pregnancy risk screening on all Medicaid-eligible pregnant women. The risk screening responses are run through a risk stratification model to generate a Maternal Infant Impactability Score™ (MIIS) that is shared with the pregnancy care manager from the local public health department. The MIIS indicates level of risk and prescribes what frequency of care management contact is needed to impact outcomes. The Pregnancy Care Manager coordinates the woman's care and works to reduce social determinants of health (SDOH) needs throughout the pregnancy.
- [New Jersey's statewide Maternal Wraparound Program \(MWRAP\)](#) provides intensive case management and recovery support services for pregnant women with substance use disorders during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women and their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The overall goal of MWRAP is to alleviate barriers to services through comprehensive care coordination that is implemented within the five major time frames when intervention in the life of a substance-exposed infant (SEI) can reduce the potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal, and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure.
- The [ZERO TO THREE HealthySteps](#) evidence-based model embeds a child developmental expert, the HealthySteps Specialist, into primary care practice to meet families' individual needs. The specialist joins the care team to promote nurturing parenting, which improves babies' and toddlers' healthy development and well-being where they are most likely to be—the pediatric primary care office.

For enhanced primary care models like HealthySteps, expanding the care team to include a child development expert enables the practice to focus on the child, the caregiver, and the child-caregiver dyad. The HealthySteps national network includes more than 200 sites in 26 states and Washington, DC.^{xxxv} This national, innovative, and low-cost approach is designed based on scientific understandings of how early childhood development works and how to best support early relational health.

- [Developmental Understanding and Legal Collaboration for Everyone \(DULCE\)](#) is a universal, evidence-based pediatric care approach with a foundational goal of reducing the risk of maltreatment and contact with child welfare. It does so by screening for health-related social needs for individual families, addressing social determinants of health gleaned through patterns across families, supporting early relational health, and providing a legal partner for families with infants in communities that are under-resourced and often marginalized by racist systems. By utilizing community health workers with lived experience, accelerating access to justice, and connecting families with concrete supports and resources, DULCE aims to address inequitable systems that preclude families from living healthy lives.^{xxxvi}

- The [Illinois Children’s Mental Health Partnership \(ICMHP\)](#) has developed a unified model for infant and early childhood mental health consultation in the state. This model is a multi-level, proactive approach that pairs multidisciplinary IECMH professionals with individuals who work with young children and their families to support and enhance children’s social and emotional development, health, and well-being.^{xxxvii}
- Federal law allows states flexibility to adopt policies that make it easier for families to apply for or continue receiving WIC benefits. For the past several years, the Center for Budget and Policy Priorities has provided technical assistance to state and local WIC agencies across the country to modernize and simplify enrollment to reach more eligible low-income families. For example, the [Maricopa County, Arizona](#) WIC sought to improve its enrollment process by establishing a single public phone number for all county WIC sites, building an online appointment request option, and expanding options for providing electronic records to document eligibility.^{xxxviii}

KEY DATA TO COLLECT⁴

- Race/ethnicity of uninsured infants and toddlers
- Receipt of prenatal care
- Infant mortality rate
- Births paid for by Medicaid
- Percent of infants and toddlers with a pediatric medical home
- Children referred to specialists for follow-up care in response to screening results
- Children referred who receive the recommended services
- Average length of time between when a referral is made and when services begin
- State Medicaid policy around screening for maternal depression and perinatal mood and anxiety disorders
- State Medicaid policy around developmental screening for young children
- State Medicaid policy around social–emotional screening for young children
- State Medicaid policy around covering IECMH services at home, at pediatric/family medicine practices, and in early childhood settings
- Number of infant and early childhood mental health specialists
- State policy includes “at-risk” children as eligible for Individuals with Disabilities Education Act (IDEA) Part C services or reports that they serve “at-risk” children
- Screened-in infants with prenatal substance exposure and their caregivers who have a Plan of Safe Care
- Screened-in infants with prenatal substance exposure and their caregivers who have a referral to appropriate services

⁴ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

KEY RESOURCES

- ZERO TO THREE, [State of Babies Yearbook: 2022](#)
- ZERO TO THREE, [Maternal and Child Health Inequities Emerge Even Before Birth—State of Babies Yearbook: 2020](#)
- Brown, E. C. B., Garrison, M. M., Bao, H., Qu, P., Jenny, C., & Rowhani-Rahbar, A. (2019). [Assessment of Rates of Child Maltreatment in States with Medicaid Expansion vs States without Medicaid Expansion](#). JAMA Network Open.
- American Academy of Pediatrics, [Screening Technical Assistance and Resource \(STAR\) Center](#)
- CLASP. (2014). [First Steps for Early Success: State Strategies to Support Developmental Screening in Early Childhood Settings](#).
- HHS Office of Early Childhood Development, [Birth to 5: Watch Me Thrive!](#)
- [Help Me Grow National Center](#)
- [ZERO TO THREE HealthySteps](#)
- [Association of Maternal & Child Health Programs](#)
- Centers for Medicare & Medicaid Services, [Improving Access to Maternal Health Care in Rural Communities](#)

The Challenge

Young children develop in the context of their families, where stability and supportive relationships best nurture their growth. Family stability is secured by having enough income to meet family needs, time to nurture family bonds and provide caregiving, safe neighborhoods where children can grow and play, and the ability to meet basic needs such as stable housing, food and nutrition, and even diaper supplies. Due to deep and longstanding economic inequality in America, including disparities in wealth due to structural racism, many babies and toddlers live in families that struggle to meet all their needs. As noted in the 2021 State of Babies Yearbook, many families with young children continue to experience high rates of crowded and unsafe housing, food insecurity, and exposure to adverse experiences.

Many outcomes are worse for families of color who, due to legacies of systemic and institutional racism, often face the most significant barriers to family and child well-being and secure environments. Infants and toddlers of color are more likely to live in neighborhoods their parents characterize as unsafe, to experience housing instability (i.e., crowded homes and frequent moves), and to have been exposed to one or more potentially traumatic experiences. Nearly 3 million children under age 3—23 percent of all infants and toddlers—are members of an immigrant family, and 83 percent of those children are children of color.

In addition to the structural barriers that confront other children of color, children in immigrant families face unique systemic challenges tied to their parents' immigration status. Under threat of deportation, immigrant families may become increasingly socially isolated, as well as more likely to not participate in public programs and services, which can lead to increased financial and material hardship.^{xxxix} As a result, infants and toddlers may lose out on health care services, early care and education experiences, and opportunities to build protective factors. Parents may experience greater levels of fear, stress, and anxiety, which is passed on to infants and toddlers and can impact their cognitive and emotional development.^{xi}

The Opportunity

All families benefit from parenting supports, and many—particularly those challenged by economic instability—can benefit from access to additional resources that help them meet their children's needs. Key supports may include home visiting services, paid sick leave, paid family and medical leave, income support through tax credits or direct cash payments, employment assistance and training, housing assistance, and nutrition supports. While addressing the needs of all families is the primary goal of an effective system, these types of supports can also help reduce the risk of maltreatment and neglect by building protective factors that help parents find resources, supports, or coping strategies enabling them to parent effectively, even under stress.

States play a key role in determining the extent to which supports for basic needs are available and accessible to families that need them. For example, 30 states provide families with a state Earned Income Tax Credit (EITC) in addition to the federal EITC to help boost families' incomes. Six states offer families a Child Tax Credit to help offset the cost of raising a child, augmenting the federal Child Tax Credit. Ten states have enacted state Paid Family and Medical Leave (PFML) policies, which research has demonstrated are associated with reduced infant and post-neonatal mortality rates.^{xii} And many states have implemented strategies to make it easier for families to access these valuable benefits or services, such as through coordinating enrollment across public programs, expanding eligibility, co-locating services, and other efforts to create "no wrong door" policies.

The American Rescue Plan Act (ARPA) enhanced both the Earned Income Tax Credit and the Child Tax Credit, both of which are significant for young children and lifting families out of poverty. The Child Tax Credit enhancement, which provides a fully refundable credit of \$3,600 per young child, is estimated to have cut child poverty in half.^{xliii} The expansion is estimated to reach 27 million children—including roughly one-half of all Black and Latino children—whose families previously did not get the full credit because their parents failed to earn sufficient income.^{xliii} The enhanced Child Tax Credit was only funded for one year, but with support from Congress it could potentially become permanent. Another key feature of the enhanced credit was its refundability, meaning that families with no income could still receive this important economic support. Improving the economic status of young children is associated with improvement in their immediate well-being, as well as the benefits of better health, education, employment, and earnings as adults. Other key programs supporting strong families that received significant funding increases through ARPA include the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Supplemental Nutrition Assistance Program (SNAP).

Children’s and families’ needs are multifaceted, often cutting across multiple program areas such as nutrition, economic needs, and housing, among others. Policymakers must consider how decisions in one area may have implications for families’ ability to use programs or services in another. These considerations should focus on strengthening cross-system coordination so that policies and programs are aligned with what families need and that high-quality services are accessible to more children and families.

To be effective, these systems should be community-based, informed by parents with lived experience, and have clearly defined entry points for families to access a comprehensive array of services and supports that can support their children’s development, meet basic needs, promote economic security, and support their emotional well-being. Approaches for delivering these services can include family resource centers, home visiting, primary care–based support, and other resource hubs.

Research and Best Practice

Young children’s healthy development is directly impacted by the social and physical environment in which their families live and whether that environment enables parents to provide nurturing care. Research shows that programs that address the social determinants of health can significantly improve individual outcomes across a range of domains, including health, education, and well-being.

Research also indicates that adequate income in the early years can boost positive development, with long-term impacts on adult earnings. Tax credits for families with low income have led to increased earnings, resulting in improved maternal and infant health outcomes.^{xliv}

Despite high rates of employment, parents of young children are more likely to live in poverty than adults without children or adults with school-age children. Two key federal tax credits provide income support to low-income working parents: the EITC and the Federal Child Tax Credit (CTC). The effects of both tax credits are particularly significant for young children and in helping lift families out of poverty. Improving the economic status of young children is associated with improvement in their immediate well-being, as well as the benefits of better health, education, employment, and earnings as adults.^{xlv}

Research also shows that meeting the economic and concrete needs of families leads to safer environments for children to live in and reduces the need for child welfare involvement.^{xlvi} Receipt of Temporary Assistance for Needy Families (TANF) benefits, enrollment in Medicaid, and receipt of nutrition benefits through WIC have also been tied to reduced reports of child abuse and neglect in families, among other benefits.^{xlvii}

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Expand economic security policies, including increasing the minimum wage, EITC, and CTC to help low-income families provide a strong foundation for their children, starting at birth.** Many babies live in families where parents and caregivers work full-time or more than one job and still fall into the low-income category; some of these families remain below the federal poverty line despite their work effort. While federal efforts to raise the minimum wage have been limited to date, many states and localities have raised their minimum wage. Since 2012, nine states representing approximately 40 percent of the U.S. workforce have approved raising their minimum wage to \$15 an hour, with 10 additional states approving minimum wages ranging from \$12 to \$14.75 an hour.^{xlviii} States can also supplement the EITC and CTC through a parallel state tax credit that provides additional support to help lift families out of poverty. In addition, making the CTC refundable would allow families with very low or no income to benefit from the policy.
- **Provide enhanced support for basic needs, including providing greater ongoing investments through food programs, housing assistance, and essentials such as diapers to help families create stable environments for their young children.** Many families with young children and very low income can benefit from family income supports available through the Temporary Assistance for Needy Families (TANF) program. Additional income can help families meet their young children's basic needs, such as diapers, and improves the ability to pay for gas and other transportation-related needs that can affect employment. Yet, slightly more than one in five (21.7 percent) families with infants and toddlers living in poverty received income-based TANF benefits. Wide variation exists across states in the proportion of families in poverty with a child under age 3 that receive TANF benefits—reflecting the different emphasis states place on using TANF funds for income support. For example, 42 states transfer \$2.6 billion in state and federal TANF funding to support child welfare efforts, primarily to pay for foster care payments.^{xlix} States may be able to redirect some of this funding to basic assistance and/or to other programs such as childcare subsidies that can help strengthen families and prevent child welfare involvement. Just under one-half of all states (24) have implemented policies that exempt single-parent heads of households from TANF work-related requirements if they are caring for a child under 12 months of age—which means that more than 50 percent do not have this policy.^l Given concerns about the overall quality of infant toddler care, this is another area that states can pursue.
- **Enact family-oriented workplace policies including paid family and medical leave, paid sick days, and fair work schedule policies as equitable ways to support all families.** Comprehensive paid family and medical leave promotes bonding between parents and babies and enables workers to care for their own and family members' extended health needs. A comprehensive policy on paid sick days would allow all workers to earn time to address short-term care needs for themselves or their ill child or family member, and to obtain preventive care.^{li} In the absence of national paid leave policies, some states have created their own initiatives. If national policies are eventually enacted, states can work to provide enhanced benefits to families.
- **Create a continuum of parent support services and resources, including child development specialists in pediatric settings, home visiting, and family resource centers.** Parenting support is a method of encouraging and reinforcing families, particularly as part of a comprehensive and coordinated system of services. These voluntary services are most effective when they are tailored to meet the needs of individual families and offer information, guidance, and support. For example, ongoing home visiting services provided directly in the home can help to

identify the strengths and risks of each family and help families connect to local resources and supports. Primary care–based parenting supports, Family Resource Centers, and WIC sites are other mechanisms that can deliver such services. In addition, some communities are working to build in widespread approaches, including universal access to newborn home visits and developmental specialists embedded in pediatric practices across the community.

- **Align eligibility requirements and coordinate enrollment processes for federal assistance programs, such as Medicaid, CHIP, TANF, SNAP, the Child Care and Development Fund (CCDF), and WIC—where federal flexibility allows—to increase access to benefits for eligible families.** Families with young children often must navigate complex, duplicative, and burdensome systems and requirements to access public assistance and other programs. When states coordinate enrollment or re-enrollment in federal assistance programs, and create presumptive eligibility pathways, they can make it easier for families to access services regardless of where they seek assistance. Examples of programs where enrollment could be coordinated include Medicaid, CHIP, early learning programs, nutrition education and support programs such as SNAP and WIC, and other means-tested programs such as TANF.^{lii}
- **Create medical–legal partnerships to help families resolve legal issues that impede good health.** Medical–legal partnerships bring the expertise of attorneys into health care settings to help clinicians, case managers, and social workers better understand and screen patients for health-related social needs, navigate systems and policy barriers, and work to address problems that would likely result in significant health issues if otherwise left unattended. For example, attorneys can help families by working on issues related to denial of public benefits, eviction, clearance of criminal or credit histories that may restrict access to public benefits, and protection against cutting off utilities. Medical–legal partnerships can be considered an “enabling service,” meaning that health centers can use federal dollars to pay for legal assistance for patients.^{liii}

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on [page 74](#).

- Ten states have enacted state Paid Family and Medical Leave (PFML) policies. **California’s** statewide paid family leave program, in effect since 2004, is associated with improved health outcomes for children in early elementary school, including reduced issues with maintaining a healthy weight, attention-deficit/hyperactivity disorder, and hearing-related problems, particularly for less-advantaged children, likely because of reduced prenatal stress, increased breastfeeding, and increased parental care during infancy. **Washington State** enacted its policy in 2017, offering 12 weeks for both family leave and personal health leave, with up to 18 weeks of leave per year available in some cases. The policy is funded through premiums paid by employers and workers in the form of paycheck withholdings. All employers in the state must either participate in the state program or offer equivalent benefits. **Maryland’s** paid family and medical leave, passed in 2022, provides up to 12 weeks of leave with partial wage replacement when workers or their loved ones are seriously ill, when welcoming a new child (for parents of any gender, including foster and adoptive parents), or to address the impact of military deployment, allowing up to 24 weeks in special circumstances.
- Early childhood and parent support programs in **New Jersey** have long understood the importance of working together to ensure families receive the services they need to thrive. One way this has been actualized is through the creation of central intake hubs, or Family Success Centers (FSCs), to systematize the process for screening, referring, and connecting families to services. As of 2015, each of New Jersey’s 21 counties has at least one FSC, providing

a single point of entry for families to access information about and referrals to a wide range of community services that promote child and family wellness, including parenting support, prenatal care, early care and education, nutrition support, education activities, Part C early intervention, housing, primary care, mental health, and substance use disorder treatment.^{lv}

- **Arapahoe County, Colorado** has rethought how it provides human services to incorporate a two-generation approach. A key aspect of doing so has been strengthening connections between county departments and the programs they offer so that families do not need to navigate a fragmented system. One very tangible way the county has done this is by creating a comprehensive resource directory with information about a variety of parent- and child-focused community-based services. Other strategies that counties are employing include co-locating adult- and child-oriented services, merging county departments for social services and housing to provide more holistic family support services, and incorporating screening for social determinants of health into existing programs.^{lv}
- The **Colorado** General Assembly established Family Resource Centers (FRCs) in 1993 to serve as a “single point of entry for providing comprehensive, intensive, integrated, and collaborative community-based services for vulnerable families, individuals, children, and youth” in local communities. Between July 2020 and May 2021, FRCs provided more than 166,000 services, most frequently in the areas of basic needs and parenting. Families demonstrated significant improvements in economic self-sufficiency, health, concrete support in times of need, social support, and family functioning and resiliency both before and after the onset of COVID-19, suggesting that FRCs provided resources and support to buffer families through the hardships of the global pandemic.
- In **Washington State**, the Family Intervention Response to Stop Trauma (FIRST) Legal Clinic is a medical–legal partnership that provides preventative legal advocacy to parents of infants at risk of child protective services (CPS) removal. FIRST Legal Clinic works directly with pregnant persons and parents of newborns to develop plans of safe care for their children to eliminate the need for removal. Referrals come from a variety of sources, including local hospitals, substance use disorder treatment programs, parent advocacy programs, the child welfare agency itself, doulas, midwives, law enforcement, and others. FIRST Legal Clinic endeavors to work with clients as early as possible, including early in the pregnancy, to forgo any child welfare agency involvement at all. The legal clinic model utilizes an attorney to work with the parent and an experienced, trained parent ally with lived experience as a resource navigator. The legal clinic connects clients with existing resources such as housing, substance use disorder treatment, public health nurses, the Parent–Child Assistance Program and parent advocacy programs, domestic violence services, and others.

KEY DATA TO COLLECT⁵

- Poverty status of infants/toddlers and parents
- Legal status of parent
- Language barriers
- TANF benefit receipt among families in poverty
- Housing data (instability, crowded housing, unsafe neighborhoods)
- Public health data (e.g., environmental hazards and water quality)
- Rates of homelessness among parents, children, and youth
- State policies on paid family leave

KEY RESOURCES

- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, [Social Determinants of Health – Healthy People 2030](#)
- Center on Poverty and Social Policy at Columbia University. (2021). [The Potential Poverty Reduction Effect of the American Rescue Plan](#).
- The National Academies of Sciences, Engineering, and Medicine. (2019). [A Roadmap to Reducing Child Poverty](#). Washington, DC: The National Academies Press.
- U.S. Department of Health and Human Services and U.S. Department of Education, [Policy Statement to Support the Alignment of Health and Early Learning Systems](#)
- ZERO TO THREE and the Center for Law and Social Policy, [Pathways to Prosperity: Report from a Convening on Economic Security for Families With Infants and Toddlers](#)

⁵ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

The Challenge

Infants and toddlers learn through interactions with the significant adults in their lives, and the quality of their early learning experiences, both at home and in other care settings, can impact their cognitive and social–emotional development, as well as early literacy. As a nation, we are falling short in our efforts to support all families to ensure their babies’ foundational development is on track. For example, fewer than one-half of babies are read to every day, less than one-third receive developmental screening, and only a handful of eligible babies and toddlers benefit from Early Head Start’s comprehensive support for parenting and early development.^{lvi}

The extent to which states support families in accessing and affording early care and learning opportunities varies significantly. Low-income children in particular can benefit from high-quality early care and learning opportunities, but they are less likely to have access to such programs and care settings. This includes experiences within a wide range of provider settings and types, including centers, family childcare homes, relatives, and faith-based providers. Childcare costs can account for more than one-third of a single parent’s paycheck in most states, yet few families receive financial assistance for this critical support.

The pandemic has profoundly impacted the childcare system—with thousands of childcare centers closing across the country and even more providers losing money or going into debt to remain open to serve their communities, even as temporary pandemic relief funds have prevented a broader collapse of the sector. These challenges have made it even more important for states to invest in high-quality care services that are accessible and affordable for all families, particularly those with low and moderate income, as well as to appropriately compensate and support the childcare workforce.

Early identification of developmental delays and participation in intervention services are also critical during the rapid growth period that babies experience during their first three years. A key tool for identifying young children with developmental delays is a developmental screening. If a screening tool indicates that a child may have such a delay, the family is referred for an evaluation to determine whether they are eligible to receive early intervention services under Individuals with Disabilities Education Act (IDEA) Part C.

In 2020, only 3 out of 10 (32.5%) children ages 9 months through 35 months received a developmental screening, and only seven percent of infants and toddlers with disabilities from birth to 2 years old received early intervention services under IDEA Part C, due in part to state restrictions on who is eligible for services. State Part C Early Intervention systems face significant challenges, including insufficient state and federal funding to meet the demand for services for infants and toddlers. This has led states to create narrow eligibility requirements and low provider reimbursement rates, both of which have resulted in fewer children receiving needed services.^{lvii}

The Opportunity

The quality of babies’ early learning experiences has a lasting effect on their preparedness for lifelong learning and success. States have a significant role in determining the quality of those early experiences and in determining the extent to which all families who need supports can receive them, particularly related to babies of color and those from low- income families. For example, Infants and toddlers in families with incomes below the federal poverty level (FPL) are eligible for Early Head Start (EHS), which provides comprehensive services that promote positive child

development. However, only 11 percent of eligible infants and toddlers have access to EHS services—and access varies widely across states.^{lviii} Despite the program’s proven ability to lessen the negative effects of poverty, consistently low levels of federal funding and increasing child poverty have kept EHS’s capacity low. States can take the lead in intensifying efforts to make this proven program available to many more infants and toddlers.^{lix}

The extent to which states support families in accessing and affording early care and learning opportunities also varies significantly by state. Families with incomes above 200 percent of the FPL—approximately \$50,000 for a family of four— are eligible for childcare subsidies in just 13 states. And only 4.2 percent of infants and toddlers in low- or moderate-income families (i.e., incomes equal to or below 150 percent of the State Median Income) receive subsidies.

The American Rescue Plan Act (ARPA) included significant one-time federal funding to help states address inequities in early childhood learning, strengthen the childcare industry, and address key issues including equitable compensation and benefits for early childhood education providers. Federal funding for the COVID-19 childcare relief and stabilization fund provided states with resources to offer immediate grants to childcare providers struggling to stay open. Federal funding increases through the Child Care Development Block Grant also provide states opportunities to serve significantly more families with low incomes through subsidized childcare.^{lx} These investments give states an opportunity to strengthen their childcare system, including raising reimbursement rates to ensure providers have the resources they need to continue serving families safely and effectively, while also supporting increased pay and benefits for early childhood educators—as well as increasing access to high-quality childcare for more low-income families.

States can make significant improvements to their early childhood education systems through the way they define what constitutes quality care for infants and toddlers and the requirements for staff education and qualifications. For example, only six states require teachers of infants and toddlers to have either a Child Development Associate (CDA) credential or state equivalent and a vast majority—45 states—require no credential beyond a high school diploma. States can also use existing coordinating structures, such as Early Childhood Advisory Councils or Children’s Cabinets, to help coordinate disparate programs, align program eligibility requirements to make it easier for parents to access services, and create shared goals.

Providing developmental and behavioral screenings, ideally as part of a comprehensive screening for families, is another important strategy that can help identify young children with developmental delays and other risks who need additional support early (see Policy #1 for more information on broad-based screening and assessment). Developmental screening works best when it is embedded in a system that holistically understands and supports families—including through screening and supports for perinatal depression, behavioral health, interpersonal violence, and the social determinants of health^{lxi}—and coordinates across service settings and family members.

Implementing early screening and following up with early intervention services, such as speech–language therapy, occupational therapy, and physical therapy, can lead to more effective and less expensive treatment during the preschool years and reduced future health and special education costs later in childhood. Children who receive a developmental screening are more likely to have delays identified, be referred for early intervention, and be determined eligible for early intervention services. States can implement a variety of strategies to reach more children and make it easier for families to access these services, particularly families of color, including providing universal screening for families and increasing investment in Child Find systems—the legal mandate that requires states to identify all children who are eligible for early intervention services.

Research and Best Practice

Language and literacy skills begin developing at birth and are fostered through the relationships a young child has with significant adults in his or her life. Long before they can read, infants and toddlers develop literacy skills and an awareness of language. Because language development is fundamental to many areas of learning, skills developed early in life help set the stage for later school success. By reading aloud to their young children, parents help them acquire the skills they will need to be ready for school. Young children who are regularly read to have a larger vocabulary; higher levels of phonological, letter name, and sound awareness; and better success at decoding words. At age 16 months to 18 months, when children begin amassing vocabulary, word learning is significantly affected by economic background. By the age of 3, trends in the amount of talk, vocabulary growth, and style of interaction are well established.^{lxii}

Second only to the early learning experience within the immediate family, childcare is the context in which early childhood development most frequently unfolds, starting in infancy. Parents of children under age 3 are more likely to use informal childcare (provided by friends, family, or neighbors) than formal childcare. The federal Early Head Start (EHS) program—which is for children younger than 3 years old and includes center-based, home-based, or family childcare services—was created to help minimize the disparities caused by poverty by supporting the healthy development of expectant mothers and low-income infants and toddlers. Research has found that children enrolled in EHS had better cognitive and language development and exhibited less aggressive behavior than children not enrolled in EHS. Further, parents involved in the program were more emotionally supportive, provided more language and learning stimulation, and read to their children more often than non-enrolled parents. Other research has shown that children who participated in EHS had significantly fewer child welfare encounters between the ages of 5 and 9 than comparable children.^{lxiii}

Developmental screening as part of a comprehensive screening for families is an efficient, cost-effective way to identify potential health or behavioral problems. Children who receive a developmental screening are more likely to have delays identified, be referred for early intervention, and be determined eligible for early intervention services. For this reason, the American Academy of Pediatrics recommends that children receive developmental screening from their physicians at least three times before their third birthday.

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Leverage existing interagency coordinating structures such as State Advisory Councils (SACs) on Early Childhood Education and Care or Children’s Cabinets to align and enhance health and early learning systems in the state.** Coordination and alignment between health and early learning systems can help promote important statewide goals such as improving healthy development, early learning, and the well-being of children.^{lxiv} Interagency coordinating structures that are focused on early childhood already exist in most states and could potentially take on this role. For example, governor-led SACs that exist in many states with the aim of developing high-quality, comprehensive systems of early childhood development and care for children include representatives from early childhood health, mental health, and education programs. Other examples of statewide and local coordinating bodies that could play a similar role in improving service coordination include the Health Resources and Services Administration’s (HRSA) Early Childhood Comprehensive Systems (ECCS) grants and State Interagency Coordinating Councils (called Early Intervention Coordinating Councils in some states) that work in conjunction with IDEA Part C. States can leverage the ongoing work of these councils to identify ways to support the types of prevention services discussed in this report and develop coordinated policies to strengthen these efforts.

- **Ensure that low-income families with infants and toddlers can afford safe, stable, high-quality childcare by working to ensure all eligible children and families have access to childcare subsidies.** Other policies that states can implement to help improve overall quality include setting adult/child ratios that meet or exceed the standards set by Early Head Start (one adult for every four infants and toddlers); setting group size requirements that meet or exceed the standards set by Early Head Start (eight infants or toddlers in a group); requiring teachers of infants and toddlers to have either a Child Development Associate (CDA) credential or state equivalent; and ensuring that reimbursement rates for childcare subsidies are set at a level that guarantees adequate compensation for early educators and allows families receiving subsidies to access high-quality care.
- **Increase state investment in infant-toddler childcare to reach more families while also improving quality.** Early childhood education programs frequently struggle to provide affordable high-quality infant-toddler childcare in part because the low child–teacher ratios required to support safe and responsive care for this age group come with significantly higher staffing costs. While expanding eligibility requirements to include more low-income families is important, states will need to invest more public resources in infant and toddler care to feasibly serve more families, given the lack of available infant-toddler care in most states. Strategies include providing higher reimbursement rates for infants and toddlers, startup grants for providers who will serve babies, contracting directly with infant-toddler care providers, and investing in high-quality family childcare programs, including both formal home-based programs and informal family, friend, and neighbor care.
- **Train early childhood professionals in trauma and trauma-responsive techniques.** Many early childhood educators work with young children who have experienced trauma. According to the National Trauma Child Stress Network, one out of every four children attending school has been exposed to a traumatic event that can affect learning and/or behavior.^{lxv} Research demonstrates that all types of trauma can impede children’s abilities to learn, create healthy attachments, form supportive relationships, and follow classroom expectations. States can invest in training that builds the skills of childhood professionals so that they are prepared to meet the needs of children who have experienced trauma.
- **Increase access for eligible pregnant people and families who participate in comprehensive early childhood services through Early Head Start.** Given the low enrollment rates of eligible families throughout the country, states should invest in expanding Early Head Start (EHS) to reach significantly more eligible infants and toddlers while prioritizing the enrollment of significantly more pregnant women. States can invest in expanding EHS, or other comprehensive programs modeled after EHS, as a proven, comprehensive approach to support families and early development, starting prenatally, using either state funds or by leveraging eligible federal funds. States can use additional funding through the American Rescue Plan to support or establish childcare programs meeting EHS standards.
- **Implement a comprehensive approach to developmental screening and assessment, as part of a comprehensive screening for families, to increase the number of children with developmental delays or disabilities who are identified early and can receive the services and support they need.** Systems should include increasing awareness of developmental milestones, promoting the importance of universal developmental and behavioral screening, and building community capacity to implement screening and assessment, referral, and linkage to appropriate services. Systems should also focus outreach efforts on reaching more Black and Hispanic children who are significantly less likely to have their need for early intervention services identified.^{lxvi}

- **Expand early detection and early intervention (EI) services to fully meet the developmental needs of infants and toddlers, including ensuring that children with factors that place them at risk for developmental delays or disabilities are made eligible for IDEA Part C services.** Other important policies that states can support include developmental screening and follow-up; helping families navigate the system; expanding the EI workforce and ensuring adequate reimbursement; ensuring coverage for more children who are at risk or could benefit from services; and incorporating more infant and early childhood mental health expertise and services.

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on [page 76](#).

- **Pennsylvania's** Infant Toddler Contracted Slots program provides one-year contracts to high-quality programs serving infants and toddlers, with a higher rate of payment than they would receive through the traditional subsidy program. To promote continuity of care from birth to age 5, only programs that also participate in the state-funded Pre-K program are eligible to participate.^{lxvii}
- **Louisiana** has created a professional credential, the Early Childhood Ancillary Certificate (ECAC), for teachers who are working in childcare programs as part of the state's effort to unify the early childhood system and professionalize the early childhood workforce. The state provides funding for professional development throughout the state to administer the training, as well as scholarships for teachers to participate. Early childhood educators who receive the new credential and stay in the field will be eligible for a refundable tax credit of more than \$3,000 annually. There are currently 29 approved programs in Louisiana, combining coursework and job-embedded coaching, typically taking a year or less. Programs are vetted and approved by Louisiana's Board of Elementary and Secondary Education before they are eligible to offer ECAC coursework.^{lxviii}
- **Help Me Grow (HMG) Connecticut** provides a central point of contact for families with young children to help them navigate services and coordinate care. The Child Development Info-line, which is a specialized call center of the United Way of Connecticut's 2-1-1 system, is the access point for HMG. Connecticut's HMG program serves pregnant women, parents, caregivers, social service agencies, child health providers, and early care and education providers. Through comprehensive physician and community outreach and centralized information and referral centers, families are linked with needed programs and services. Connecticut's HMG program uses universal developmental screening to identify and treat potential developmental delays early. Through HMG, families can receive information on various topics related to their child's development, such as managing difficult behaviors, toilet training, sleep issues, promoting language development, and typical developmental milestone information.^{lxix}

KEY DATA TO COLLECT⁶

- Cost of childcare as a percent of income for single parents and for married families
- Locations of childcare deserts
- Childcare regulations related to infants and toddlers, including ratios and group sizes
- Adoption of the infant/toddler teaching credential
- Income-eligible infants and toddlers with Early Head Start access
- How often and by whom children are screened for developmental problems
- IDEA Part C Services
 - Children under 3 referred to IDEA Part C
 - Referred children who receive a complete Part C evaluation
 - Referred children who meet state eligibility for Part C services
 - Children who are referred to services
 - Referred children who receive services

KEY RESOURCES

- Ullrich, R., Cole, P., Gebhard, B., & Schmit, S. (2017). [Early Intervention: A Critical Support for Infants, Toddlers, and Families](#). ZERO TO THREE and the Center for Law and Social Policy.
- Heckman, J. J. (2016). [There's More to Gain by Taking a Comprehensive Approach to Early Childhood Development](#). The Heckman Equation.
- Hains, D. and Neuenswander, A. (2021). [The State of Child Care for Babies: The Need to Do Better for Our Youngest Children](#). ZERO TO THREE.

⁶ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

The Challenge

Any parent can become overwhelmed with the stressors of caring for young children; with compounding factors such as poverty, poor health or mental health, or crowded housing, families may require additional services and supports to help ensure children are healthy and safe. It is important that families feel they can reach out for support before a problem escalates without being stigmatized and that resources are available and accessible in their community.

To meet the varied needs of families, including those facing the most significant barriers, community-level systems are necessary to help strengthen families and connect them to needed resources and supports. This continuum should include supports to help families address everyday problems that can lead to significant crises if not addressed, such as access to nutritious food, safe and stable housing, civil legal services, and health care, as well as services for children and families with more significant needs, including mental health and substance use disorder services for parents, and infant and early childhood mental health supports for children.

Currently, most communities only have pieces of this system in place. Common challenges to creating a more comprehensive system include the lack of identifiable entry points for families to access services, inadequate funding, restrictive eligibility requirements, and a lack of available or accessible services for families that need them. In many communities, services are delivered by multiple agencies with limited or no coordination, leaving families to navigate accessing these services on their own.

It should go without saying that families should be able to access this continuum of services without ever having to encounter the child welfare system. However, existing child welfare policies often deter families from seeking the help they need, particularly families of color, because of a fear that reaching out for assistance could lead to an investigation of abuse and neglect. For example, many states have expanded mandatory reporting requirements that place legal responsibility on any individual, regardless of profession or role for reporting abuse and neglect, which can lead to significant increases in the number of families investigated for abuse and neglect. Yet, while there is little evidence that such policies are effective in reducing abuse and neglect rates, there is significant evidence that such policies unfairly target low-income communities, particularly families of color.^{lx} These policies have led to significant over-representation of families of color in the child welfare system while simultaneously leaving many families of color without access to services that could significantly improve the health and well-being of their children.

The Opportunity

Healthy and strong families and communities are fundamental to ensuring that children reach their potential. Building a continuum of services—as outlined in Policies #1 through #3 of this report—is an important first step, but to improve community-level indicators of health and well-being, communities must have a structure in place to coordinate the supports and services that families need. This coordinating entity, which may look different across communities, can provide navigation services and/or case management to connect families to the relevant services and supports they need and increase their engagement in those services.

To ensure families can access and take advantage of these services, communities must also create identifiable entry points that are accessible to families, enabling them to overcome common barriers. Examples of these access points can include family resource centers, home visiting,

primary care–based support such as those offered through HealthySteps, and Head Start or Early Head Start centers.

Creating effective child and family well-being systems at the community level requires collaborative partnerships across child- and family-serving systems, including early care and education, infant and early childhood mental health, behavioral health, maternal and child health, housing, economic security, and child welfare. Rather than lead these efforts, the child welfare system can be an important partner, working with key stakeholders to strengthen families and prevent maltreatment and the unnecessary removal of children from their families.

At the local level, organizations working with young children and families can collaborate to identify common goals and create standard processes for assessing needs and connecting families to resources. Over time, partners can work toward achieving collective impact through building strong communities in which families feel empowered and supported. For example, Hand in Hand, a framework for community collaboration that aims to achieve positive, equitable outcomes for all young children and families, can be used at every level of program implementation to deepen engagement among partners and support the building of strong communities. This framework was developed by the Model Convening Project, a partnership of four complementary, evidence-based, early childhood models: Family Connects, HealthySteps, Help Me Grow, and Nurse-Family Partnership.⁷ States have a key role in supporting community-based early childhood entities to implement and develop a continuum of services, including providing guidance and oversight to promote consistency across communities—creating a unifying vision, goals, and outcome measures that communities can use and adapt to track progress over time.

Funding provided through the Family First Prevention Services Act provides states an opportunity to help keep children safely with their families. States with an approved Title IV-E Prevention Services Plan can provide prevention services for mental health, substance use, and in-home parent skill-based programs for children who are “candidates for foster care,” pregnant or parenting foster youth, and parents or kin caregivers of those children. While several programs targeted to families with infants and toddlers have been approved by the Title IV-E Prevention Services Clearinghouse,^{lxxi} it is important that states consider the complex needs of infants and toddlers and their families and prioritize these evidence-based programs in their state plans as they continue to develop a prevention-focused infrastructure.

By making improvements to policies and practices related to child maltreatment reporting and investigation, state child welfare agencies can also make progress in addressing systemic racism and improve the well-being of children and families, while better identifying and targeting responses to actual safety risks.^{lxxii} States can review their current child welfare investigation and child removal policies in an effort to change punitive practices that contribute to over-surveillance of families of color.^{lxxiii} States can also develop differential response systems to establish multiple pathways for responding to child maltreatment reports, including those involving families that are considered low risk. A study of six states that used differential response systems between 2004 and 2013 found that higher rates of family participation in alternative response processes were associated with lower rates of reported cases of child abuse or neglect.^{lxxiv}

Research and Best Practice:

Creating partnerships between child welfare and other health, human services, and early childhood agencies can expand access and utilization of the types of services and supports that can help mitigate risks and prevent future child welfare involvement. Recent guidance from

⁷ [The Hand in Hand framework](#) was developed by the Model Convening Project, a multi-year initiative with leadership and facilitation from ZERO TO THREE and funding from the Pritzker Children’s Initiative.

the Children’s Bureau calls on child welfare agencies to use supplemental Child Abuse Prevention and Treatment Act (CAPTA) funding through the American Rescue Plan Act to enhance these collaborative partnerships.^{lxxv} Additional guidance from the Children’s Bureau acknowledges the challenges faced by state and local service providers in responding to immediate familial needs during the global pandemic because of rigid federal funding requirements. The guidance calls for state child welfare agencies to partner with other HHS grantees to design systems that increase access to services, including efforts such as developing universal intake forms or processes that are used across agencies, or a single universal application with a process to determine individual program eligibility.^{lxxvi}

Addressing basic needs such as housing instability and homelessness also supports the child welfare system’s goals of safety, permanency, and well-being for children, youth, and families. Studies have shown that providing housing-related services can significantly reduce repeat maltreatment and facilitate reunification for families with children in foster care.^{lxxvii} Addressing family homelessness has also been linked to improved physical and psychological health and educational outcomes among children.^{lxxviii} The need for civil legal advocacy services has also been identified as a key strategy to help prevent families from entering the child welfare system. Research has found that 71 percent of all low-income families experienced at least 1 civil legal issue that would benefit from representation and 24 percent had 6 or more civil legal issues.^{lxxix}

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Meaningfully partner with parents, including fathers and other caregivers, when designing and implementing community-based family strengthening and prevention systems to ensure they are accessible, inclusive, and relevant to community needs.** Engaging families, particularly those who have lived experience in navigating health and human service systems, brings a critical perspective that can inform discussions of how services are developed and delivered and can help ensure programs are a good fit within a community or neighborhood.
- **Create central access points for families that are community-based and can provide a range of services and supports—both onsite and virtual—to help strengthen families and increase protective factors.** These access points should be easily identifiable to families and provide a range of services, including navigation supports to help families access eligible benefits and services. For example, Family Resource Centers are community-based resource hubs where families can access a range of formal and informal supports and services to increase parenting skills and protective factors.
- **Implement targeted outreach efforts, including providing adequate funding to support enabling services such as transportation, childcare services, and health education, to increase access to and participation in services among families with the greatest needs.** Many families with young children face multiple barriers to accessing services that can negatively impact a child’s development (e.g., a lack of transportation or limited English proficiency). Enabling services can help bridge this gap by making it easier for families to participate, which can help promote better health and well-being outcomes.
- **Coordinate funding across child- and family-serving agencies to help shift from funding individual programs in silos to building coordinated systems that give families broad-based access to services and supports.** For example, agencies can leverage federal child abuse and prevention funding to support community-based collaboratives that are outside of the child welfare system.

- **Create alignment between state and local systems-building efforts to improve the coordination and efficiency of providing a continuum of family strengthening and prevention services and supports to families.** States can support community-based efforts by providing guidance, setting standards, collecting data, and monitoring progress to measure the effectiveness of local efforts.
- **Improve policies and practices related to reporting and investigating child maltreatment.** State child welfare agencies can reevaluate their maltreatment definitions with a focus on distinguishing low-risk, poverty-related neglect and using non-punitive approaches to provide supports to impacted families. States can also create alternative, non-investigative pathways for reporting low-risk concerns (such as helplines) and coordinate responses with non-child welfare entities as appropriate to enhance the ways in which mandated reports can support families.

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on [page 77](#).

- **Allegheny County, Pennsylvania** created a new approach to supporting families with new babies and reducing the number of infants and toddlers experiencing abuse and neglect in recent years. The approach is based on an extensive community and family engagement process that found that parents would be more likely to engage in services that were universally offered, with outreach conducted by relatable home visitors. The initiative, called Hello Baby, offers a tiered approach to prevention including a variety of supports designed to meet families' individual needs and interests. The program uses a deliberate and differentiated approach to reach more parents early, before a crisis can occur, including a predictive risk model that matches parents with services based on their level of risk. In the first year, universal services are offered to all Allegheny County families with a baby born at any county birthing hospital. Families with moderate needs are contacted by outreach workers at a subset of Family Centers based in neighborhoods throughout the county. Families with the most complex needs are offered more intensive services by Healthy Start Pittsburgh, with a family engagement specialist and social worker reaching out to families to better determine their needs and connect them to the best resources the county has to offer.
- In **Guilford County, North Carolina**, Get Ready Guilford is partnering with Family Connects, HealthySteps, and Nurse-Family Partnership to build a continuum of services for families and children prenatally to age 3. Community Navigators collaborate with three early childhood programs to ensure that all families with young children get the services they need, when they need them. Over time, the county aims to offer universal assessment prenatally; at birth; and at 12, 24 and 36 months to every family in Guilford County—as well as targeted referrals based on assessment results and ongoing support for families.^{xxxx} Get Ready Guilford is part of the Model Convening Project, using the Hand in Hand framework.
- **North Carolina's Care Coordination for Children (CC4C)** is a free and voluntary program that helps families find and use community services. CC4C care coordinators serve children from birth to age 5 who have or are at risk for developmental delay or disability, long-term illness, social-emotional problems, or toxic stress. Common referrals include infants who are discharged from the newborn intensive care unit, children with special health care needs, children in foster care, and children and families who have had a positive screen in their primary care practices (including developmental and behavioral health screening, autism screening,

and maternal depression screening). The program uses a two-generational model to assess risks and strengths and set goals with families. CC4C staff are primarily registered nurses or social workers employed by local health departments. They regularly communicate and collaborate with the child's medical home and help connect families to services such as quality childcare, family support, mental health resources, and GED resources.^{lxxxii}

- **Bring Up Nebraska** is a statewide effort that provides a framework for organizations in local communities to form a collaborative to help prevent problems from becoming a crisis for area families. Bring Up Nebraska is based on a philosophy that local communities are best situated and most motivated to understand their own needs and strengths, identify solutions to challenges, and help families connect to services that can prevent a crisis potentially resulting in entry into the child welfare system or other higher systems of care. Bring Up Nebraska supports local communities through technical assistance, tools, and resources to help communities identify service gaps, develop plans using strategies and data, and commit to common goals, measurements, and practices to improve well-being.^{lxxxiii}

KEY DATA TO COLLECT⁸

- Number of families who come to the attention of the child welfare system and are referred for differential response
- Demographics of infants, toddlers, and families served by differential response
- Rates of investigation
- Rates of substantiation
- Rate of re-reports compared to use of differential response
- Number of families reached via centralized access points (e.g., Help Me Grow)
- Data-sharing agreements across relevant entities and partners
- Family Resource Centers (FRCs)
 - Demographics of infants, toddlers, and families currently served by FRCs
 - Impact data from neighborhoods with existing FRCs
 - Connection to state National Family Support Network
 - Types and number of services to which families are referred
 - Barriers to accessing services (transportation, language, waitlists)

KEY RESOURCES

- Administration for Children and Families. (2018). [Information Memorandum: Reshaping Child Welfare in the United States to Focus on Strengthening Families through Primary Prevention of Child Maltreatment and Unnecessary Parent-Child Separation.](#)
- American Academy of Pediatrics. (2020). [Reimagining Child Welfare: Recommendations for Public Policy Change.](#)

⁸ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

- [Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. \(2016\). Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities.](#) Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- [U.S. Department of Health and Human Services, Administration for Children and Families, 2021/2022 Prevention Resource Guide](#)
- [Citrin, A., Anderson, S., Martinez, V., Lawal, N., & Houshyar, S. \(2021\). Supporting the First 1,000 Days of a Child's Life: An Anti-Racist Blueprint for Early Childhood Well-Being and Child Welfare Prevention.](#) Washington, DC: Center for the Study of Social Policy.
- [ZERO TO THREE, Hand in Hand Framework: A Community Framework for Early Childhood Collaboration Developed by the Model Convening Project](#)

SECTION 2.

INFUSE FAMILY STRENGTHENING, CHILD DEVELOPMENT, AND PARENT VOICE INTO CHILD WELFARE SYSTEMS



Some families may come to the attention of the child welfare system due to complex needs that are unable to be addressed and supported fully in the community and may need additional support to ensure children are safe and healthy. Federal data reveals that many of these children are infants and toddlers for whom prevention and early intervention efforts are especially important.

Between 2011 and 2018, the number of infants (1 year old or under) entering foster care increased 13 times as much as that of other age groups, accounting for more than 70 percent of the total increase in entries during the period.^{lxxxiii} Many factors, often co-occurring, influence the rates of entry into foster care at the state level, including generational trauma, interpersonal violence, mental health issues rooted in traumatic histories, prenatal substance use, and conditions affecting social determinants of health. Other factors influencing entry into foster care are the policies and practices of state child welfare agencies, including policies on mandated reporting. At the community level, factors may include access to basic needs, housing stability, prevalence of substance use, and access to health care and behavioral health treatment, among others. Race is also a factor. Although race and ethnicity do not strongly correlate with rates at which maltreatment is substantiated, systemic racism and over-surveillance of communities of color has led to reports of maltreatment of African American children being investigated at significantly higher rates than those of White children, contributing to their over-representation in the child welfare system.^{lxxxiv}

Research indicates that maintaining relationships with a trusted caregiver is critical for children’s health and well-being and that removing children from struggling parents, even when necessary, can inflict and/or increase existing trauma for children, parents, and families. Given these factors, most children who come to the attention of the child welfare system can and should continue to remain at home whenever possible—if there are no critical safety concerns—where they can receive services and supports needed to protect and support the whole family.^{lxxxv} State and local policies can help to prevent family separation, help families and children heal from trauma, and prevent recurrence of maltreatment and reentry into the child welfare system.

Placing a child in out-of-home care, including foster care and kinship care, can compound problems if the placements are not supportive of the child’s early development. A growing body of research shows that early identification of needs and services for young children and parents involved in the child welfare system can improve child safety, increase well-being, facilitate permanent child placements, and strengthen families. Research also demonstrates the importance of actively engaging parents in decision-making and in creating judicial policies and practices that empower parents and reinforce the importance of maintaining the child–parent relationship.

Effective policies described in more detail in this section include: adopting practices that are attuned with the rapid development of infants and toddlers (Policy #5); ensuring access to timely screening, assessment, and linkage to services (Policy #6); providing high-quality legal services for children and parents (Policy #7); increasing the frequency of hearings and case reviews to ensure family needs are addressed in a timely manner (Policy #8); ensuring regular family team meetings to empower parents and other caregivers in making decisions (Policy #9); requiring frequent, quality family time or visitation between infants and toddlers in foster care and their parents (Policy #10); and creating a network of family support partners or mentors to help parents navigate the child welfare system (Policy #11).

The policy recommendations highlighted in this section are focused on tertiary prevention services and supports for families with infants and toddlers with an open child welfare case, either placed in out-of-home care or remaining at home.

The Challenge

The earliest years of a child's life are critical to their long-term development. Yet, while infants and toddlers represent the largest age group entering foster care, child welfare systems generally adopt a one-size-fits-all approach that is not responsive to the developmental needs of infants, toddlers, and their families. A 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.^{lxxxvi} In short, a healthy relationship with a caregiver in infancy builds a strong foundation for all learning and behavior to come.^{lxxxvii} When children are removed from the home and placed in foster care, they often experience multiple placement changes and disruptions in attachment relationships.^{lxxxviii} Without timely access to appropriate supports and services, these early experiences can jeopardize children's long-term social, behavioral, mental health, and health outcomes.^{lxxxix} Case workers and their supervisors, attorneys, and judges are often not trained in key issues related to early childhood development, child trauma, and other critical issues that require additional training and expertise. As a result, there is limited awareness among judges, attorneys, and child welfare workers about best practices for infants, toddlers, and their families, despite the critical role these professionals play in determining the services and supports that young children receive.

Key child welfare processes, systems, and services—including the frequency of court reviews, visitation between parents and children, and screening and assessment for health, social–emotional, and educational needs—are often implemented without regard to the unique needs of babies. Child welfare agencies often lack staff that can provide consultation on cases of infants and toddlers and advise on the services they need based on their developmental needs. Also, as states and local communities develop their continuum of services, the specific needs of infants and toddlers are often not adequately considered. State policies often reflect this. The Child Trends and ZERO TO THREE state survey^{xc} of state child welfare polices shows that very few states have created policies that differentiate between infants/toddlers and any other age group.

The Opportunity

Because of the rapid development of infants and toddlers, prevention and early intervention efforts are critical to help minimize negative effects of neglect or abuse that may prove to be irreversible later in life. By embedding key principles of early childhood development into all systems that support infants and toddlers and their families, states have the unique opportunity to drive change in child welfare policy and practice that promotes early childhood development,^{xcii} while also preventing families from entering the child welfare system. This includes training and ongoing coaching of staff that interacts with children—such as attorneys, judges, early childhood educators, and health professionals—on important topics including the science of early childhood brain development, attachment, infant mental health, and the impacts of trauma on young children. To promote stability and mitigate potential trauma that can occur when a child is removed from his or her home, states can implement policies and practices that prioritize placement with relatives to help maintain the child's connections with his or her family.^{xciii} State child welfare agencies can implement relative preference policies that restrict non-relative placements and support caseworkers in prioritizing routine placement with kin.

States must also build capacity to ensure that best practices in child development are being used in ongoing case planning and decision-making for infants and toddlers. This includes conducting case consultations and reviews. States can also employ Infant mental health specialists to provide needed social–emotional support to young children and families and embed those staff members in child welfare agencies. Many states are using bench cards, which provide judges with a set of questions related to important aspects of child development, during court hearings.^{xciii} These efforts can help create a child welfare system that is able to address the unique needs of infants and toddlers.

Developing a continuum of services that can address the needs of infants and toddlers, including services to support families in preventing the need for out-of-home care, is also critical. States can review their existing programs and services to ensure they are developed to support infants and toddlers and look at contracting or building services to fill gaps as needed. States can also help foster partnerships between early childhood service providers, such as home visiting and infant mental health, and child welfare agencies to develop strategies for working with families with young children who are experiencing adverse conditions—to help prevent abuse and neglect and reduce out-of-home care placements.

Research and Best Practice

Protecting attachment relationships between infants, toddlers, and their caregivers is a critical aspect of a child welfare system that focuses on the developmental needs of young children. Research shows that 82 percent of infants who experience maltreatment exhibit disturbances in their attachment to their caregivers—and that formally removing children from trusted caregivers, even for a short time, can result in challenges to maintain and rebuild relationships.^{xciv} When young children do not form an attachment with at least one trusted adult, their development can deteriorate rapidly, resulting in delays in cognition and learning, relationship dysfunction, and difficulty expressing emotions.

Services that help build parental capacity to care for young children, such as evidence-based home visiting programs, have been proven to effectively prevent the need for removing young children from their homes and disrupting critical attachments^{xcv}. Dyadic therapies, which involve treatment delivered to a parent and child simultaneously, have shown evidence of effectiveness in treating social–emotional and behavioral problems in young children.^{xcvi} These evidence-based interventions are part of a continuum of care that recognizes the unique needs of infants and toddlers, as well as the critical need for interventions that support the parent–child relationship, and reinforces a developmental approach to child welfare.

Maintaining or healing attachments can be particularly difficult when children are in out-of-home placement. For children in foster care, policies that support frequent, high-quality family time for infants and toddlers and their parents are critical to preserving attachment bonds, and these experiences should be conducted in home-like locations that are familiar to the child (See Policy #9 on [page X](#) for additional research on family time). Multiple moves while in foster care also pose a significant concern for infants and toddlers. When a baby faces a change in placement, fragile new relationships with resource parents are severed, reinforcing feelings of abandonment and distrust. When children are removed from the home, kinship placements can help create stability and consistency for babies and families. A systematic review of research studies on kinship care⁹ found that the behavior, mental health, and well-being of children placed in kinship care is better than that of children placed in traditional/non-relative foster care, and that children placed with relatives are least likely to experience placement instability.^{xcvii}

⁹ Kinship care refers to the placement of children with relatives.

Infant and early childhood mental health (IECMH) is a key strategy to promote children’s healthy social and emotional development in a variety of settings, including for children both in and at imminent risk of entering foster care. An emerging evidence base demonstrates the range of outcomes that can result from the delivery of IECMH. IECMH has been linked to improvements in teacher–child interaction and classroom climate, reductions in children’s problem behavior, increases in social skills, prevention of expulsion (including among young children of color), less work missed by families, lower parenting stress, and decreased teacher stress and rates of turnover.^{xcviii}

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Provide training on developmentally appropriate care for infants, toddlers, and their families to a wide range of professionals, including child welfare workers and supervisors; parents, resource parents, or other caregivers; attorneys, judges, treatment providers, and other court staff; and additional professionals engaged in the child welfare system.** Because of the roles these workers play with young children, it is critical to have a baseline knowledge of early childhood development, including developmental milestones.
- **Support recruitment and retention of resource caregivers who are prepared to address the special needs of young children and their parents.** Ensuring the healthy development of infants and toddlers in foster care requires that resource caregivers, including kinship caregivers, foster-to-adopt families, and resource parents (foster parents) have the level of knowledge and skills necessary to respond effectively to the needs of abused and neglected children and other at-risk young children. This includes training resource caregivers specifically on the needs of infants and toddlers; promoting the social–emotional, cognitive, and healthy development of the children in their care; training resource caregivers as mentors for parents; and encouraging these caregivers to continue as resources to parents, guardians, or adoptive families once permanency is achieved.^{xcix}
- **Prioritize placements with kin or fictive kin, where possible, to increase connection to parents and provide continuity to the child.** Notifying kin or fictive kin before or during pre-removal conferences prior to infants and toddlers being removed from their homes creates a critical opportunity to promote their stability and secure attachment.
- **Create a high-quality child welfare workforce guided by the science of early childhood development that includes recruitment of frontline workers and supervisory staff with training in child development and utilizes infant mental health specialists to support child welfare agencies.** Infant and early childhood mental health specialists can serve as consultants to staff, birth parents, and other caregivers and can help address the relationship between baby and parent and/or between baby and resource parent. These specialists can provide case consultation and reviews of cases of infants and toddlers in child welfare to ensure the use of best practices in child development.
- **Create a continuum of services that addresses the specific needs of infants and toddlers. Key strategies include:**
 - Reviewing the existing array of available services to ensure they address the specific needs of infants and toddlers, including preventive services that are reimbursable through the Title IV-E Prevention Program (For example, dyadic therapy between a parent and child can be a critical service for infants and toddlers when they first come to the attention of the child welfare system.)

- Facilitating partnerships between child welfare and two-generational early childhood agencies like Early Head Start and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program around their shared goals of promoting optimal development for children and families
- Ensuring case plans include services for infants and toddlers and their families that are developmentally appropriate (e.g., screening for early intervention services)

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on page 79.

- **ZERO TO THREE's Infant-Toddler Court Program (ITCP)** works with local communities to implement a proven approach for children from birth to 3 years of age in foster care, or at risk of removal, and their families. This evidence-based approach connects babies and their families with the support and services they need to ensure healthy development and lasting permanency. A family team, including a dedicated community coordinator, parent, family and other supports, caseworker, judge, and attorney work intensively to address child and parent needs, participating in monthly family team meetings and monthly review hearings and providing timely screening, assessment, and linkage to timely prevention and intervention services. The ITCP provides training and technical assistance to a broad range of stakeholders at local sites on a range of topics related to early childhood development—including attorneys and judges, early childhood education providers, child welfare caseworkers, and other stakeholders working with children and families—and reinforces this training through regular site visits, observations, and one-on-one team calls. As of January 2022, there are more than 100 infant-toddler court team sites operating across the country. Evaluations have found that children who participated in the program exit the foster care system eight months earlier than children in traditional child welfare, with significant reductions in the recurrence of maltreatment within 12 months. Also, children achieved the same outcomes regardless of ethnicity, race, or time in foster care.^c
- **Arkansas Building Effective Services for Trauma (ARBEST)** has worked toward building a continuum of care to address the mental health needs of and improve outcomes for young children exposed to trauma across the state. The ARBEST advisory board represents a broad range of stakeholders coming together for collaborative visioning, including the Office of the Governor, Child Advocacy Centers, the Mental Health Council, the Infant Mental Health Association, Court Improvement, child welfare, the Department of Education, and more. ARBEST focuses on working across sectors as a way to develop impactful interventions that will be sustained across a long period of time. Supported by state funding, ARBEST has worked for more than a decade to increase access to evidence-based trauma treatment services by providing training for mental health professionals in Arkansas and by building consumer knowledge of evidence-based treatments. This has resulted in EBT-trained therapists in 64 of the state's 75 counties, totaling more than 2,000 providers. In 2018, Arkansas Medicaid released new standards and enhanced reimbursements for clinicians providing mental health services for children ages 0–47 months under Medicaid, with the goal of increasing the use of evidence-based practices. To meet these standards, clinicians must be trained in ZERO TO THREE's DC:0–5™ as well as in evidence-based dyadic treatment. ARBEST supports clinicians in meeting these standards by offering regular, no-cost trainings in the DC:0–5, as well as in Parent–Child Interaction Therapy and Child–Parent Psychotherapy.

- In [Washington State](#), a new initiative aims to strengthen the linkages between the state’s child welfare and early learning systems by funding Child Welfare Early Learning Navigators who collaborate with child protective services (CPS) caseworkers to support and connect families with young children to high-quality early learning and family support experiences. The program was started after data showed that fewer than one-half of Washington’s eligible families involved with CPS were accessing early childhood programs, including childcare, Head Start, home visiting, and other early intervention and prevention services. The program, which is being funded through Washington’s Preschool Development Grant, has been implemented in three regions of the state, including South King, Grays Harbor, Mason, Pacific, and Yakima counties, and will soon be expanded to serve tribal communities in the state.^{ci}

KEY DATA TO COLLECT¹⁰

- Children under 3 disaggregated by race and ethnicity
- Children under 3 in the child welfare system disaggregated by race and ethnicity
- Number of out-of-home child placements
- Number of families offered in-home preservation services
- Time to permanency
- Time from referral to receipt of service, for both parents and children
- Language spoken by children and families in the community
- Language spoken by providers in the community
- Accessibility of services by demographic and geographic metrics
- Children who are in the child welfare system due to parental substance use
- Children who are in the child welfare system due to a parent being detained because of legal status
- Children in justice-involved families
- Rate of parent incarceration
- Parents who were previously in the child welfare system
- Rate of teen pregnancy and childbearing
- Adolescent parents involved with child welfare, including rates of delinquency

KEY RESOURCES

- American Academy of Pediatrics. (2021). [Reimagining Child Welfare: Recommendations for Public Policy Change](#).
- Center on the Developing Child at Harvard University. (2016). [Applying the Science of Child Development in Child Welfare Systems](#).

¹⁰ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

The Challenge

Because all families in the child welfare system have different challenges, strengths, and support systems, services must be tailored to meet the assessed needs of each family. However, there is often a disconnect between the screening and assessment of families and the services they receive, including a lack of effective and appropriate treatment or care. A significant percentage of children in foster care do not even receive basic health care, such as immunizations, dental services, hearing and vision screening, and testing for exposure to lead and communicable diseases.^{cii} As evidence of this, the Children’s Bureau’s most recent review found that local agencies provided appropriate services to address the needs of fathers in only 42 percent of foster care cases and mothers in only 57 percent of cases.^{ciii}

Despite research demonstrating the benefits of early screening, assessment, and linking young children with needed services, state child welfare policies and practices are not comprehensive enough to meet the varying needs of young children and their families involved in the child welfare system. The Child Trends and ZERO TO THREE state survey found that few states require adherence to visit/screening schedules for children at risk of entering foster care, and only one-quarter of states require adherence to schedules for well-child visits, immunizations, or preventive dental or oral health surveillance.^{civ}

The compounding challenges of poverty and systemic racism can make it more difficult for families of color to access services. This is often due to limited access to transportation, unreliable transportation, and the experiences of discrimination that have cultivated distrust of the child welfare system and other service providers. Research shows that Black children who come into the child welfare system are less likely to receive developmental or psychological evaluations, which could otherwise identify and help address developmental delays, as well as less likely to receive support for family reunification.

Because of these factors, it is not surprising that rates of developmental delay for children in foster care are much higher than those found in the general population. Nearly 40 percent of young children in foster care are born at low birth weight, premature, or both—factors that increase their likelihood of medical problems or developmental delay. They are also more likely to have fragile health and disabilities.

Alcohol or substance use among parents is the leading driver of child welfare involvement for children under age 1, a trend that has been increasing in recent years. As of 2016, the prevalence of parental alcohol or other drug use serving as a contributing factor for removal of a child from his or her home was 35 percent (up from 18 percent in 2000) of cases.^{cv} Research shows that prenatal substance exposure (PSE)—and, in particular, prenatal alcohol exposure (PAE)—can result in long-term neurodevelopmental impairments in children that continue into adulthood. These impairments can also present significant challenges for parents and caregivers.

Many states have policies stipulating that prenatal exposure to drugs or alcohol is sufficient evidence to substantiate maltreatment and remove a child from the home. However, evidence suggests that such laws may not decrease rates of newborn exposure to narcotics and may reduce participation in substance use treatment. Black and low-income families have been disproportionately impacted by such laws requiring that children be removed from the home.^{cvi} Also, state policies and processes for identifying prenatal exposure using in-hospital toxicology testing at birth have significant drawbacks, including their focus on illegal drugs but not alcohol, which can lead

to impairments such as fetal alcohol spectrum disorders (FASDs) and misses opportunities to identify and treat substance use earlier in the process, such as during pregnancy, rather than waiting until a child is born.

The Opportunity

Even in the face of multiple adverse childhood experiences, young children can bounce back with the appropriate protective factors in place to support resilience.^{cvi} Building on the health recommendations from Policy #1 of this framework, states should work to establish comprehensive and coordinated service systems for young children in out-of-home care and their families that are developmentally focused, trauma-informed, culturally relevant, and family-oriented. The child welfare system should focus on collaboration across systems, ensuring that every infant and toddler receives a comprehensive assessment for physical health, social–emotional health, developmental delays, and complex trauma, as well as providing screening, assessment, and access to services for every parent.

Together, these assessments can provide a clear picture of the family with the family’s input, including consideration of attachment, resilience, and protective factors. Having a systematic approach to integrated services plans can ensure that the needs of every child and family in the child welfare system are fully identified as early as possible in the case process, are made in highly individualized ways to address specific needs with effective services and interventions, and build on parental resilience and capacity for self-advocacy, confidence, and motivation.

Child welfare agencies and their community and state partners should work together to identify prenatal substance exposure among children in care and help families obtain the services they need. Providing timely referrals to substance use treatment services for parents, particularly those approaches that are family focused and oriented toward the parent–child relationship, can help prevent maltreatment, reduce the need for child removals, and increase the likelihood of reunification of children with their families.

The need for supportive services does not decline, and may even increase, when a child returns home either through reunification or adoption. 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. Providing more post-permanency supports for families can help prevent reentry of children into foster care.

Research and Best Practice

The American Academy of Pediatrics (AAP) acknowledges the many barriers to providing high-quality, comprehensive health care services to children and adolescents in foster care—most notably, poor care coordination, prolonged waits for community-based services, poor communication, and lack of health information.^{cvi} For children who remain at home but are at risk of entering foster care, services are significantly less available.

Moreover, when families 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. Although the Child Trends and ZERO TO THREE state survey revealed that nearly every state in the survey routinely offers at least one post-permanency support, many states lack a robust array of services.^{cix} 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.

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Provide babies and toddlers with a universal initial screen for health, mental health, complex trauma, and developmental delays within 72 hours of coming to the attention of the child welfare system; subsequent screenings/assessments and connection to a medical home should occur within 30 days of coming to the attention of the child welfare system.** Following the AAP Bright Futures guidelines for universal screening, care coordination or integrated behavioral health in primary care is critical for infants and toddlers entering foster care and those receiving at-home preservation services.
- **Provide training and guidance to child welfare staff and other key partners to help them identify children with prenatal substance exposure and learn how to work with parents who may be using substances during pregnancy.** State and local child welfare policymakers can develop policies and procedures to help staff systematically screen all children in care.
- **Provide universal screening prenatally to increase detection of prenatal substance use and related conditions.** Ideally, the screening would occur during the first prenatal visit, with a verbal screening tool. Universal screening that connects families to treatment early, both before and during pregnancy, can keep families together, reach more families, and greatly reduce biases toward different racial, ethnic, and socioeconomic groups. Research shows that selective screening based on clinician suspicion leads to diagnosis in only three percent of patients, while screening of all patients leads to diagnosis in 16 percent of patients.^{cx}
- **Support implementation of evidence-based, family-centered substance use disorder treatment and mental health services for parents with children in the child welfare system.** A family-centered approach to SUD treatment provides a comprehensive array of clinical treatment and related support services to meet the needs of each family member, not only the individual requesting care. While the length of the services, type of setting (e.g., residential or outpatient), and program size may vary, having a consistent process in place for assessment and referral with a common objective ensures that parents are fully supported in their parenting roles and children receive the necessary services and supports to remain with their parent(s) during treatment and recovery.^{cx}
- **Use Family First Act and other federal funding to support a continuum of services for families at risk of entering the child welfare system.** States with approved Title IV-E Prevention Program Plans can utilize funding to help ensure families receive evidence-based mental health, substance use, and parenting services as part of an array of supports focused on keeping children's early development on track. Importantly, states and counties should ensure when possible that funding is used toward advancing interventions developed by and designed for people of color.^{cxii}
- **Support interagency collaboration between child welfare and Early Intervention Part C staff to allow more eligible children to receive early intervention services.** Ensuring familiarity with and training on Individuals with Disabilities Education Act (IDEA) Part C, including a clear delineation of roles and responsibilities across agencies, can help secure consistent and comprehensive referrals and increase access to services for children who can benefit from them. Key stakeholders, including Early Head Start and the state Medicaid agency, should be consulted and provide input on policy and practice changes.

- **Support post-permanency plans that include robust services for all parents and caregivers who reunify, adopt, or take guardianship of infants and toddlers.** Available services should include linkages with community-based services; referrals to services, including mental health and recovery support; educational support and advocacy; material support; support groups; and more.

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on page 80.

- **Arkansas, Washington, and Nebraska** implemented differential response as part of a Title IV-E Waiver Demonstration Project. Each state’s project was evaluated by independent researchers, with findings showing that families who participated in the differential response pathway experienced fewer removals and were less likely to have a subsequent child protective services (CPS) case open compared with similar families who did not receive differential response services.^{cxiii}
- The **Kentucky Sobriety Treatment and Recovery Team (START) program** works with families involved in the child welfare system with substance use disorders by pairing specially trained CPS workers with family mentors using a system-of-care and team decision-making approach with families, treatment providers, and the courts. The program places families at the center of treatment and includes them in the decision-making team during treatment and case planning. The program aims to reduce recurrence of child abuse and neglect, improve SUD treatment rates, build protective parenting capacities, and increase the county and state’s capacity to address co-occurring substance abuse and child maltreatment.^{cxiv}

KEY DATA TO COLLECT¹¹

- **Adherence to schedules for well-child visits for infants and toddlers in child welfare**
- **Adherence to schedules for health screenings for infants and toddlers in child welfare**
- **Formal information-sharing between IDEA Part C and Child Welfare**
- **Number/percent of infants and toddlers and families receiving parent–child relationship interventions**
 - **Data on types of interventions (e.g., Child–Parent Psychotherapy, Parent–Child Interaction Therapy)**
- **Screening and referrals for parents in child welfare for:**
 - **Substance use disorders**
 - **Mental health issues**
 - **Physical health issues**

¹¹ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

KEY RESOURCES

- [HHS Office of Early Childhood Development, Birth to 5: Watch Me Thrive!](#)
- [Help me Grow National Center](#)
- [Association of Maternal & Child Health Programs](#)
- U.S. Department of Health and Human Services Administration for Children and Families (ACF) and Centers for Medicare & Medicaid Services (CMS), [Toolkit: Data Sharing for Child Welfare Agencies and Medicaid](#)
- Ingoldsby, E., Richards, T., Usher, K., Wang, K., Morehouse, E., Masters, L., & Kopiec, K. (2021). [Prenatal Alcohol and Other Drug Exposures in Child Welfare Study: Final Report](#). Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

The Challenge

Parents involved in the child welfare system face the grave prospect of permanently losing custody and contact with their child, while children face potentially harmful disruption of critical bonds with their parents. Yet in many states, access to representation by an attorney for children and parents is not guaranteed. Even when representation is provided, the quality of and point in the process when legal services are made available can vary significantly. The lack of high-quality legal representation has been shown to negatively impact families in the child welfare system, creating worse outcomes for children including increased lengths of stay in out-of-home care and lower levels of engagement of parents in their child's case, reducing their involvement in case planning, services, and court hearings.^{cxv}

A recent study found that 39 states have a categorical right to counsel for "parent respondents" in child protection proceedings in family court, while 32 states require the same right to counsel for children.^{cxvi} However, even in those states that guarantee counsel to children and/or their parents, funding for such services varies greatly, as does the quality and consistency of the legal representation provided. For parents whose children are at risk of entering foster care, access to legal services is rarely required according to the Child Trends and ZERO TO THREE state survey.^{cxvii}

The Opportunity

Recent federal policy changes aim to encourage all states to make high-quality legal representation a top priority in creating a more equitable and effective child welfare system. In 2017, the Children's Bureau within the U.S. Department of Health and Human Services (HHS) issued an information memorandum encouraging all child welfare agencies and courts to ensure that all parties to child welfare proceedings, including children and their parents, receive high-quality legal representation.^{cxviii} The Children's Bureau has also identified high-quality legal representation as a key strategy for keeping families together and promoting the well-being and safety of children and parents.^{cxix}

A 2018 policy change by the Children's Bureau allows states to seek reimbursement for 50 percent of administrative costs of attorneys for parents and their children through federal Title IV-E funding.^{cxx} The policy allows states to raise the quality of legal representation to families involved in the child welfare system in a variety of ways, including hiring additional attorneys to lower average caseloads, ensuring that all parents are provided with an attorney at or before the initial hearing, piloting or expanding interdisciplinary representation by hiring social workers and/or parent mentors to support attorneys, and providing pre-petition representation for legal support prior to a child's removal from home.

Research and Best Practice

The American Bar Association (ABA) and the National Council of Juvenile and Family Court Judges (NCJFCJ) have both created policies concerning the importance of the court in ensuring that all parties in abuse and neglect cases have high-quality legal representation. The ABA has created a series of best practice standards, including for children involved in child abuse and neglect cases (developed in 1996) and child welfare agencies (2004), as well as for parents of children involved in such cases (2006). These best practice standards identified several core components of high-quality representation of parents involved in child welfare proceedings, including ensuring that

the parent's voice is heard and understood in the proceedings; understanding the parent's life circumstances, including strengths, needs, and available resources; working collaboratively with a multidisciplinary team, including parent mentors and parent social workers; and advocating for parent-child contact through visitation and permanency planning.^{cxxi} NCJFCJ's Enhanced Resource Guidelines also identify the need for children and parents to have the opportunity to be present in court and meaningfully participate in their case planning and in the court process.^{cxxii}

In reviewing the available research, the Children's Bureau noted that "numerous studies and reports point to the importance of competent legal representation for parents, children, and youth in ensuring that key information is conveyed to the court, parties' legal rights are protected, and that the wishes of parties are effectively voiced." The Children's Bureau further noted that "there is evidence to support that legal representation for children, parents, and youth contributes to or is associated with increases in party perceptions of fairness; increases in party engagement in case planning, services, and court hearings; more personally tailored and specific case plans and services; increases in visitation and parenting time; expedited permanency; and cost savings to state government due to reductions of time children and youth spend in care."^{cxxiii}

Multidisciplinary legal representation is one approach to delivering high-quality representation. Teams typically include attorneys, social workers, and parent mentors/advocates, as well as professionals with expertise in substance use treatment or other legal matters affecting families, such as domestic violence, education, delinquency, employment, or housing concerns.^{cxxiv} An evaluation of more than 10,000 families referred to interdisciplinary law office representation (ILO) in New York City Family Court found that for parents who received interdisciplinary representation, their children spent 118 fewer days on average in foster care during the four years following the abuse or neglect filing. Additional analysis found that children whose parents received services through this model achieved overall permanency, reunification, and guardianship more quickly. Parent support partners/mentors can be important members of a team that provides interdisciplinary support.

Early appointment of counsel in child welfare proceedings can help prevent unnecessary removals of children into foster care, and when children are removed from the home can lead to improved case planning, higher rates of permanency, and cost savings to state government.^{cxxv} Attorneys can contest removals, identify relatives to serve as respite care providers, advocate for safety plans and identify resources, and provide a range of services to address family needs, including housing, immigration, domestic violence, and other related issues—all of which may help prevent unnecessary removal and placement.

For example, a randomized controlled trial of a program in Washington State found strong evidence that the early appointment of a well-trained attorney for children and youth increased time to permanency. Children represented by attorneys trained and practicing under the model were 40 percent more likely to experience permanency within the first six months of placement than children represented by attorneys employing standard practice.^{cxxvi}

Though research is still nascent, some jurisdictions have seen promising results piloting pre-petition programs through which parents are represented by attorneys before the child welfare agency removes a child from the home or files a petition seeking removal or court oversight. For children at risk of entering out-of-home care, pre-petition involvement of parents' attorneys can help prevent unnecessary removals into foster care and keep families together. In such cases, attorneys can provide confidential legal advice, negotiate with the agency to achieve better outcomes for children and families, and address legal matters that may be putting families at risk of entering the child welfare system (e.g., medical needs, access to benefits, housing issues).^{cxxvii}

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Adapt ABA standards of practice^{cxxviii} and Family Justice Initiative fundamental attributes of high-quality legal representation^{cxxix} to ensure that parents' and children's attorneys are properly supported to meet the obligations of the families they represent.** These attributes address such issues as caseload size and compensation, interdisciplinary and multidisciplinary models of representation, diversity, timing of appointment, support and oversight, and the use of continuous quality improvement.
- **Develop a policy requiring all children and parents involved in the child welfare system to receive high-quality legal assistance through the appointment of an attorney throughout the life of the case, including during early stages of the case.** Recent federal guidance allows states to utilize Title IV-E funding to support efforts to expand representation statewide.
- **Provide legal support to families at risk of becoming involved in the child welfare system, such as pre-petition legal services, to prevent unnecessary removal of children.** Legal advocates can represent families in the early stages of a child welfare case before a child is removed from the home and often before an abuse or neglect petition is filed. Early legal advocacy aims to keep the family together, keep children in the home, and prevent the need for foster care.
- **Provide civil legal services to families to address issues such as housing, domestic violence, paternity, immigration, and work issues that, if not addressed, can lead to family instability.** Civil legal advocacy can include an array of supports, including representation by an attorney to enforce procedural or substantive rights, providing information to help families understand their rights and eligibility for services. Civil legal advocacy can help prevent families from unnecessary contact with the child welfare system by helping resolve challenges that can otherwise become a crisis if not addressed.

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on page 81.

- **The Washington State Office of Public Defense** began implementing the Parent's Representation Program in 2000 with a pilot program in two counties to provide access to multidisciplinary representation for indigent parents in dependency cases. The state legislature gradually expanded the program to additional counties over time, and in 2018 the program was expanded statewide. The program has been evaluated multiple times and has found higher permanency rates and shorter times to permanency in counties implementing the program compared with non-participating counties.^{cxxx}
- **The Iowa Legal Aid Parent Representation Project** provides civil legal assistance to families who are currently in or at risk of entering the child welfare system. The program uses a multidisciplinary team approach comprised of an attorney, case manager, and parent advocate with lived experience to advocate for families through legal assistance, help connect families to needed services, and help navigate the child welfare system. The program receives referrals from the Iowa Department of Human Services (IDHS) and works with parents or caretakers to resolve any civil legal issues to help stabilize the family and prevent out-of-home placement. Legal assistance may address a range of concerns, including custody, orders of protection, affordable housing, and other issues often faced by those in poverty. The program, which was initially funded with a grant from the state's Court Improvement Program and has since expanded its reach using philanthropic funding, has more recently been able to use Title IV-E funding through a contract with the Iowa State Public Defender.^{cxxxi}

- In 2018, **New York State** created the Commission on Parental Legal Representation to examine the current state of parental representation and develop a plan to improve the quality and availability of representation across the state.^{cxxxii} In 2019, the commission recommended the establishment of a State Office of Family Representation to provide oversight of parental representation. In late 2019, the NYS Office of Indigent Legal Services (ILS) issued an RFP to solicit proposals for the establishment of a model Family Representation Office in counties outside of New York City to provide legal representation to parents in child protective proceedings under New York Family Court.^{cxxxiii} NYS ILS, with support from the commission, issued guidelines for financial eligibility for assigned counsel, which includes a presumption of eligibility if a parent is facing a child protective proceeding with possible removal of the child. Additionally, ILS issued RFPs in 2021 for a model of comprehensive, multidisciplinary representation, which may start during the child protective investigative stage, not simply when the case is filed in court.
- Models of pre-petition legal representation have been used in **Iowa, Michigan, New Jersey, Oklahoma, and Washington, DC**, and have proven successful in minimizing the need to remove children from their home and place them in foster care.^{cxxxiv}

KEY DATA TO COLLECT¹²

- State statute on when the court must appoint a representative for a child, including appointing a guardian ad litem to investigate and advocate for the child’s best interests; appointing an attorney specifically to advocate for the child’s position and expressed wishes before the court; appointing a court-appointed special advocate (CASA) to assist the court by investigating a child’s circumstances; and providing recommendations on meeting the child’s needs
- Training received and qualifications required for a person assigned to represent a child in a child abuse or neglect proceeding
- Use of Title IV-E reimbursement to increase funding of legal representation for both eligible children and their parents

KEY RESOURCES

- The American Bar Association. (2021). [Practice Standards & Tools](#).
- Family Justice Initiative, [High-Quality Legal Representation](#)
- Children’s Bureau. (2017). [Information Memorandum: High-Quality Legal Representation for All Parties in Child Welfare Proceedings](#).
- ABA Center on Children and the Law, [Legal Representation in Child Welfare Proceedings](#)
- Gatowski, S., Miller, N., Rubin, S., Escher, P., & Maze, C. (2016). [Enhanced Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases](#). National Council of Juvenile and Family Court Judges.
- ZERO TO THREE and ABA Center on Children and the Law. (2021). [Reasonable and Active Efforts: A Tool to Prevent Removal and Reunify Families](#).
- ABA Center on Children and the Law and the National Council of Juvenile and Family Court Judges. (2021). [Supporting Early Legal Advocacy Before Court Involvement in Child Welfare Cases](#).

¹² These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

The Challenge

Court hearings can be an intimidating and confrontational experience for parents, and their limited frequency can often lead to delays in providing needed services to children or their parents. Such delays can undermine the successful development of an infant or toddler. Research shows that the shorter the time a child spends in foster care separated from his or her family, the less likely there is to be prolonged damage to the child's development of trust and security. With these considerations in mind, dependency courts and family treatment courts are entrusted to make timely decisions for children and families in their custody. This help ensures that cases are heard expediently while also providing sufficient time for hearings to permit the engagement of all parties and meaningfully move the case forward toward permanency, as well as additional time for parents who need to achieve goals in the case plan.^{cxxxv} The frequency with which children's cases are reviewed by the court, either through a review hearing or a case review, can help ensure that permanency plans are implemented, recommended services are received, and children are safe, healthy, and thriving.

Despite the unique developmental needs of infants and toddlers, few states require more frequent court oversight for infants and toddlers in child welfare. Most states adhere to federal requirements of holding review hearings every six months, a permanency planning hearing within 12 months of the date the child entered care, and permanency planning hearings every 12 months thereafter.^{cxxxvi} For infants and toddlers who experience exponential growth in terms of both cognitive and physical development during this period, this represents a significant missed opportunity to address critical challenges that could result in long-term damage for these children and their families.

According to the Child Trends and ZERO TO THREE state survey, less than one-third of states reported that court hearings and meetings were routinely held on a more frequent basis for infants and toddlers in foster care as compared with children of other age groups. Only three states reported that case reviews were routinely held on a more frequent basis, and just four reported that permanency hearings were held more frequently for infants and toddlers.^{cxxxvii}

The Opportunity

Dependency and family treatment courts are charged with providing oversight of young children and their families in foster care in local communities. To be effective, the judges who operate these courts must work to ensure reasonable efforts toward reunification, protect infants and toddlers from harm, support stable and nurturing early caregiving relationships, and promote engagement with parents.

One key strategy states can implement to achieve these goals is increasing the frequency of court review hearings or case reviews. Federal law requires that a court or administrative body conducts a review of children in out-of-home care at least once every six months from the date the child entered care; however, states can require more frequent court hearings or case reviews, as several have already done.^{cxxxviii} Ongoing and timely reviews are needed to ensure that all parties are making progress on the child's plan; that the child's development is on track, particularly during this period of rapid growth and brain development; and that the child spends as little time as possible in a temporary placement or multiple placements.

By scheduling frequent court hearings or case reviews, the court can provide close oversight and monitoring to ensure that parents' and young children's needs are being identified and addressed in a timely and effective manner, that case plans are still relevant and meaningful, and that the child welfare agency and other responsible agencies are providing needed attention to supporting the child and family. In addition, judges have the ability to require more frequent court hearings at critical junctures in a case, regardless of statute, and do not have to wait until a hearing to allow children to be reunited with their parents if the circumstances allow. In creating such a policy, judicial leaders should ensure that the timing of court hearings does not interfere with parent's other commitments, including requirements from their case plan, and should maintain flexibility for special circumstances such as parents who are incarcerated or enrolled in inpatient substance use treatment.

Research and Best Practice

Evaluations of courts implementing the Safe Babies Court Team™ (SBCT) approach have shown that frequent court hearings, including monthly case reviews, are one of several important factors that lead to improved results for infants and toddlers in child welfare, such as shorter time to permanency and lower repeat maltreatment rates.^{cxvix} Sites implementing the SBCT approach typically hold monthly review hearings for infants and toddlers in foster care. A more recent, random assignment evaluation of the SBCT approach found similar evidence supporting more frequent court hearings in local SBCT sites as one of several factors that resulted in reduced time spent by infants and toddlers in out-of-home care and lower rates of repeat maltreatment.^{cxl}

In 2016, the National Council of Juvenile and Family Court Judges (NCJFCJ) created a set of enhanced resource guidelines and judicial bench cards that serve as promising practices for serving families with child welfare cases.^{cxli} The guidelines note that more frequent and timely court oversight can effectively move children to safe permanency sooner by providing a sense of urgency. In 2020, NCJFCJ developed the Child Welfare Caseworkers' Companion Guide to the Enhanced Resource Guidelines.^{cxlii} This issue is particularly important for infants and toddlers where delays in reviewing and ordering services can impact the ability of children to reach developmental milestones.

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Develop a policy requiring more frequent court reviews for infants and toddlers and embed into court docket calendars with monthly reviews recommended as best practice for infants and toddlers.** Some states have chosen to do this through state statute, while others have chosen to implement at the court level. Monthly reviews are recommended as best practice for infants and toddlers. As a starting point, courts can review docket space and attorney capacity to determine the frequency with which cases involving infants and toddlers can be heard.
- **Consider ways to use technology to increase participation among families in court hearings.** Policymakers should also consider best practices for holding court proceedings virtually when feasible, particularly if doing so would increase attendance from parents or caregivers. Research in this area is still emerging. Some initial studies have shown promising benefits from virtual hearings, such as increased participation among families and greater representation from social supports, including extended family and other services providers who work with the family.^{cxliii} Research indicates an important part of this strategy is ensuring families have access to technology to adequately participate in virtual hearings and are included in the decision-making process.^{cxliv}

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on page 82.

- More than 100 communities across the country are implementing the [Safe Babies Court Team™ \(SBCT\) approach](#), an evidence-based model to working with infants, toddlers, and their families who are involved in the child welfare system. One of the core components of the approach is to hold frequent review hearings—in many cases monthly—to ensure that child development is on track and that families receive timely services.
- Several states provide a shorter time frame for permanency hearings for very young children. [Arizona](#), [Colorado](#), [Georgia](#), [Oklahoma](#), and [Rhode Island](#) all have policies that require more frequent permanency planning hearings for infants and toddlers in foster care than for children of other ages.^{cxliv} For example, in [Arizona](#), the time frames for court reviews for children under age 3 are expedited from six-month reviews and 12-month permanency hearings to three months and six months, respectively. Comparatively, for children over the age of 7, hearings must take place within 12 months of removal.^{cxlvi} [Vermont](#) requires a permanency hearing within three months if the child is younger than age 3 or within 6 months if the child is age 3 to 6.^{cxlvii} In [California](#), hearings are required within 120 days for children age 3 or younger.^{cxlviii}
- Other states have statutes that require more frequent review hearings for children of all ages compared with the federal statute. [Minnesota](#), [North Dakota](#), [Ohio](#), and [West Virginia](#) require case review hearings every three months for children of all ages who remain in out-of-home care, while [Virginia](#) requires the first review hearing to be held within 60 days and then every four months thereafter.^{cxlix}

KEY DATA TO COLLECT¹³

- Frequency of court hearings for infants and toddlers
- Quality of hearings (e.g., meaningful engagement of parents)
- Average time frame for initial permanency hearing for infants and toddlers
- Frequency of case reviews for infants and toddlers
- Average time frame for initial case review for infants and toddlers

KEY RESOURCES

- Gatowski, S., Miller, N., Rubin, S., Escher, P., & Maze, C. (2016). [Enhanced Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases](#). National Council of Juvenile and Family Court Judges.
- Child Welfare Information Gateway. (2020). [Court Hearings for the Permanent Placement of Children](#). U.S. Department of Health and Human Services, Children's Bureau.

¹³ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

The Challenge

Engaging families early and often in making decisions for their child welfare case can contribute to reductions in the recurrence of maltreatment, an increase in reunification of families, and improved emotional adjustment in children.^{ci} However, extensive interviews with parents—conducted as part of recent federal Child and Family Service Reviews of state child welfare systems—have found that parents often feel left out of the decision-making process involving their children’s child welfare case and are not consulted when determining the services and supports they or their children need to thrive.

One of the most effective strategies for increasing the engagement of families involved in the child welfare system is the use of family team meetings, with a team of family members and other supports in the child’s life coming together to develop a plan for supportive services and agreeing on accountability measures.¹⁴ Yet, few states have policies that require or promote such meetings to help children move expediently towards permanency. Most states responded to the Child Trends and ZERO TO THREE state survey that they either do not have a policy in place requiring a family team meeting or other teaming model, or they have these meetings quarterly or every six months. Only one state noted that they hold such conferences more frequently than four times per year for each case.^{ci}

Even fewer states have policies that promote more frequent reviews for infants and toddlers as compared with older populations. Only two states report that family group decision-making was held on a more frequent basis for infants and toddlers in foster care, as compared with children of other age groups. Of the nine states reporting that they require pre-removal conferences before an infant or toddler is removed from the home, none reported that the time frame for the pre-removal conference differed for infants and toddlers as compared with children from other age groups.

The Opportunity

Family team meetings and other types of family teaming models can be used effectively before and between court hearings to advocate for expedited and individualized services for children and families and to promote inclusive decision-making processes. Because they occur outside of the court process, family team meetings can help increase engagement of parents by reducing the confrontational nature often inherent in the court process, and by including parents as key partners in working to create a possible plan for their child’s transition. Such meetings can also provide a safe environment for parents and other professionals to work collaboratively in ensuring that any transition to out-of-home care is done in a way that limits trauma for the child and parent.

Family team meetings should occur at regular intervals throughout a child’s case. At a minimum, these meetings should include a pre-removal conference before an infant or toddler is removed from the home and a post-removal conference once the infant or toddler is removed and placed in out-of-home care. Pre-removal conferences involve working with a family to devise a plan for removal of their child; exchange key information such as child health records; discuss screening, assessment, or services needed for the child or parent; and help maintain continuity of any

¹⁴ There are a variety of family teaming models that states use, including family team conferencing, family team meetings, family group conferencing, and family team decision-making, all of which involve a broad team of family members and other supports in the child’s life coming together to develop a plan for services.

existing services being provided. A post-removal conference provides the opportunity to revisit the case plan, discuss relevant services or supports, discuss opportunities to increase family time, and make needed adjustments to the case plan. As with the recommendation for more frequent court hearings for infants and toddlers ([see Policy #8](#)), it is important that family team meetings are scheduled so they are convenient for parents and caregivers to attend and do not create an undue burden on families (e.g., require them to miss a full day of work).

Research and Best Practice

Research has shown that engaging families early and often in making decisions for their child welfare cases can contribute to reductions in the recurrence of maltreatment, an increase in reunification of families, and improved emotional adjustment in children.^{clii} Engaging families in decision-making and planning processes also improves the alignment between identified family needs and the services provided, increasing the likelihood that a family will participate and complete the services outlined in their case plan.^{cliii} The Children’s Bureau recently noted that family team meetings, along with other engagement processes, can help increase rates of reunification between children placed in foster care and their parents, help reduce the risk of child maltreatment, and/or prevent children from being removed in the first place.^{cliv} An independent evaluation of family teaming efforts in Texas found that Family Group Decision Making meetings (including Family Team Meetings or Family Group Conferences) had a significant positive impact on the desired outcomes of reducing the odds of removal and of faster reunification with family or permanent placement with relatives.^{clv}

The National Council of Juvenile and Family Court Judges (NCJFCJ) Enhanced Resource Guidelines recommend family group decision-making as an effective means to bring families, including children and extended family members, together with the child welfare agency and community organizations to express concerns, problem-solve, and develop a comprehensive plan that includes the voice of the parent and other family supports. NCJFCJ’s Enhanced Guidelines also recommend “front-loading” court processes, which include family team meetings or family group decision-making, as ways to create a more collaborative, problem-solving court environment that can lead to more productive court hearings and minimize the length of time children remain in temporary placement.^{clvi}

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Create a standard process for implementing family team meetings, or family teaming models, across all child welfare cases involving infants and toddlers.** Meetings can be staggered so they occur periodically between court hearings to ensure that parents are consistently engaged and supported to take part in the decision-making process for their children, and to ensure that parents and caregivers are receiving services identified in the case plan.
- **Train staff on facilitating and/or participating in family team meetings.** Some family teaming models require an independent facilitator position, while others allow existing caseworker staff members to be trained as facilitators. To provide consistency, states should ensure that protocols for leading family team meetings are embedded into case practice manuals and training protocols.

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on [page 83](#).

- In **Pennsylvania**, the Court Improvement Program is implementing a Family Engagement Initiative in several counties, using Crisis or Rapid Response Family Meetings to quickly support families when a crisis or other event occurs that could result in the need to remove a child from the home. This inclusive, family approach is designed to actively involve the family in decision-making. The goal of the family meeting is to address the immediate concern(s) leading to the need to remove a child from his or her home. In instances where there continue to be safety concerns and a child must be placed out of the home, a family meeting can help reduce trauma through placement with kin and supporting consistent family time or visitation.^{clvii}
- In **Missouri**, child welfare workers utilize the Team Decision Making (TDM) practice model or required family support team meeting to discuss placement-related decisions made by a team of people who are closest to the child. TDM focuses on gathering individuals involved with the family and coordinating a meeting to make the best safety decision possible. Initial TDM meetings are to be held in situations where a child and parent have been separated through a Temporary Alternative Placement Agreement (TAPA) and must be held within 10 days of the execution of a TAPA. An initial TDM meeting may be held prior to the diversion of the child only if the child can be safely maintained in the home prior to such a meeting. During the initial TDM meeting, the team will explore all options available to the family and work to mitigate any safety threats. Ongoing TDM meetings must be held at least once every month for the duration of the TAPA.^{clviii}
- The **California** Department of Social Services and the Department of Health Care Services have implemented a policy requiring the regular use of family team meetings for children and youth in the child welfare and probation systems, as well as for children and youth receiving Specialty Mental Health Services.^{clix} A child is required to have a child and family team meeting within the first 60 days of entering the child welfare system. The frequency of meetings depends on the needs of the family but should take place at least every 90 days for children receiving intensive care coordination, intensive home-based services, or therapeutic foster care.

KEY DATA TO COLLECT¹⁵

- Frequency of family team meetings for each family
- Participation rates by parents in family team meetings
- Rates of reunification for parents who participate in family team meetings
- Rates of preventing removal for families who participate in family team meetings

KEY RESOURCES

- Administration for Children and Families. (2019). [Information Memorandum: Engaging, Empowering, and Utilizing Family and Youth Voice in All Aspects of Child Welfare to Drive Case Planning and System Improvement](#).
- Children's Bureau and Child Welfare Information Gateway. (2021). [Family Engagement: Partnering with Families to Improve Child Welfare Outcomes](#).
- Annie E Casey Foundation. (2013). [Four Approaches to Family Team Meetings](#).

¹⁵ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

The Challenge

Maintaining a strong relationship with a safe and stable caregiver is critical to the healthy development of young children, and these attachments help form the foundation for a child's social, emotional, and cognitive development later in life.^{clx} Yet, the time and quality of visitation provided to families seldom fulfills the needs that parents and young children have for meaningful and nurturing time together. State child welfare systems require visitation plans between parents and children; however, these plans frequently reinforce minimum standards rather than promote best practices. This is a significant challenge for infants and toddlers placed in foster care, where early attachments are formed, and disruption of these attachments can cause significant trauma for both young children and their parents. Such trauma can lead to a reduced likelihood of reunification.

While most states have policies that set the minimum frequency of parent–child visitation, less than one-half of states reported that visitation is required to occur at least once a week. Further, only six states have policies requiring more frequent visitation for infants and toddlers compared with older children in foster care, despite research showing that this age group is the most vulnerable to disruption and most likely to suffer long term as a result.^{clxi} Not surprisingly, a recent Children Bureau's report found that child welfare agencies made concerted efforts to promote, support, and otherwise maintain a positive and nurturing relationship between children in foster care and their parents in only 58 percent of foster care cases.^{clxii}

The Opportunity

States can create policies ensuring that young children and their families have frequent opportunities to spend quality time together. These policies can specify the importance of ongoing, frequent interaction, as well as provide guidance on best practices to ensure family time is meaningful and safe for children. Federal funding, including Title IV-E and IV-B that all states receive, can be used to pay for a variety of activities designed to ensure that children have access to and visitation from their parents and siblings, including some transportation costs.^{clxiii}

In a 2020 information memorandum (IM), the Children's Bureau noted that states "must do more" to promote and facilitate active participation among parents in their children's dependency court cases, and the IM lists high-quality family time as a critical, evidence-based approach that states can implement to address this issue.^{clxiv}

When crises or other situations prevent in-person family time for children in out-of-home care, such as during the COVID-19 pandemic, it remains critical that parents and children maintain contact. The pandemic has demonstrated that virtual family time can also be an effective strategy to help strengthen or maintain the relationship between child and caregiver, when used appropriately. States and local governments can use lessons learned from the pandemic to identify opportunities to supplement family time through virtual visits so that families can continue to strengthen their bonds.

Research and Best Practice

Secure attachment with a primary caregiver is essential for healthy infant-toddler development.^{clxv} Research shows that children participating in more frequent and/or regular time with parents exhibit more positive outcomes—including enhanced parental engagement, greater likelihood of reunification, expedited permanency, increased chance of sustained reunification, and improved emotional well-being for parents and children—when compared with peers who participate in fewer regular visits.^{clxvi}

Recent changes to the Enhanced Resource Guidelines emphasize the important role that judges play in ensuring that children and parents have frequent opportunities for high-quality family time together.^{clxvii} The guidelines recommend that judges ensure that quality family time is an integral part of every case plan and that these visits be unsupervised whenever possible unless there is a demonstrated safety risk to the child.

Experts also recommend that judicial and child welfare workers tailor the family time schedule to include frequent family time visits, both in-person and virtual, to increase in frequency and duration as the parent progresses with the case plan tasks. Research has found that because babies are still developing their memory capacity, frequent, shorter face-to-face family time visits are more helpful to the attachment process than once-a-week, longer, or virtual visits.^{clxviii}

We know from existing studies that children under 5 are more comforted when they have access to a parent via video chat than when they are left alone in a room. And children between 2 and 3 ½ years of age are also more comforted by a parent on video chat than by speaking on the phone. This suggests that video chatting is in some way meaningful to very young children, or that it at least provides more comfort than nothing at all or a telephone call. Observations reveal that while there is reason to think that babies would be a little put off or challenged by video chat, their sensitive, engaged parents and family members do a great job scaffolding the interaction and making it as engaging as a face-to-face interaction.^{clxix}

Each family has their own strengths and challenges when it comes to spending time together, and plans for supporting their relationship must be formed on an individualized basis. The goal of parent–child contact is to permit the child and parent to keep the other a living presence in their lives and to improve the parent’s responsiveness to the child’s needs. Through supported parent–child contact, a desired goal is to nurture the relationship between parent and child and to address any challenges to developing the attachment. At the same time, children’s substitute caregivers (whether extended family members or unrelated resource parents) are critical allies in assisting children and their parents in maintaining or building healthy, loving relationships.

An example of a program engaging the entire family unit in building on their strengths and identifying areas for growth during family time is GIFT (Guided Interaction for Family Time). GIFT is designed to equip the guide to prepare parents with a set of skills and resources to engage them in active, hands-on parenting, with interventions and strategies to create behavior modifications for children affected by prenatal alcohol exposure. This service typically takes place in a safe, family friendly environment a minimum of two 2.5-hour visits per week, facilitated by a trained coach who works consistently with the same family for approximately two to three months. Visit coaching is fundamentally different from supervised visits because of the focus on the strengths of the family and the needs of the children. Visit coaching supports families in meeting the unique needs of each child.

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Create policies and promote practices that require frequent opportunities for high-quality family time.** These policies can specify the importance of ongoing, frequent interaction, as well as provide guidance on best practices to ensure family time is meaningful and safe for the child.
- **Create training and educational opportunities to ensure judges, attorneys, and other child welfare personnel are aware of the importance of family time to child and parent well-being and understand how frequent family time can buffer the trauma caused by parent–child separation.** Training should emphasize the importance of family time, with coaching to involve parents in their child’s everyday routines and activities. Family time should include keeping

parents abreast of their child’s development; strengthening the parent–child relationship; ensuring family time with siblings; and creating family time arrangements that allow and support parents to not just visit with their child, but to parent them.

- **Work with the Administrative Office of the Courts to create or update family time–specific court rules that reflect current knowledge about the importance of family time in mitigating child trauma and expediting reunification.** This should also reflect the research and practice suggesting that infants and toddlers can benefit from frequent, even daily, visitation—ideally several times per week when individual circumstance permit. Policies and practice around family time should be presumed unsupervised unless there is a documented safety risk to the child.
- **Provide guidance to judges, attorneys, and court personnel on best practices, such as including discussion of family time at every hearing and review, as well as on identifying family time as a critical reasonable effort to finalize permanency goals of reunification.** This guidance should include important questions on what can be done to help advance quality time, ensuring visitation occurs frequently and as early as possible from when a child is removed from his or her parents’ care; making opportunities for therapeutic visitation when possible; and identifying a location for family time that enhances the parent–child interaction, is logistically possible for the family, and supports the child’s needs.^{clxx}
- **Include qualitative measures that look at the substance of family time discussions, as well as decisions in court observation and other instruments utilized as part of mandatory Court Improvement Program hearing quality projects.** These qualitative observations should be used to ensure that judges receive all available information about family time and can understand how children, parents, and siblings are spending time together; if visit coaching is being offered; how parents—both mothers and fathers—are being involved in appointments and other services their child is receiving; and how the visits may help inform their decisions on whether more relaxed supervision and/or more frequent family time can be implemented.

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on [page 84](#).

- Six states have policies that require more frequent parent–child visits for infants/toddlers than for children of other ages in foster care. For example, in [Georgia](#), children ages 0 to 2 have visits twice per week, while those ages 3 to 5 have visits once per week. In [Nebraska](#), infant and toddler visitation with parents occurs minimally three times a week, while older youth visitation occurs twice a week.^{clxxi}
- Other states have developed additional policies that support high-quality family time:
 - In [Georgia](#), state statute also specifies that visitation is presumed to be unsupervised unless the court determines otherwise. Georgia’s Court Improvement Program has issued guidance to judges on family time, providing information on best practices for assessing and ordering family time plans.^{clxxii} Among other things, the guide notes that the child and parent have a constitutional right to maintain their bond through quality family time (visitation) and that child welfare system stakeholders have a moral obligation to provide “as much family time as possible consistent with the best interests of the child (both in frequency and duration), and in as natural a place and manner as is possible.”^{clxxiii}

- In [Illinois](#), state policy implements a special service fee for family reunification support. This fee provides reimbursement to foster and relative caregivers participating together with parents of children in their care in activities supporting family reunification. To qualify for reimbursement, the activities must engage parents with their children in a family setting—such as the home of the caregiver, parent, relative, or friend—or at a church or community institution that offers an appropriate environment for parenting activities. An activity qualifies for caregiver reimbursement if the caregiver provides the location, supervision, mentoring, and/or transportation for these activities.^{clxxiv}
- [New Jersey](#) has created a bench card for judges to ensure parent–child contact is maintained and strengthened through parenting time.^{clxxv} The form includes relevant state or federal statutes on family time and a decision tree to help judges make determinations on specific case circumstances.^{clxxvi} Courts must include a visitation schedule for the child and his or her parents, siblings, and other family members. In cases where family time does not occur, courts must provide information on the reasons for the delay and develop a plan to mitigate barriers (e.g., transportation, work and school schedules). The bench card was developed by the Statewide Children in Court Improvement Committee, which is comprised of judges, attorneys, advocates, representatives from the juvenile justice and children’s behavioral health care systems, and officials from the Administrative Office of the Courts.

KEY DATA TO COLLECT¹⁶

- [Frequency of supervised family time/visitation for infants and toddlers](#)
- [Frequency of therapeutic family time for infants and toddlers \(visitation between a parent and child supervised by a licensed mental health professional\)](#)
- [Time between removal and first family time/visitation](#)
- [Frequency of visitation between infants/toddlers and their siblings](#)

KEY RESOURCES

- [Irving Harris Foundation, Meaningful Family Time Suite of Resources](#)
- [Quality Parenting Initiative](#)
- [Dr. Rachel Barr, Professor, Georgetown University, Virtual Visitation: What Courts Should Know \(Webinar\)](#)
- [Gatowski, S., Miller, N., Rubin, S., Escher, P., & Maze, C. \(2016\). Enhanced Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases. National Council of Juvenile and Family Court Judges.](#)
- [Osofsky, J., Cohen, C., Huddleston, J., Hudson, L., Zavora, K., & Lewis, M. \(2017\). Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System. National Council of Juvenile and Family Court Judges.](#)
- [ZERO TO THREE National Infant-Toddler Court Program, Video Chat Checklist, ZERO TO THREE, Five Tips to Make the Most of Video Chats](#)

¹⁶ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

The Challenge

Parents who are investigated by the child welfare system often feel isolated and confused by what can be a complicated and bureaucratic process. Without the proper guidance—including supports to understand complex legal rules, access to and understanding of available services, and emotional support—parents can become frustrated, overwhelmed, and disengaged, leading to potentially negative outcomes for children, including longer time to permanency.

Parent mentors, also known as parent support partners or family allies, are one approach to helping address these challenges by increasing the engagement of parents, including greater involvement in planning and decision-making in their child’s welfare case. However, only a handful of states require support partners or mentors for parents of maltreated infants and toddlers to successfully navigate the child welfare and court systems or require mentoring for parents by caregivers. Such services are also among the least likely to be routinely offered to parents according to the Child Trends and ZERO TO THREE state survey.^{clxxvii}

The Opportunity

When a family’s protective factors are bolstered and supported—through actions such as valuing parents and honoring their family’s language and culture, supporting parents as decision-makers, and supporting parents from a strengths-based perspective—pathways can lead to improved outcomes for children and families.^{clxxviii}

The Children’s Bureau has identified parent mentors as a key strategy that states should implement to help parents better understand what to expect as they interact with the child welfare system and as an effective strategy for increasing engagement in services and planning efforts.^{clxxix} Parent mentors are mothers and fathers with prior experience in the child welfare system who are trained to provide peer support and guidance to help other parents currently involved in the system. Similar to “system navigator” programs in the health care field,^{clxxx} parent mentor programs help parents who are new to the system become more comfortable with the process, enabling them to gain trust in working with other professionals, including caseworkers, attorneys, and other service providers, and to increase their engagement in addressing the issues that brought their child to the attention of the court.

Parent mentors can also be valuable stakeholders in systems change efforts. Their close connection and relationship with parents gives them a distinct perspective on what is working and what is not working for families navigating investigations and court proceedings.

Research and Promising Practice

Research on parent mentor programs in child welfare, though limited, has found some promising results, including higher rates of reunification for participating parents, lower rates of reentry for children involved in the program, and increased participation in services and court hearings.^{clxxxi}

An evaluation of Iowa’s Parent Partner Approach found that participating parents were significantly more likely to have a child in out-of-home care return home and less likely to experience subsequent removal from the home after 12 months.^{clxxxii} There was no significant difference in the length of stay in care for children among participating parents. An evaluation of a parent partner program in Contra Costa County, CA, found that parents working with partners had significantly higher rates of reunification than families without parental partner support.^{clxxxiii} A study of Washington State’s Parents for Parents program found higher rates of reunification among participating parents, while earlier studies found increased rates of participation in court hearings and greater compliance with court-ordered case plans among participating parents.^{clxxxiv}

RECOMMENDED STATE AND LOCAL STRATEGIES

- **Develop a program and related policy via which parent partners and parent mentors are provided to support families in the child welfare system, including during the investigation process.** In developing a new program, or adapting an existing model, consider available research and evidence on effectiveness, including how the program incorporates cultural competency in working with families of color. Parent partner models may vary by location; for example, in states such as Washington the program is embedded in the court system, whereas in Iowa it is part of the child welfare agency.
- **Create payment mechanisms to support parent partners, including creating state positions or contracting with community-based organizations to provide the services.** It is important to value peer parents' time. Funding for parent partners should be identified as early on as possible in program development. Some child welfare agencies pay peer parents directly or contract with peer parent providers who pay peer parents as employees. In other communities, certification of parent mentors or peer parents allows programs to bill Medicaid. Peer parents should be compensated fairly and with a wage at which they do not fall victim to the benefit cliff that exists within our safety net programs. For example, peer parents should not be forced to choose between work and losing access to childcare benefits.
- **Provide training to parent partners and parent mentors, as well as to child welfare agency and court staff, to prepare them to be effective advocates for parents.** Training for parent partners and staff is critical in helping develop a supportive but professional relationship with parents being mentored. Such trainings often include sessions on domestic violence, mental health, family team meetings, cultural competency, and substance use. Trainings should also support parent partners/mentors in serving as role models for parents in the child welfare system as early as possible, including during the investigation phase, receiving training in advocacy skills as they become leaders in their communities.
- **Establish advisory boards of persons with lived experience in the child welfare system to serve as advisors on policies and practices.** Advisory board members should be compensated for their work, and the composition of advisory boards should reflect the racial, ethnic, and cultural diversity of families in the state.

STATE AND LOCAL EXAMPLES

Additional resources and contact information available in the State Examples Appendix on [page 86](#).

- In **Hawaii**, Project First Care is a program for children ages 0–3 who are in foster care for the first time and, at the time of removal, do not have relatives available for immediate placement. This initiative uses mentoring by trained resource parents to help parents acquire skills for their child's care and return babies home faster. Project First Care provides temporary care with intensive upfront services such as Family Finding, Ohana (Family) Conferencing, mentoring with birth parents, and enhanced Ohana Time. The program aims to reunify children with their parents or place them with relatives within 60 days of removal; if unsuccessful, the child is transitioned to a general licensed resource home. Approximately 75 percent of the children whose parents participate in the program are reunified or placed with relatives or kin within 60 days of their initial placement.^{clxxxv}
- In 2015, **Washington State** passed legislation to expand the implementation of its parent mentor program. The legislation is based on the state's Parents for Parents program, which connects parent allies with parents who are new to the child welfare system. The legislation authorized funding to expand the program at new sites, as well as funding for evaluation. Currently, the program is operating in all 39 counties in Washington.^{clxxxvi}

- Children & Families of Iowa operates the Parent Partner Program for the [Iowa Department of Human Services](#), a statewide effort to support families involved in the child welfare system through the support of parents who were formerly involved in the child welfare system and successfully reunited with their children. These parent partners provide social support and guidance on how to navigate the reunification process, including what to expect, as well as help parents access needed services or supports. The program has expanded operations, as an entity was contracted through the state in 2015 to manage all 99 counties. In state fiscal year 2022, parent partners provided support to roughly 1,565 parents through 103 trained parent mentors. The program is rated as a promising practice in the Title IV-E Prevention Services Clearinghouse based on its success in supporting reunification and reducing recurrence of child maltreatment.^{clxxxvii}
- Recognizing that parents' voices need to be valued as a key part of planning and decision-making, the [National Infant-Toddler Court Program](#) developed the [National ITCP Advisory Group for Parents' Voices](#). This group is made up of parent leaders from across the country with lived experience in child welfare, each of whom are currently serving as peer mentors, supporting systems change and improvement efforts, and advocating for parents across the country. The parent leaders of the National ITCP Advisory Group provide consultation, training, and technical assistance to the more than 100 ITCP sites across the country, including dependency courts, family treatment courts, child welfare agencies, and statewide collaborations to support understanding the importance of and enhancing parental voice and partnership as families navigate the child welfare system.^{clxxxviii}

KEY DATA TO COLLECT¹⁷

- [Type of and use of parent partner, peer parent, or peer mentor program models across the state](#)
- [Diversity of parent mentors and peer parents](#)
- [Data on training curricula \(such as for the Iowa Parent Partner Program\) for training peer parents](#)
- [Reunification data for families involved in the parent partner program](#)

KEY RESOURCES

- [Irving Harris Foundation, Diversity-Informed Tenets for Work with Infants, Children, and Families \(Overview\)](#)
- ZERO TO THREE, [National Infant-Toddler Court Program Advisory Group for Parents' Voices](#)
- Iowa Department of Human Services, [Parent Partner Resources](#)
- Child Welfare Capacity Building Collaborative, [Center for States: Parent Partner Program Navigator](#)
- ZERO TO THREE, [Trauma-Informed Child and Family Service Systems](#)
- ZERO TO THREE, [Equity and Social Justice in Child Welfare](#)
- Casey Family Programs. (2021). [How Do Parent Partner Programs Instill Hope and Support Prevention and Reunification?](#)
- National Child Welfare Workforce Institute. (2019). [Racial Equity Discussion Guide](#).

¹⁷ These are examples of data that will be useful for providing a clearer picture of system strengths and gaps while simultaneously focusing attention on disparities and disproportionality. All data should be disaggregated by age, geography, race, ethnicity, and socioeconomic status.

CONCLUSION

State and local policies can play a key role in ensuring children thrive and reach their full potential. State and community systems focused on promotion of positive development nurtured within strong families beginning at birth and prenatally offer a unique opportunity to address the adverse conditions that pose great risks to families. Supporting families as early as possible can provide children, parents, and communities with resilience—or capacities and skills that allow them to respond to adversity in a healthy, adaptive manner.

All families should be able to receive the supports they need to strengthen their parenting skills and support the positive development of their children without becoming involved in the child welfare system. To be effective, states must leverage a broad range of prevention supports to help keep families together, support long-term family protective factors, and work with communities to strengthen the conditions where families live. This collaborative approach to family strengthening and prevention will require support from a wide range of state and community leaders that work with infants, toddlers, and their families. Child welfare systems will need to form partnerships with a broad coalition of health, human service, and early childhood organizations so that families experiencing conditions or factors placing them at higher risk for entering the child welfare system can receive the support they need outside of the system.

Some families may come to the attention of the child welfare system due to complex needs that are unable to be addressed and supported in the community and may need additional support to ensure children are safe and healthy. Placing a child in out-of-home care, including foster care and kinship care, can compound these problems if the placements are not supportive of the child's early development. A growing body of research shows that early identification of needs and services for young children and parents involved in the child welfare system can improve child safety, increase well-being, facilitate permanent child placements, and strengthen families. Research also demonstrates the importance of actively engaging parents in decision-making and in creating judicial policies and practices that empower parents and reinforce the importance of maintaining the child–parent relationship. States have an opportunity to transform their child welfare systems to be more responsive to the physical, mental health, and developmental needs of infants and toddlers—and the complex needs of their parents.

This policy framework provides a roadmap for states to identify and implement policies and practices that can best support the needs of infants and toddlers and strengthen families.

STATE AND LOCAL EXAMPLES APPENDIX

POLICY 1	Resources and Contact Information
<p>The role that Medicaid can play in reducing racial disparities in maternal and infant health is demonstrated in initiatives such as North Carolina’s Pregnancy Medical Home Program, a partnership between state Medicaid, Community Care of North Carolina, and the state Division of Public Health. This program provides participating health care providers with incentives to complete a pregnancy risk screening on all Medicaid-eligible pregnant women. The risk screening responses are run through a risk stratification model to generate a Maternal Infant Impactability Score™ (MIIS) that is shared with the pregnancy care manager from the local public health department. The MIIS indicates level of risk and prescribes what frequency of care management contact is needed to impact outcomes. The Pregnancy Care Manager coordinates the woman’s care and works to reduce social determinants of health (SDOH) needs throughout the pregnancy.</p>	<p>Community Care of North Carolina, Pregnancy Medical Home</p> <p>https://www.communitycarenc.org/what-we-do/clinical-programs/pregnancy-medical-home</p> <p>For more information:</p> <p>Kimberly DeBerry Maternal Child Health Director, Community Care of North Carolina kdeberry@communitycarenc.org</p>
<p>New Jersey’s statewide Maternal Wraparound Program (MWRAP) provides intensive case management and recovery support services for pregnant women with substance use disorders during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women and their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The overall goal of MWRAP is to alleviate barriers to services through comprehensive care coordination that is implemented within the five major time frames when intervention in the life of a substance-exposed infant (SEI) can reduce the potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal, and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure.</p>	<p>Southern New Jersey Perinatal Cooperative Project Embrace/Maternal Wraparound Program 2500 McClellan Avenue, Suite 250 Pennsauken, NJ 08109 Contact: Quinn Ingemi qingemi@snjpc.org 856-665-6000 (main)</p> <p>JSAS HealthCare, Inc. Maternal Wrap Around Program 685 Neptune Boulevard, Suite 101 Neptune, NJ 07753 Contact: Rebecca Greene rgreen@jsashealthcare.org 732-988-8877</p> <p>Rutgers University Behavioral Health Care Maternal Wraparound Program 671 Hoes Lane West Piscataway, NJ 08855 Contact: James Shipman shipmaja@ubhc.rutgers.edu 973-972-4800</p> <p>Zufall Health Center Maternal Wrap Around Program 18 W. Blackwell Street Dover, NJ 07801 Contact: Nereida Mendez nmendez@zufallhealth.org 973-328-3344 ext. 322</p>

The **ZERO TO THREE HealthySteps** evidence-based model embeds a child development expert, the HealthySteps Specialist, into primary care practice to meet families' individual needs. The specialist joins the care team to promote nurturing parenting, which improves babies' and toddlers' healthy development and well-being where they are most likely to be—the pediatric primary care office. For enhanced primary care models like HealthySteps, expanding the care team to include a child development expert enables the practice to focus on the child, the caregiver, and the child-caregiver dyad. The HealthySteps national network includes more than 200 sites in 26 states and Washington, DC.^{clxxxix} This national, innovative, and low-cost approach is designed based on scientific understandings of how early childhood development works and how to best support early relational health.

HealthySteps
<https://www.healthysteps.org>

For more information:

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ZERO TO THREE
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Developmental Understanding and Legal Collaboration for Everyone (DULCE) is a universal, evidence-based pediatric care approach with a foundational goal of reducing the risk of maltreatment and contact with child welfare. It does so by screening for health-related social needs for individual families, addressing social determinants of health gleaned through patterns across families, supporting early relational health, and providing a legal partner for families with infants in communities that are under-resourced and often marginalized by racist systems. By utilizing community health workers with lived experience, accelerating access to justice, and connecting families with concrete supports and resources, DULCE aims to address inequitable systems that preclude families from living healthy lives.^{cx}

DULCE, Center for the Study of Social Policy
<https://cssp.org/our-work/project/dulce/>

For more information:

Azieb Ermias, Center for the Study of Social Policy
azieb.ermias@cssp.org

The **Illinois Children's Mental Health Partnership (ICMHP)** has developed a unified model for infant and early childhood mental health consultation in the state. This model is a multi-level, proactive approach that pairs multidisciplinary IECMH professionals with individuals who work with young children and their families to support and enhance children's social and emotional development, health, and well-being.^{cxci}

"Illinois Infant/Early Childhood Mental Health Consultation (I/ECMHC)"
<https://www2.illinois.gov/sites/OECD/Pages/Illinois-Infant-Early-Childhood-Mental-Health-Consultation.aspx>

Federal law allows states flexibility to adopt policies that make it easier for families to apply for or continue receiving WIC benefits. For the past several years, the Center for Budget and Policy Priorities has provided technical assistance to state and local WIC agencies across the country to modernize and simplify enrollment to reach more eligible low-income families. For example, the [Maricopa County, Arizona](#) WIC sought to improve its enrollment process by establishing a single public phone number for all county WIC sites, building an online appointment request option, and expanding options for providing electronic records to document eligibility.^{cxvii}

For more information:

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Nutrition & Breastfeeding Program
1645 East Roosevelt

Phoenix, AZ 85006
Carrie.Zavala@Maricopa.Gov
www.Maricopawic.com

WIC Case Study: Maricopa County, Arizona
<https://www.cbpp.org/sites/default/files/atoms/files/8-30-19fa-casestudies-maricopa-county.pdf>

POLICY 2

Resources and Contact Information

Ten states have enacted state Paid Family and Medical Leave (PFML) policies. [California's](#) statewide paid family leave program, in effect since 2004, is associated with improved health outcomes for children in early elementary school, including reduced issues with maintaining a healthy weight, attention-deficit/hyperactivity disorder, and hearing-related problems, particularly for less-advantaged children, likely because of reduced prenatal stress, increased breastfeeding, and increased parental care during infancy. [Washington State](#) enacted its policy in 2017, offering 12 weeks for both family leave and personal health leave, with up to 18 weeks of leave per year available in some cases. The policy is funded through premiums paid by employers and workers in the form of paycheck withholdings. All employers in the state must either participate in the state program or offer equivalent benefits. [Maryland's](#) paid family and medical leave, passed in 2022, provides up to 12 weeks of leave with partial wage replacement when workers or their loved ones are seriously ill, when welcoming a new child (for parents of any gender, including foster and adoptive parents), or to address the impact of military deployment, allowing up to 24 weeks in special circumstances.

California Work & Family Coalition:
"Understanding Paid Leave"
<https://www.paidfamilyleave.org/understanding-paid-leave>

Washington Paid Family & Medical Leave
<https://paidleave.wa.gov/>

Maryland's Time to Care Act
https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0275?utm_medium=email&utm_source=email_link&utm_content=baby_monitor_04142022&utm_campaign=Q3_2022_Policy+Center_Resources

Early childhood and parent support programs in [New Jersey](#) have long understood the importance of working together to ensure families receive the services they need to thrive. One way this has been actualized is through the creation of central intake hubs, or Family Success Centers (FSC), to systematize the process for screening, referring, and connecting families to services. As of 2015, each of New Jersey's 21 counties has at least one FSC, providing a single point of entry for families to access information about and referrals to a wide range of community services that promote child and family

National Family Support Network
www.nationalfamilysupportnetwork.org

New Jersey Department of Children and Families,
Family Success Centers
<https://www.nj.gov/dcf/families/support/success/>

wellness, including parenting support, prenatal care, early care and education, nutrition support, education activities, Part C early intervention, housing, primary care, mental health, and substance use disorder treatment.^{cxiii}

Arapahoe County, Colorado has rethought how it provides human services to incorporate a two-generation approach. A key aspect of doing so has been strengthening connections between county departments and the programs they offer so that families do not need to navigate a fragmented system. One very tangible way the county has done this is by creating a comprehensive resource directory with information about a variety of parent- and child-focused community-based services. Other strategies that counties are employing include co-locating adult- and child-oriented services, merging county departments for social services and housing to provide more holistic family support services, and incorporating screening for social determinants of health into existing programs.^{cxiv}

The **Colorado** General Assembly established Family Resource Centers (FRCs) in 1993 to serve as a “single point of entry for providing comprehensive, intensive, integrated, and collaborative community-based services for vulnerable families, individuals, children, and youth” in local communities. Between July 2020 and May 2021, FRCs provided more than 166,000 services, most frequently in the areas of basic needs and parenting. Families demonstrated significant improvements in economic self-sufficiency, health, concrete support in times of need, social support, and family functioning and resiliency both before and after the onset of COVID-19, suggesting that FRCs provided resources and support to buffer families through the hardships of the global pandemic.

In **Washington State**, the Family Intervention Response to Stop Trauma (FIRST) Legal Clinic is a medical–legal partnership that provides preventative legal advocacy to parents of infants at risk of child protective services (CPS) removal. FIRST Legal Clinic works directly with pregnant persons and parents of newborns to develop plans of safe care for their children to eliminate the need for removal. Referrals come from a variety of sources, including local hospitals, substance use disorder treatment programs, parent advocacy programs, the child welfare agency itself, doulas, midwives, law enforcement, and

Arapahoe County ArapaSOURCE Resource Finder
<http://www.arapahoegov.com/1906/Arapa-SOURCE>

The Colorado Guide to 2Gen
<https://ascend.aspeninstitute.org/resources/colorado-guide-to-2gen/>

National Family Support Network
<https://www.nationalfamilysupportnetwork.org/membership>

For more information:

Teri Haymond, LCSW, Program Director
2543 California Street
Denver, CO 80205-2929
Phone: 303-388-1001 ext. 104
Fax: 888-439-2650
www.cofamilycenters.org

Family Intervention Response to Stop Trauma (FIRST) Clinic
<https://thefirstclinic.org/>

For more information:

Taila AyAy, Vice President and Executive Director, FIRST Legal Clinic
tailaayay@thefirstclinic.org

others. FIRST Legal Clinic endeavors to work with clients as early as possible, including early in the pregnancy, to forgo any child welfare agency involvement at all. The legal clinic model utilizes an attorney to work with the parent and an experienced, trained parent ally with lived experience as a resource navigator. The legal clinic connects clients with existing resources such as housing, substance use disorder treatment, public health nurses, the Parent–Child Assistance Program and parent advocacy programs, domestic violence services, and others.

POLICY 3	Resources and Contact Information
<p>Pennsylvania's Infant Toddler Contracted Slots program provides one-year contracts to high-quality programs serving infants and toddlers, with a higher rate of payment than they would receive through the traditional subsidy program. To promote continuity of care from birth to age 5, only programs that also participate in the state-funded Pre-K program are eligible to participate.^{cxv}</p>	<p>Pennsylvania Office of Child Development and Early Learning https://www.education.pa.gov/Early%20Learning/Pages/default.aspx</p> <p><i>Infant and Toddler Contracted Slots Pilot Program: Evaluation Report</i> https://s35729.pcdn.co/wp-content/uploads/2020/11/IT-Pilot-Evaluation-Report_PA_Final.V2.pdf</p>
<p>Louisiana has created a professional credential, the Early Childhood Ancillary Certificate (ECAC), for teachers who are working in childcare programs as part of the state's effort to unify the early childhood system and professionalize the early childhood workforce. The state provides funding for professional development throughout the state to administer the training, as well as scholarships for teachers to participate. Early childhood educators who receive the new credential and stay in the field will be eligible for a refundable tax credit of more than \$3,000 annually. There are currently 29 approved programs in Louisiana, combining coursework and job-embedded coaching, typically taking a year or less. Programs are vetted and approved by Louisiana's Board of Elementary and Secondary Education before they are eligible to offer ECAC coursework.^{cxvi}</p>	<p>For more information:</p> <p>Leslie Roy Doyle, Early Childhood Chief of Staff Louisiana Department of Education 1201 North Third Street Baton Rouge, LA 70802 leslie.doyle@la.gov</p>
<p>Help Me Grow (HMG) Connecticut provides a central point of contact for families with young children to help them navigate services and coordinate care. The Child Development Infoline, which is a specialized call center of the United Way of Connecticut's 2-1-1 system, is the access point for HMG. Connecticut's HMG program serves pregnant women, parents, caregivers, social service agencies, child health providers, and early care and</p>	<p>Help Me Grow Connecticut https://www.ctoec.org/educational-campaign-materials/help-me-grow/</p>

education providers. Through comprehensive physician and community outreach and centralized information and referral centers, families are linked with needed programs and services. Connecticut’s HMG program uses universal developmental screening to identify and treat potential developmental delays early. Through HMG, families can receive information on various topics related to their child’s development, such as managing difficult behaviors, toilet training, sleep issues, promoting language development, and typical developmental milestone information.^{cxcvii}

POLICY 4

Allegheny County, Pennsylvania created a new approach to supporting families with new babies and reducing the number of infants and toddlers experiencing abuse and neglect in recent years. The approach is based on an extensive community and family engagement process that found that parents would be more likely to engage in services that were universally offered, with outreach conducted by relatable home visitors. The initiative, called Hello Baby, offers a tiered approach to prevention including a variety of supports designed to meet families’ individual needs and interests. The program uses a deliberate and differentiated approach to reach more parents early, before a crisis can occur, including a predictive risk model that matches parents with services based on their level of risk. In the first year, universal services are offered to all Allegheny County families with a baby born at any county birthing hospital. Families with moderate needs are contacted by outreach workers at a subset of Family Centers based in neighborhoods throughout the county. Families with the most complex needs are offered more intensive services by Healthy Start Pittsburgh, with a family engagement specialist and social worker reaching out to families to better determine their needs and connect them to the best resources the county has to offer.

In **Guilford County, North Carolina**, Get Ready Guilford is partnering with Family Connects, HealthySteps, and Nurse–Family Partnership to build a continuum of services for families and children prenatally to age 3. Community Navigators collaborate with three early childhood programs to ensure that all families with young children get the services they need, when they need them. Over time, the county aims to offer universal assessment prenatally; at birth; and at 12, 24, and

Resources and Contact Information

Hello Baby
<https://hellobabypgh.org/>

For more information:

Susan Bertonaschi, Early Childhood Sr. Advisor
Allegheny County Department
of Human Services
Office of Community Services
susan.bertonaschi@alleghenycounty.us
412-350-4033

Ready for School, Ready for Life (Ready Ready)
<https://www.getreadyguilford.org/>

Stories of communities implementing the
Hand in Hand Framework
<https://www.zerotothree.org/resources/3968-hand-in-hand>

36 months to every family in Guilford County—as well as targeted referrals based on assessment results and ongoing support for families. Get Ready Guilford is part of the Model Convening Project, using the Hand in Hand framework.

North Carolina’s Care Coordination for Children (CC4C) is a free and voluntary program that helps families find and use community services. CC4C care coordinators serve children from birth to age 5 who have or are at risk for developmental delay or disability, long-term illness, social–emotional problems, or toxic stress. Common referrals include infants who are discharged from the newborn intensive care unit, children with special health care needs, children in foster care, and children and families who have had a positive screen in their primary care practices (including developmental and behavioral health screening, autism screening, and maternal depression screening). The program uses a two-generational model to assess risks and strengths and set goals with families. CC4C staff are primarily registered nurses or social workers employed by local health departments. They regularly communicate and collaborate with the child’s medical home and help connect families to services such as quality childcare, family support, mental health resources, and GED resources.^{cxcviii}

Bring Up Nebraska is a statewide effort that provides a framework for organizations in local communities to form a collaborative to help prevent problems from becoming a crisis for area families. Bring Up Nebraska is based on a philosophy that local communities are best situated and most motivated to understand their own needs and strengths, identify solutions to challenges, and help families connect to services that can prevent a crisis potentially resulting in entry into the child welfare system or other higher systems of care. Bring Up Nebraska supports local communities through technical assistance, tools, and resources to help communities identify service gaps, develop plans using strategies and data, and commit to common goals, measurements, and practices to improve well-being.^{cxcix}

Care Coordination for Children

<https://medicaid.ncdhhs.gov/beneficiaries/get-started/find-programs-and-services/care-coordination-children>

Bring Up Nebraska

<https://bringupnebraska.org/>

POLICY 5

Resources and Contact Information

ZERO TO THREE's Infant-Toddler Court Program (ITCP) works with local communities to implement a proven approach for children from birth to 3 years of age in foster care, or at risk of removal, and their families. This evidence-based approach connects babies and their families with the support and services they need to ensure healthy development and lasting permanency. A family team, including a dedicated community coordinator, parent, family and other supports, caseworker, judge, and attorney work intensively to address child and parent needs, participating in monthly family team meetings and monthly review hearings and providing timely screening, assessment, and linkage to timely prevention and intervention services. The ITCP provides training and technical assistance to a broad range of stakeholders at local sites on a range of topics related to early childhood development—including attorneys and judges, early childhood education providers, child welfare caseworkers, and other stakeholders working with children and families—and reinforces this training through regular site visits, observations, and one-on-one team calls. As of January 2022, there are more than 100 infant-toddler court team sites operating across the country. Evaluations have found that children who participated in the program exit the foster care system eight months earlier than children in traditional child welfare, with significant reductions in the recurrence of maltreatment within 12 months. Also, children achieved the same outcomes regardless of ethnicity, race, or time in foster care.^{cc}

National Infant-Toddler Court Program
<https://www.zerotothree.org/resources/series/national-infant-toddler-court-program>

For more information:

Janie Huddleston, Director,
National Infant-Toddler Court Program,
ZERO TO THREE
jhuddleston@zerotothree.org

Arkansas Building Effective Services for Trauma (ARBEST) has worked toward building a continuum of care to address the mental health needs of and improve outcomes for young children exposed to trauma across the state. The ARBEST advisory broad represents a broad range of stakeholders coming together for collaborative visioning, including the Office of the Governor, Child Advocacy Centers, the Mental Health Council, the Infant Mental Health Association, Court Improvement, child welfare, the Department of Education, and more. ARBEST focuses on working across sectors as a way to develop impactful interventions that will be sustained across a long period of time. Supported by state funding, ARBEST has worked for more than a decade to increase access to evidence-based trauma treatment services by providing training for mental health professionals in Arkansas and

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by building consumer knowledge of evidence-based treatments. This has resulted in EBT-trained therapists in 64 of the state's 75 counties, totaling more than 2,000 providers. In 2018, Arkansas Medicaid released new standards and enhanced reimbursements for clinicians providing mental health services for children ages 0–47 months under Medicaid, with the goal of increasing the use of evidence-based practices. To meet these standards, clinicians must be trained in ZERO TO THREE's DC:0–5™ as well as in evidence-based dyadic treatment. ARBEST supports clinicians in meeting these standards by offering regular, no-cost trainings in the DC:0–5, as well as in Parent–Child Interaction Therapy and Child–Parent Psychotherapy.

In **Washington State**, a new initiative aims to strengthen the linkages between the state's child welfare and early learning systems by funding Child Welfare Early Learning Navigators who collaborate with child protective services (CPS) caseworkers to support and connect families with young children to high-quality early learning and family support experiences. The program was started after data showed that fewer than one-half of Washington's eligible families involved with CPS were accessing early childhood programs, including childcare, Head Start, home visiting, and other early intervention and prevention services. The program, which is being funded through Washington's Preschool Development Grant, has been implemented in three regions of the state, including South King, Grays Harbor, Mason, Pacific, and Yakima counties, and will soon be expanded to serve tribal communities in the state.^{cci}

Child Welfare Early Learning Navigators
<https://www.dcyf.wa.gov/news/child-welfare-early-learning-navigators>

For more information:

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POLICY 6

Arkansas, Washington, and Nebraska implemented differential response as part of a Title IV-E Waiver Demonstration Project. Each state's project was evaluated by independent researchers, with findings showing that families who participated in the differential response pathway experienced fewer removals and were less likely to have a subsequent child protective services (CPS) case open compared with similar families who did not receive differential response services.^{ccii}

Resources and Contact Information

"Differential Response: A Primer for Child Welfare Professionals"
<https://www.childwelfare.gov/pubs/factsheets/differential-response/>

The **Kentucky Sobriety Treatment and Recovery Team (START)** program works with families involved in the child welfare system with substance use disorders by pairing specially trained CPS workers with family mentors using a system-of-care and team decision-making approach with families, treatment providers, and the courts. The program places families at the center of treatment and includes them in the decision-making team during treatment and case planning. The program aims to reduce recurrence of child abuse and neglect, improve SUD treatment rates, build protective parenting capacities, and increase the county and state’s capacity to address co-occurring substance abuse and child maltreatment.^{cciii}

Sobriety Treatment and Recovery Team (START)
<https://chfs.ky.gov/agencies/dCBS/oc/Pages/start.aspx>

START Model
<https://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed>

POLICY 7	Resources and Contact Information
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The **Washington State Office of Public Defense** began implementing the Parents Representation Program in 2000 with a pilot program in two counties to provide access to multidisciplinary representation for indigent parents in dependency cases. The state legislature gradually expanded the program to additional counties over time, and in 2018 the program was expanded statewide. The program has been evaluated multiple times and has found higher permanency rates and shorter times to permanency in counties implementing the program compared with non-participating counties.^{cciv}

Washington’s Parents Representation Program
<https://partnersforourchildren.org/resources/briefs/washingtons-parents-representation-program>

The **Iowa Legal Aid Parent Representation Project** provides civil legal assistance to families who are currently in or at risk of entering the child welfare system. The program uses a multidisciplinary team approach comprised of an attorney, case manager, and parent advocate with lived experience to advocate for families through legal assistance, help connect families to needed services, and help navigate the child welfare system. The program receives referrals from the Iowa Department of Human Services (IDHS) and works with parents or caretakers to resolve any civil legal issues to help stabilize the family and prevent out-of-home placement. Legal assistance may address a range of concerns, including custody, orders of protection, affordable housing, and other issues often faced by those in poverty. The program, which was initially funded with a grant from the state’s Court Improvement Program and has since expanded its reach using philanthropic funding, has more recently been able to use Title IV-E funding through a contract with the Iowa State Public Defender.^{ccv}

Iowa Legal Aid Project
<http://iowalegalaidfoundation.org/improving-lives/special-projects/>
 “Preserving Families Through High-Quality Pre-Petition Representation”
<https://www.americanbar.org/groups/litigation/committees/childrens-rights/articles/2021/spring2021-preserving-families-through-high-quality-pre-petition-representation/>

In 2018, [New York State](#) created the Commission on Parental Legal Representation to examine the current state of parental representation and develop a plan to improve the quality and availability of representation across the state.^{ccvi} In 2019, the commission recommended the establishment of a State Office of Family Representation to provide oversight of parental representation. In late 2019, the NYS Office of Indigent Legal Services (ILS) issued an RFP to solicit proposals for the establishment of a model Family Representation Office in counties outside of New York City to provide legal representation to parents in child protective proceedings under New York Family Court.^{ccvii} NYS ILS, with support from the commission, issued guidelines for financial eligibility for assigned counsel, which includes a presumption of eligibility if a parent is facing a child protective proceeding with possible removal of the child. Additionally, ILS issued RFPs in 2021 for a model of comprehensive, multidisciplinary representation, which may start during the child protective investigative stage, not simply when the case is filed in court.

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<https://www.ils.ny.gov/>

Models of pre-petition legal representation have been used in [Iowa](#), [Michigan](#), [New Jersey](#), [Oklahoma](#), and [Washington, DC](#), and have proven successful in minimizing the need to remove children from their home and place them in foster care.^{ccviii}

"Prepetition Legal Representation"
https://www.americanbar.org/groups/public_interest/child_law/project-areas/family-justice-initiative/prepetition-legal-representation/

POLICY 8

More than 100 communities across the country are implementing the [Safe Babies Court Team™ \(SBCT\) approach](#), an evidence-based model to working with infants, toddlers, and their families who are involved in the child welfare system. One of the core components of the approach is to hold frequent review hearings—in many cases monthly—to ensure that child development is on track and that families receive timely services.

Resources and Contact Information

ZERO TO THREE National Infant-Toddler Court Program
<https://www.zerotothree.org/resources/series/national-infant-toddler-court-program>

For more information:

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Several states provide a shorter time frame for permanency hearings for very young children. [Arizona](#), [Colorado](#), [Georgia](#), [Oklahoma](#), and [Rhode Island](#) all have policies that require more frequent permanency planning hearings for infants and toddlers in foster care than for children of other ages.^{ccix} For example, in [Arizona](#), the time frames for court reviews for children under age 3 are expedited from six-month reviews and 12-month permanency hearings to three months and six months, respectively. Comparatively, for children over the age of 7, hearings must take place within 12 months of removal.^{ccx} [Vermont](#) requires a permanency hearing within three months if the child is younger than age 3 or within 6 months if the child is age 3 to 6.^{ccxi} In [California](#), hearings are required within 120 days for children age 3 or younger.^{ccxii}

ZERO TO THREE and Child Trends State Child Welfare Survey Report
<https://www.zerotothree.org/resources/3498-states-can-improve-supports-for-infants-and-toddlers-who-are-in-or-at-risk-of-entering-foster-care>

Children’s Bureau Report on Court Hearings for the Placement of Children
<https://www.childwelfare.gov/pubpdfs/planning.pdf>

Other states have statutes that require more frequent review hearings for children of all ages compared with the federal statute. [Minnesota](#), [North Dakota](#), [Ohio](#), and [West Virginia](#) require case review hearings every three months for children of all ages who remain in out-of-home care, while [Virginia](#) requires the first review hearing to be held within 60 days and then every four months thereafter.^{ccxiii}

Children’s Bureau Report on Court Hearings for the Placement of Children
<https://www.childwelfare.gov/pubpdfs/planning.pdf>

POLICY 9

Resources and Contact Information

In [Pennsylvania](#), the Court Improvement Program is implementing a Family Engagement Initiative in several counties, using Crisis or Rapid Response Family Meetings to quickly support families when a crisis or other event occurs that could result in the need to remove a child from the home. This inclusive, family approach is designed to actively involve the family in decision-making. The goal of the family meeting is to address the immediate concern(s) leading to the need to remove a child from his or her home. In instances where there continue to be safety concerns and a child must be placed out of the home, a family meeting can help reduce trauma through placement with kin and supporting consistent family time or visitation.^{ccxiv}

Office of Children and Families In the Court
<http://ocfcpacourts.us/childrens-roundtable-initiative/family-engagement-initiative/>

Family Engagement Initiative Counties
<https://ocfcpacourts.us/childrens-roundtable-initiative/family-engagement-initiative/fei-counties/>

In **Missouri**, child welfare workers utilize the Team Decision Making (TDM) practice model or required family support team meeting to discuss placement-related decisions made by a team of people who are closest to the child. TDM focuses on gathering individuals involved with the family and coordinating a meeting to make the best safety decision possible. Initial TDM meetings are to be held in situations where a child and parent have been separated through a Temporary Alternative Placement Agreement (TAPA) and must be held within 10 days of the execution of a TAPA. An initial TDM meeting may be held prior to the diversion of the child only if the child can be safely maintained in the home prior to such a meeting. During the initial TDM meeting, the team will explore all options available to the family and work to mitigate any safety threats. Ongoing TDM meetings must be held at least once every month for the duration of the TAPA.^{ccxv}

For more information:

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Children’s Division Child Welfare Manual, Temporary Alternative Placement Agreement (TAPA) statute
<https://dssmanuals.mo.gov/child-welfare-manual/section-1-chapter-9-safety-planning-overview/#tapa>

The **California** Department of Social Services and the Department of Health Care Services have implemented a policy requiring the regular use of family team meetings for children and youth in the child welfare and probation systems, as well as for children and youth receiving Specialty Mental Health Services.^{ccxvi} A child is required to have a child and family team meeting within the first 60 days of entering the child welfare system. The frequency of meetings depends on the needs of the family but should take place at least every 90 days for children receiving intensive care coordination, intensive home-based services, or therapeutic foster care.

FAQ’s for Child and Family Teams
[https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/CFT_FAQs_ACL16-84_MHSUDIN16-049\(3\).pdf](https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/CFT_FAQs_ACL16-84_MHSUDIN16-049(3).pdf)

POLICY 10

Six states have policies that require more frequent parent–child visits for infants/toddlers than for children of other ages in foster care. For example, in **Georgia**, children ages 0 to 2 have visits twice per week, while those ages 3 to 5 have visits once per week. In **Nebraska**, infant and toddler visitation with parents occurs minimally three times a week, while older youth visitation occurs twice a week.^{ccxvii}

Resources and Contact Information

ZERO TO THREE and Child Trends State Child Welfare Survey Report
<https://www.zerotothree.org/resources/3498-states-can-improve-supports-for-infants-and-toddlers-who-are-in-or-at-risk-of-entering-foster-care>

In **Georgia**, state statute also specifies that visitation is presumed to be unsupervised unless the court determines otherwise. Georgia’s Court Improvement Program has issued guidance to judges on family time, providing information on best practices for assessing and ordering family time plans.^{ccxviii} Among other things, the guide notes that the child and parent have a constitutional right to maintain their bond through quality family time (visitation) and that child welfare system stakeholders have a moral obligation to provide “as much family time as possible consistent with the best interests of the child (both in frequency and duration), and in as natural a place and manner as is possible.”^{ccxix}

A Guide to Providing Appropriate Family Time for Children in Foster Care
<http://www.gacip.org/family-time-practice-guide/>

In **Illinois**, state policy implements a special service fee for family reunification support. This fee provides reimbursement to foster and relative caregivers participating together with parents of children in their care in activities supporting family reunification. To qualify for reimbursement, the activities must engage parents with their children in a family setting—such as the home of the caregiver, parent, relative, or friend—or at a church or community institution that offers an appropriate environment for parenting activities. An activity qualifies for caregiver reimbursement if the caregiver provides the location, supervision, mentoring, and/or transportation for these activities.^{ccxx}

Illinois Department of Children & Family Services
<https://www2.illinois.gov/dcf/Pages/default.aspx>

New Jersey has created a bench card for judges to ensure parent–child contact is maintained and strengthened through parenting time.^{ccxxi} The form includes relevant state or federal statutes on family time and a decision tree to help judges make determinations on specific case circumstances.^{ccxxii} Courts must include a visitation schedule for the child and his or her parents, siblings, and other family members. In cases where family time does not occur, courts must provide information on the reasons for the delay and develop a plan to mitigate barriers (e.g., transportation, work and school schedules). The bench card was developed by the Statewide Children in Court Improvement Committee, which is comprised of judges, attorneys, advocates, representatives from the juvenile justice and children’s behavioral health care systems, and officials from the Administrative Office of the Courts.

Visitation Bench Card
https://acnj.org/downloads/2014_08_00_visitation_bench_card.pdf

POLICY 11

Resources and Contact Information

In [Hawaii](#), Project First Care is a program for children age 0–3 who are in foster care for the first time and, at the time of removal, do not have relatives available for immediate placement. This initiative uses mentoring by trained resource parents to help parents acquire skills for their child’s care and return babies home faster. Project First Care provides temporary care with intensive upfront services such as Family Finding, Ohana (Family) Conferencing, mentoring with birth parents, and enhanced Ohana Time. The program aims to reunify children with their parents or place them with relatives within 60 days of removal; if unsuccessful, the child is transitioned to a general licensed resource home. Approximately 75 percent of the children whose parents participate in the program are reunified or placed with relatives or kin within 60 days of their initial placement.^{ccxxiii}

Hawaii Department of Human Services,
Child Welfare Services
<http://humanservices.hawaii.gov/ssd/home/child-welfare-services/>

In 2015, [Washington State](#) passed legislation to expand the implementation of its parent mentor program. The legislation is based on the state’s Parents for Parents program, which connects parent allies with parents who are new to the child welfare system. The legislation authorized funding to expand the program at new sites, as well as funding for evaluation. Currently, the program is operating in all 39 counties in Washington.^{ccxxiv}

Children’s Home Society of Washington,
Parents for Parents
<https://www.childrenshomesociety.org/parentsforparents>

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Children & Families of Iowa operates the Parent Partner Program for the [Iowa Department of Human Services](#), a statewide effort to support families involved in the child welfare system through the support of parents who were formerly involved in the child welfare system and successfully reunited with their children. These parent partners provide social support and guidance on how to navigate the reunification process, including what to expect, as well as help parents access needed services or supports. The program has expanded operations, as an entity was contracted through the state in 2015 to manage all 99 counties. In state fiscal year 2022, parent partners provided support to roughly 1,565 parents through 103 trained parent mentors. The

Iowa Department of Human Services: Parent Partners Resources <https://dhs.iowa.gov/child-welfare/ParentPartner/Families/Resources>

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program is rated as a promising practice in the Title IV-E Prevention Services Clearinghouse based on its success in supporting reunification and reducing recurrence of child maltreatment.^{CCXXV}

Recognizing that parents' voices need to be valued as a key part of planning and decision-making, the [National Infant-Toddler Court Program](#) developed the [National ITCP Advisory Group for Parents' Voices](#). This group is made up of parent leaders from across the country with lived experience in child welfare, each of whom are currently serving as peer mentors, supporting systems change and improvement efforts, and advocating for parents across the country. The parent leaders of the National ITCP Advisory Group provide consultation, training, and technical assistance to the more than 100 ITCP sites across the country, including dependency courts, family treatment courts, child welfare agencies, and/or statewide collaborations to support understanding the importance of and enhancing parental voice and partnership as families navigate the child welfare system.^{CCXXVI}

National Infant-Toddler Court Program
<https://www.zerotothree.org/resources/series/national-infant-toddler-court-program>

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