Safe Babies
A Program of ZERO TO THREE™

Foundations of Well-being:
Policy Strategies for Integrating Infant and Early Childhood Mental Health into Child Welfare

ZERO TO THREE
Early connections last a lifetime

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OVERVIEW

From birth to age 3, the brain undergoes its most dramatic period of growth, as babies learn to think, speak, walk, reason, and interact with others. Every baby is born with enormous potential that can be fully realized through healthy, nurturing relationships with family and other caregivers. We all have a shared responsibility to nurture and protect each child and to support communities and families in creating the safe, stable, and supportive 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.

Infant and early childhood mental health (IECMH), a foundational element of early childhood development for babies and toddlers, refers to the developing capacity to form secure, healthy connections with caregivers and peers, explore and manage a range of emotions, and discover their environment and learn. Nurturing relationships with caring adults that are built on safety and trust are core components of these developmental processes.

Early childhood system partners, including child welfare, have a critical role in ensuring timely access to high-quality IECMH services and supports across the prevention continuum. Working together through these partnerships, with meaningful centering of families with lived expertise, we can change the trajectory of families with infants and toddlers who have experienced trauma. A set of prevention strategies is needed at the state level that "crosses disciplines, service sectors, policies, and funding streams to build the safe, stable, and supportive environments that all children deserve."[1]

This brief will discuss why IECMH is important for families involved in child welfare and the components of the IECMH continuum of care that are essential to strengthening families and keeping them together. This brief also outlines policy strategies that states can consider when intentionally building capacity and interconnectedness between IECMH, child welfare, and other early childhood systems partners.

An early childhood system brings together health (holistically defined and for all members of the family); child welfare, including the dependency court; early care and education other human services; and family support program partners—as well as community leaders, families, and other partners—to achieve agreed-upon goals for thriving children and families.

UNDERSTANDING THE LINK BETWEEN INFANT AND EARLY CHILDHOOD MENTAL HEALTH AND CHILD WELFARE

As with older children and adults, babies and toddlers can experience mental health needs, and those who come to the attention of child welfare agencies are significantly more likely to have these concerns. Regardless of the placement setting, very young children in child welfare have high rates of mental health concerns. Research indicates that children in foster care are three to four times more likely to have a mental health diagnosis than children of similar socioeconomic status from the same geographic area who are not in foster care.[2,3] Among children aged 12 months to 18 months, 34% have demonstrated clinically significant mental health issues at the time of maltreatment investigation, indicating significant needs even for children who may remain at home.[4]

Examples of how mental health concerns can present in children from birth to age 3:

- Chronic eating or sleeping difficulties
- Inconsolable "fussiness" or irritability
- Incessant crying, with little ability to be consoled
- Extreme upset when left with another adult who is not the primary caregiver
- Inability to adapt to new situations
- Easily startled or alarmed by routine events
- Inability to establish relationships with other children or adults
- Excessive hitting, biting, or pushing of other children, or very withdrawn behavior
- Flat affect (showing little to no emotion at all)
- Refusal of comfort from caregivers

From ZERO TO THREE's The Basics of Infant and Early Childhood Mental Health: A Briefing Paper

A variety of adverse circumstances can affect the mental health of infants and toddlers, destabilizing families, creating toxic stress, and putting children at risk for developmental delays, mental health disorders, and deeper systems involvement. Research has shown that many very young children have already accumulated adverse childhood experiences (ACES) by the time they become known to child welfare, with 38% of children from birth to age 2 and 51% of those aged 3 to 5 having four or more ACES at the time of contact with child welfare services.[5] Children of color experiences ACEs at a higher rate than their white and Asian peers.[6] Infants and toddlers who are exposed to early trauma such as witnessing intimate partner violence or being a victim of physical or sexual abuse, may be developing emotional responses to toxic stress,[a] which puts their healthy development at great risk. It is important for early childhood systems to provide support to the families of such children as early as possible, including screening and other early detection, as well as services that address children's mental health needs.

a From the Harvard Center on the Developing Child: "Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years."

When children are removed from their home and enter the child welfare system, they may experience additional negative impacts on top of already existing trauma. Child welfare involvement has a direct relationship with the mental health of children, including babies and toddlers who are dependent on early attachments to their adult caregivers. Disruption to these attachments, such as the removal of children from their primary caregivers, is strongly correlated with poor outcomes.[7] Children's primary relationships with their trusted adult caregivers are so central to the well-being of babies and toddlers that removing them—even from struggling parents—can inflict further trauma on both children and their families, especially if appropriate supports and services are not in place.

Even after becoming involved in the child welfare system, very few children and parents receive services to directly address their mental health needs. **Untreated mental health needs in early childhood can increase the risk of developmental delays and lead to lifelong mental health disorders, substance use disorders, and long-term systems involvement, with a high cost to the affected individual and to society.** These facts, coupled with the devastatingly high rates of serious mental health disorders and suicidality in older foster youth,[9] indicate an urgent need to reshape the system as one that prioritizes keeping families intact and provides holistic supports to make this possible. IECMH services and supports are a critical foundation of a continuum of care that is needed to help children thrive.

The Importance of Caregiver Health and Mental Health for Young Children

All children, especially babies and toddlers, must be seen in the context of their family system and culture, which may include biological family, resource families, kinship care, adoptive families, and fictive kin. Increasingly, the needs of parents and caregivers are being recognized in policy and practice as central to supporting child well-being. Poverty, substance use, multigenerational trauma, and homelessness are just a few of the circumstances that can create extraordinary strain for primary caregivers. When it comes to mental health, research has documented the profound link between caregiver mental well-being and child outcomes.[10]

Parents involved in child welfare have been shown to experience higher rates of trauma/ACES, substance use disorders, and mental health conditions than the general population, yet oftentimes are unable to find or access services and supports to address these issues.[11] Children whose parents report suboptimal mental health are more likely to have poorer mental health too. In addition, children living with a caregiver experiencing depression are more likely to have clinically significant behavioral and emotional issues.[12]

BUILDING A CONTINUUM OF CARE TO ADDRESS THE MENTAL HEALTH NEEDS OF YOUNG CHILDREN

An IECMH system is founded upon relationship-based approaches where a primary caregiver[b] is always included in the interventions provided. Investment in these services and supports helps families build critical buffers to adversities they may be experiencing now or in the future. The philosophies and approaches of IECMH are strongly aligned with the goals of many child welfare leaders to work upstream alongside families and partners to strengthen families and prevent the need for deeper system involvement.

Child welfare systems and their partners have an opportunity to innovate around the array of IECMH services and supports in their communities to ensure that babies, toddlers, and their caregivers have what they need to thrive. However, child welfare is not equipped to provide all needed IECMH services and supports, nor should families have to enter the child welfare system to receive such services. In fact, IECMH services are found across the prevention continuum, in varied settings, and are financed by a multitude of funding streams. Connecting these systems requires intentional and thoughtful planning at a state and local level and an understanding of the existing assets and resource deficits.

Research shows that families coming into contact with child welfare, whether or not they are ultimately investigated for maltreatment, have significant mental health needs. Families who are screened out[c] may not have access to needed supports that would otherwise be available with more formalized child welfare system involvement.[13] A study of national child welfare data found that children who remain in their homes after a maltreatment investigation have mental health concerns as great as those who enter foster care.[14]

Aligned and integrated early childhood systems provide supports and interventions across the entire continuum. The IECMH services and supports found throughout this continuum [see chart on page 8] often cross over into more than one promotion and prevention category, which means that they can support family strengths and needs as they evolve over time. Importantly, states have policy options to provide specialized IECMH supports for babies and toddlers across this continuum, with the aim of keeping families together and reducing or preventing involvement in child welfare.

b **Caregiver** is broadly defined in this brief as including biological parents, adult relatives, fictive kin, resource parents, and adoptive family.

c **Screened out:** State and local definitions vary, but this term generally refers to a family that has been referred to Child Protective Services, with the child welfare agency ultimately deciding that no investigation of maltreatment is warranted. State and local policies vary on what happens next with such families. In some systems, these families are referred to community partners for services. However, other systems make no referrals and close these cases.

Critical Considerations for a Robust IECMH Continuum of Care

- All the services and supports in the continuum should be available and accessible to families regardless of child welfare involvement. (Most of these services can be provided as primary and secondary prevention approaches.)
- Multiple coordinated access points should be available at primary and secondary prevention levels.
- The continuum should have a robust workforce with capacity to serve families throughout different stages, including prenatally and during infancy and early childhood.
- The IECMH system needs to have capacity and flexibility to serve any primary caregiver, including mothers, fathers, grandparents, other relatives, fictive kin, and child care providers.
- While IECMH services are primarily focused on the caregiver-child relationship, an adequate service array must be available for adult caregivers who need individualized support for their own mental health or substance use concerns or other issues such as poverty and chronic health conditions. These adult-serving systems must be intentionally connected to early childhood systems and oriented and trained in IECMH.
- Where possible, IECMH services should be co-located in integrated care settings to facilitate easy access for already overwhelmed and overburdened families.

A Prevention Continuum of IECMH Supports and Services

Rooted in and guided by IECMH Guiding Principles and Best Practices

Promotion and Primary Prevention	Secondary Prevention	Tertiary Prevention
Screening for IECMH and SDOH		
IECMH Consultation		
Support and Referral Hotlines/Warmlines		
Economic Supports (housing, food, etc.)		
Doula Care, Community Health Worker Approaches, Fatherhood Initiatives		
Care Coordination/Case Management		
Home Visiting		
Parent Mentoring/Peer Support		
Early Care and Learning		
	Family-based Residential Substance Use Treatment	
	Infant-Toddler Court Teams	
	Parent Skills Training/Parenting Support Groups (nonclinical)	
	Family Preservation (including in-home stabilization)	
	Therapeutic Nurseries/Therapeutic Preschool	
	Respite (planned and crisis)	
	Mobile Crisis Response System (9-8-8)	
	IECMH Clinical Assessment/Diagnosis Using DC:0-5 (medical rule out)	
		Therapeutic Foster Care
		Crisis Nurseries
		Psychotropic Medication Monitoring
		Family Time*
		Psychiatric Teleconsultation Between Providers
		Multigenerational IECMH Treatment^

* Family time, sometimes referred to as family visitation, is provided to families with a child in foster care. It is planned time for parents and children to interact and connect in a safe environment.

^ Across settings: community mental health clinics, private practice, prison nurseries, therapeutic nurseries, intimate partner violence programs, home-based, telehealth, family-centered residential substance use treatment, family resource centers. Foster families, biological families, fictive kin, etc., may participate where appropriate.

POLICY STRATEGIES AND CONSIDERATIONS FOR STATES

The following strategies are organized across the prevention continuum and include options for states to build a system that can be responsive to the mental health of babies, toddlers, and their caregivers. The first recommendation below is a potential preliminary step for states that have not yet assessed the landscape of IECMH services in relationship to the child welfare system.

Promotion and Primary Prevention

Promotion and primary prevention is a broad area including services and supports that match the strengths and needs of the whole family, with the aim of giving very young children a strong start in life. Prevention efforts can create positive family outcomes despite negative experiences by recognizing and working with family cultures and strengths to reduce risk of child maltreatment and child welfare involvement. Promotion and primary prevention strategies should be available to all families in the community regardless of risk for child welfare system involvement. Interventions in this category, which are widely available across a variety of settings, include direct services such as screening; high-quality and affordable early care and education; home visiting; care coordination; economic support; and IECMH consultation.

POLICY STRATEGY: Map out the IECMH service system alongside how families flow into and through the child welfare system.

This process should include families who are screened out or otherwise ineligible for child welfare system services but may still have significant needs. This exercise will increase understanding of access points and gaps, including where there is a need for better coordination of services across early childhood system partners. This process illuminates opportunities for earlier identification and warm handoffs between service systems.

POLICY STRATEGY: Screen all families, including both children and their caregivers, for mental health needs and social determinants of health.

The high prevalence of mental health conditions among babies and toddlers and their caregivers indicates a need for universal screening policies. The American Academy of Pediatrics (AAP) recommends screening for mental health concerns at all well-child visits from birth to age 21.[15] Screening, including maternal and paternal depression screening, can also be embedded in many different settings as a prevention and early intervention mechanism. Many programs serving young children can include screening for mental health concerns as part of their work, including early care and learning, home visiting, and early intervention programs, among others.

The circumstances that put families most at risk for child welfare involvement include poverty, a history of trauma, mental health conditions, substance use issues, and intimate partner violence. Thus, family screenings should include a wide range of social determinants of health such as poverty, chronic disease, and intimate partner violence. Additionally, primary caregivers should be screened during well-child visits and at touchpoints in the adult-serving systems where they may access health services. This includes settings such as perinatal health care, adult primary care, and substance use treatment services.

The Redleaf Center: Integrated Family Mental Health Care in Minneapolis

The Redleaf Center for Family Healing, part of Hennepin Healthcare, has established a continuum of care in Minneapolis to identify and address family and perinatal mental health issues. The center's growing continuum of mental health supports includes the Family Support Team (FST), Mother-Baby Connections outpatient groups, the Mother-Baby Day Hospital (partial day hospital), the Perinatal Outpatient Program (an intensive group-based program), and the Redleaf Outpatient Clinic, which offers perinatal psychiatry and psychotherapy and parent-child therapy for children birth to 5.

Established in 2021 through foundation funding, the FST comprises an integrated team of social workers and other mental health professionals that supports families seeking care in different settings across the health system. The FST is a resource available throughout the medical system, collaborating with Ob/Gyn practices, pediatricians, pediatric intensive care, pediatric inpatient and neonatal intensive care, and adult inpatient psychiatric units at the hospital. All referrals to the FST are generated from other health care providers in the Hennepin Healthcare system, and there are multiple touchpoints for families with the FST staff. The Redleaf Center's FST is primarily supported through philanthropic funds, and they continue to plan for sustainability.

Within the system, providers can request FST support through HIPAA compliant texting, a Microsoft Teams message, or the Epic medical records system. During a clinical visit, if health providers identify a family with mental health needs, they can be referred directly to an FST member. For example, pediatricians conduct social-emotional check-ins with patients, incorporating the Patient Health Questionnaire-9 and the Edinburgh Postnatal Depression Scale with the adult caregivers. The infants and toddlers are screened using the M-CHAT, ASQ-3, and ASQ-SE.

If a screening identifies a need, timely clinical support is available on site through the FST, with referrals available for the Mother-Baby program as needed. Mental health clinicians meet briefly with family members while they are seeking care in one of the health system settings, or they can follow up after the family goes home. To increase access for non-English speaking parents, FST utilizes phone or video interpreter services. Short-term counseling and parenting support is a billable service that is provided to caregivers for up to three sessions without the need for a diagnostic assessment per the flexibilities of Minnesota Medicaid. Referrals are made for longer-term mental health care through the Redleaf Center or through relationships with external community clinics.

Mental health therapists on staff are trained in a variety of therapeutic modalities, including relational therapy, child-parent psychotherapy, Circle of Security Parenting, and dialectical behavioral therapy.[16] Additionally, several on-staff reproductive psychiatrists work with individual clients at the Redleaf Center. Redleaf psychiatrists also offer provider-to-provider consultation.

M-CHAT: Modified Checklist for Autism
ASQ-3: Ages and Stages Questionnaire Third Edition
ASQ-SE: Ages and Stages Questionnaire: Social-Emotional

POLICY STRATEGY: Ensure Medicaid reimbursement is available for IECMH screening, assessment, and treatment across settings.

Because so many children involved in the child welfare system are covered by Medicaid (about 99%), the program is the primary payor for health-related services in most instances, including IECMH services. Challenges may arise for child welfare agencies and families when state Medicaid plans do not have clear policies related to the coverage of IECMH services and supports or lack qualified workforce within their provider networks. Other barriers can exist for families not covered by Medicaid, and more of these families are found in family preservation programs where the state has not taken custody of the child. In these cases, the child welfare agency should use other state or federal funds to purchase IECMH services on the family's behalf through a contracted provider.

Adequate and age-appropriate screening is an important first step to allow access to other parts of the system. While much progress has been made within state policy and practice for routine developmental screening, gaps remain related to IECMH screening and linkages to appropriate follow-up care and therapeutic services in the community. Many states, but not all, have established Medicaid policy pathways for families to access IECMH screening, age-appropriate diagnosis, and treatment.[17] For instance, 37 states currently allow Medicaid reimbursement for IECMH treatment services.[18]

Strategies that states have used to increase reimbursement include working with their Medicaid partners to adopt the ZERO TO THREE Crosswalk from DC:0-5™ to DSM-5 and ICD-10 or creating a state-specific adaptation as a tool for treatment planning and ongoing billing and reimbursement for IECMH services (e.g., assessment and dyadic treatment). Currently, 25 states either "allow" the use of DC:0-5 diagnoses or "require" it.[19] Examples of states that have adapted their own crosswalks include Georgia, Minnesota, and Oregon. Some states have also assessed the need to adjust service limits for IECMH clinical assessments since this specialized approach to diagnosis involves multiple sessions in different settings.

POLICY STRATEGY: Integrate IECMH consultation (IECMHC) into multiple settings where children and their caregivers may need additional support.

IECMHC is a prevention strategy to improve the social, emotional, and behavioral development of infants and toddlers, as well as the adults who care for them. An IECMH consultant partners with other professionals and staff working with young children to infuse approaches to promote healthy social and emotional development/mental health in their ongoing work. IECMH consultants are mental health professionals with specialized expertise in early childhood. They can work in a variety of settings, such as early care, home visiting, and child welfare programs, and they provide a range of services, including skilled observations, assessments, individualized strategies, and early identification of children at risk for mental health conditions.[20] Additional programmatic and policy consultation can be provided to support the mental health of staff and caregivers working with at-risk children. The mental health of these adults impacts the care they provide to babies and toddlers. IECMHC has shown positive outcomes, including improved teacher-child relationships, increased child social skills, reduced behavioral issues, and reduced adult burnout and turnover rates.[21]

IECMHC is a best practice approach that child welfare agencies can incorporate for families and their staff with varying levels of need. For instance, IECMH consultants can support home visiting program staff that work with families at risk for deeper systems involvement. The consultants can provide reflective consultation with supervisors, group reflective consultation with home visitors, case consultation, and training on early childhood mental health topics. Like other services and supports in this brief, IECMHC can also be implemented as a secondary and tertiary prevention strategy.[22]

Michigan has taken this approach and, after piloting it, is now expanding IECMHC to support more child welfare home visiting programs across the state. Michigan has leveraged state and Title IV-E Family First Prevention Services Act funds to provide IECMHC alongside evidence-based programs such as Family Spirit (tribal home visiting), Healthy Families America, the Nurse-Family Partnership, and Parents as Teachers.[23]

IECMHC can also be used with child welfare workers, court staff, and community-based providers such as early care and learning staff. IECMHC support for these unique workforces can infuse reflective practices[d] across different roles, creating a more trauma-responsive system. There is also potential to reduce burnout and build stronger relationships through these approaches.

Secondary Prevention

Secondary prevention services aim to reach families who may be experiencing significant stressors that put them at risk for removal of their children. In a child welfare system context, the secondary prevention tier can include families that are already known to child welfare systems through a maltreatment allegation (substantiated or unsubstantiated), or those that are screened out (e.g., not eligible for child welfare services) but still have unmet needs. Unmet needs may include access to healthy foods, safe and stable housing, or health care, including mental health and substance use treatment, among others. Secondary prevention strategies aim to promote healthy relationships and support parents in developing parenting capacity and skills. Examples of interventions in this category include mental health assessment, home visiting, and parent support and skill-building programs.

POLICY STRATEGY: All children involved in the child welfare system should be automatically eligible for timely IECMH services, including screening, diagnosis, and treatment.

National recommendations around best practices in pediatric health care strongly encourage pediatricians to screen all children for mental health concerns within 72 hours of foster care placement. The AAP also recommends that a comprehensive assessment of health, mental health, and developmental progress occur as soon as possible following placement (no later than 30 days).[24, 25]

While this recommendation has been promoted by leading health care experts and researchers, policies related to IECMH screening, assessment, and referral to services within state-level child welfare systems are highly inconsistent. In addition, these policies do not always differentiate between the applicability to babies and toddlers or acknowledge the need to build and engage a specialized IECMH professional workforce for this purpose.[26] States should adopt policies that align with or exceed recommendations by the AAP, with special consideration for the specific needs of infants and toddlers entering child welfare.

Policies at the state level vary in terms of child welfare requirements related to the timeliness of screening and assessment, and how they are implemented. Past surveys of state child welfare agencies show a range of state-level policies. Within a cohort of 38 states, the timeline for mental health screening requirements after foster care entry ranged from one day to 90 days, with three states having no required time frame.[27] Of the 27 states that required more intensive mental health assessments, a majority required completion of the assessment within 30 to 60 days.

ZERO TO THREE and Child Trends also surveyed state child welfare agencies in 2013 about practices related to screening infants and toddlers. The findings revealed a wide range of timelines for screening and referral for further assessment—anywhere between two days and 60 days.[28] These parameters around timeliness are critical to the well-being of infants and toddlers, and gaps appear to exist in state-level policies because there is no distinction made among children from birth to age 3, despite a wealth of research and best practices to support specific policy solutions.

d Reflective practice is a tool that invites professionals to pause and slow down to become aware of thoughts, feelings and reactions that arise in everyday interactions.

LA County's Multidisciplinary Assessment Team for Children in Child Welfare

In Los Angeles County, the Multidisciplinary Assessment Team (MAT) works with families who have recently entered the county's Department of Children and Family Services (DCFS). MAT, which is currently implemented in all 20 regional DCFS offices, is a collaboration between LA County's DCFS and Department of Mental Health (DMH). For all children up to age 18, including babies and toddlers, MAT has a process in place to fully assess their functioning, strengths, and needs across several domains (mental health, development, medical, dental, hearing/language, education, and family caregiver supports), with special consideration given to the "3 E's" of a child's trauma (experience, events, and effects) as quickly as possible upon entry to foster care. The first step is the Mental Health Referral (MHR), which, along with a Child and Adolescent Needs and Strengths (CANS) assessment, is submitted by an emergency response social worker at the time of case promotion within 30 days of entering care. Based on the results, a child will be referred to a mental health provider for routine mental health assessment or triaged for more intensive mental health services.

The local DCFS liaison facilitates relationships with the mental health professionals and clinics that are contracted to provide assessment—and, where appropriate, ongoing treatment interventions. The DCFS liaison is able to reach out to local mental health providers to discuss capacity and availability for referrals when children have entered care. For routine mental health assessments, one of the 50 contracted mental health providers in LA County will work to assess the child. Local mental health provider agencies must have experts on staff to serve all children, including babies and toddlers, with a wide range of language needs met through multilingual assessors countywide.

For children from birth to age 3, DMH assigns an IECMH clinician, who begins the assessment process with the goal of having a full evaluation completed within 45 days. During this time, the IECMH clinician is also reaching out to key informants who know the child to develop a full picture of their health and development, family history, and current functioning. The IECMH clinician will speak with a range of people, including biological and fictive kin, case workers, and resource families. Record review and/or consultation and collaboration with medical and/or education staff is also conducted when appropriate.

The final report, called the MAT Summary of Findings, is shared with the court, the family, LA County staff, and other providers who are involved in the child's care. The clinician may recommend IECMH interventions based on the needs identified during the assessment process. A Child and Family Team (CFT) meeting is then held with the family, child, and LA County staff to develop an agreed-upon treatment plan, integrated with the DCFS case plan, based on the Summary of Findings presented by the IECMH clinician.

POLICY STRATEGY: Ensure access to multi-generational IECMH treatments for all families at risk for or already involved in child welfare.

In addition to screening and assessment, access to services for families remains an important issue. Across the prevention continuum, IECMH services and supports should be available to all families that need them, and service providers must have capacity to receive referrals from screening providers. However, most children are not receiving the IECMH services they need; in fact, just 2.2% of babies and toddlers in child welfare identified as needing mental health care actually receive these services.[29]

Given the prevalence of mental health issues among children involved in child welfare and the large proportion of children in the system that are under the age of 3, access to IECMH assessment, diagnosis, and treatment is essential. While screening and assessment are more common practices, referrals to parent-child relationship interventions are not routinely offered to families in child welfare.[30] An IECMH assessment will result in a comprehensive mental health summary for a child, along with recommendations made by the assessing clinician for ongoing clinical treatment or other IECMH services, as appropriate. The IECMH professional may be available to consult with the dependency court and child welfare on the assessment findings and further discuss options for the child and family.

IECMH professionals can partner with a variety of community agencies that serve families with very young children, including child welfare. These clinicians are highly trained in best practices with infant and early childhood development and mental health. Some IECMH professionals are trained in specific evidence-informed interventions, such as child-parent psychotherapy and Parent-Child Interaction Therapy. These clinicians bring critical skills and expertise, along with advanced training in IECMH, to support healing of the caregiver-child relationship.

IECMH treatment services can be embedded in settings across the community, including homes, mental health clinics, outpatient substance use services, multiservice organizations that support families, and intimate partner violence programs, among others. Referral pathways can be established across these partnerships. For instance, Family Preservation Services can support families in accessing the services recommended by the IECMH professional who completed the clinical assessment. It is critical to note, however, that intentional partnerships need to be developed between IECMH professionals and child welfare agencies so that there is an active, ongoing working relationship that facilitates collaboration with families across roles.

POLICY STRATEGY: Build infrastructure to ensure all parents involved in the child welfare system have access to a parent partner/parent peer support during system involvement and following reunification.

Parent partner/parent peer support is a service provided to parents by other parents who have lived experience in the dependency court system. For example, a peer support specialist with relatable child welfare experience may be paired with parents currently involved in the system to provide advocacy, peer coaching, and help in navigating and understanding systems and services. Like peer support specialists, parent partners often have personal experience with substance use and mental health systems. Parent partners create meaningful connections with parents navigating child welfare and recovery by relating through their own lived expertise. Parent partners coach, support, and inform parents about the child welfare process, helping parents build and tap into their own strengths. Parent mentors also help lessen the social isolation and stigma that often impacts those with child welfare involvement.

Peer support for adults has been researched and proven effective in building participants' confidence, knowledge, and connectedness to others.[31] Emerging program-level evaluations of parent mentoring in child welfare have demonstrated positive outcomes, including higher rates of reunification and lower rates of repeat maltreatment.[32] However, few states make these critical supports available to parents involved in child welfare. In a 2019 survey, only 16 states indicated that such a service was offered to parents to support them in navigating the child welfare and court systems.[33]

States have options to develop programs and related policies to include parent partners as support for families in the child welfare system, including during the investigation process. Parent partners and peer support specialists bridge connections to additional support. For example, they can help families in linking across multiple complex service systems, including prenatal and postpartum services, behavioral health, courts, and child welfare. This support is not only essential while a child welfare case is open but is also critical as an ongoing service for families after reunification. For that reason, when designing the peer support/parent partner service array, policy and program leaders should consider how to ensure this support follows the family beyond their child welfare involvement.

Parent Partners at Tru Vista in Washoe County

In Washoe County, Nevada, parent partners have a long history of supporting families with child welfare involvement. As neutral allies in the process, the parent partners at Tru Vista Foundation work in advocating for and supporting such families. Crystal Hallock is a certified peer recovery support specialist and peer support supervisor who has been a parent partner at Tru Vista for 17 years. She leads a team of three other parent partners who, like herself, have experienced the removal of a child or children from their home—and have experienced their own recovery journeys with substance use and/or mental health. Because of these shared life experiences, the parent partner team at Tru Vista is able to develop a unique and meaningful connection with families currently going through the child welfare system.

Tru Vista launched its parent partner program as part of Family Treatment Courts, where staff worked part time as "mentor moms." Eventually, another grant opportunity came along that allowed for expansion of services to those involved in child welfare outside of Washoe County. The parent partner team now serves up to 30 families at a time involved in the Safe Babies approach. The parent partner team also serves additional families that are involved in dependency courts, even if they are not involved in Safe Babies.

The support that parent partners provide is critical to families given how isolating it can be for parents trying to navigate the system once their child is in out-of-home placement. By providing social support and building an alliance with parents, parent partners reduce their sense of isolation and bring out their strengths. They also help parents understand what the steps are to reunify with their children. For instance, parent partners help with answers about court and child welfare processes and terminology, attend court hearings with parents, and help parents understand what to expect during family time (parent visits with a child). Tru Vista's parent partners are available 24/7 to talk with parents to help them navigate crises, address worries and concerns, and/or offer a supportive perspective.

The HRSA-funded Infant-Toddler Court Program promotes a collaborative practice designed to advance the health and well-being of infants and toddlers under court jurisdiction who are in foster care or at risk of removal from their homes and families. Infant-Toddler Court Teams (ITCTs) are rooted in the Safe Babies approach, which puts IECMH at the center of decision making to meet the urgent developmental need of very young children for safe, stable, nurturing, and protective caregiving. ITCTs enhance judicial oversight and practice with more frequent court hearings and engage families with compassion and a healing approach. A key role in ITCTs is the community coordinator, who builds linkages across early childhood systems that increase access to timely, effective, and meaningful services and supports.

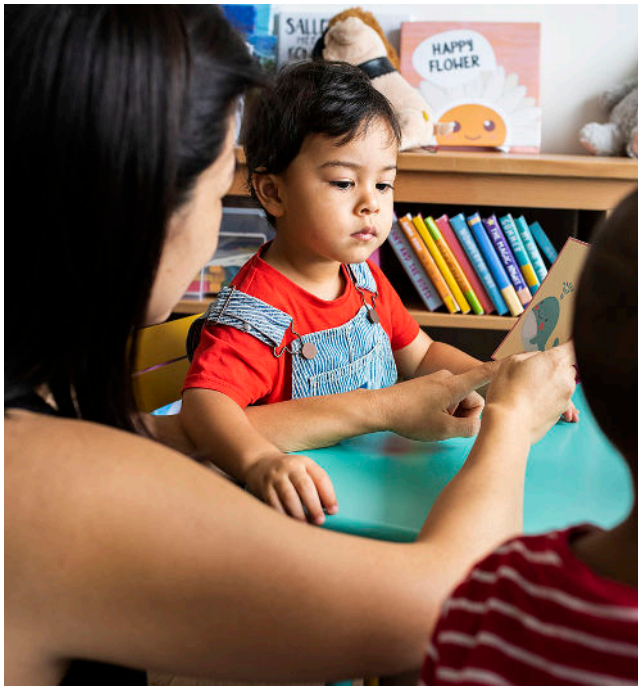
Parent partners can continue to be a support to families following reunification and long after closure of a child welfare case. Ms. Hallock has worked with some families for years, including one whose children initially came into foster care at the ages of 3 and 4. Eleven years later, Ms. Hallock is still a parent partner working alongside this family to help them navigate crises and celebrate successes when they occur. This long-term role for parent partners is critical to preventing new involvement in child welfare and keeping families connected to ongoing supports and services.

"I will work as hard as the parents do, side by side – 100%"
– Crystal Hallock, Tru Vista

Part of what makes the parent partner role so valuable is the depth of community partnerships and relationships they establish. Ms. Hallock has longstanding relationships with residential substance use providers, Early Head Start home visiting, early intervention services, judges and court staff, mental health providers, and many others. These connections allow for warm handoffs when a parent needs to access services, and they help Ms. Hallock best guide parents in navigating the logistics of and eligibility for various types of programs.

POLICY STRATEGY: Implement therapeutic nurseries/therapeutic preschools.

Therapeutic nurseries, also known as therapeutic preschools, are a proven approach to supporting families who have already experienced trauma and intense stressors. Children with traumatic histories may experience challenges in mainstream child care settings that are not fully equipped to help such children manage their emotions, learn, and engage in play with peers. This can lead to multiple negative outcomes, including high rates of expulsion from early care and learning settings, instability for families in their child care plan, and even a disruption in foster care placement.[34] Therapeutic preschools have been shown to improve a range of developmental outcomes, [35, 36] including among babies and toddlers with child welfare involvement.[37] Studies have also demonstrated a positive impact on caregiver mental health and the quality of caregiver-child relationships.[38]



Therapeutic preschools may offer therapy for the whole family in conjunction with the child's in-person attendance at the school during the day. Staff at the therapeutic preschool are highly trained paraprofessionals who are supervised by IECMH professionals. The staff-to-child ratio in these settings is usually lower than that of a traditional child care setting, allowing for more focused attention and intensive work with the children. High-quality therapeutic preschool programs also provide access to a multidisciplinary team, including early educators, occupational therapists, speech-language pathologists, child psychiatrists, and clinicians. In some instances, therapeutic preschools are implemented as a mental health day-treatment program through the children's mental health system. An example of this is illustrated in the case study of the Children's Center of Utah.

Oregon Association of Relief Nurseries: A Network of Therapeutic Nurseries Supporting Families

In 1976, Relief Nursery, Inc. of Oregon launched a model designed to strengthen families raising children from birth to age 5. To date, that model has been successfully replicated throughout the state at 38 sites across 22 counties. The Oregon Association of Relief Nurseries (OARN) provides support to existing and emerging sites statewide. Each year, Oregon's Relief Nurseries serve more than 1,700 families by providing wraparound support and caring for children in a therapeutic setting. While Relief Nurseries are primarily designed as a secondary prevention approach for families at risk of child welfare involvement, these programs also serve children and families who have experienced removal from the home. Oregon's Relief Nurseries are voluntary programs with markedly low family attrition. Referrals come from various community partners, including judges, pediatricians, and child welfare workers; however, 80% are self-referrals through community word of mouth.

"We only serve families that have children; we do not just serve the child. This is the essence of a two-generation approach."

— Cara Copeland, Executive Director, OARN

Some of the core components that contribute to the success of Oregon's Relief Nursery network include the following:

- Lower ratio of adult teachers to children than traditional early care and education settings —typically 3 to 4 adults per classroom (e.g., 11 children max in preschool-aged groups, eight children max for toddlers, six max for infants)
- Specialized training for teachers in attachment, relational care, trauma, and attunement
- Special education and early intervention services embedded in the classroom
- Home visiting by teachers, with frequency varying from weekly to biweekly to monthly, depending on family needs
- Assistance in getting families to court and appointments, as well as connected with services and concrete supports
- Staff patterns that vary from site to site but typically include a substance use counselor, IECMH counselor, and family counselor (If these services are not directly staffed at the Relief Nursery, they have referral partnerships to provide care.)

OARN recognizes that they are currently serving 25% of the state's needs and are therefore working on strategies to sustainably increase services. The sustainability of Oregon's Relief Nurseries has been supported by a long-term public-private partnership. The state budget includes a biennial allocation of $24.4 million, which covers 52% of the operational costs for the statewide network. While the state investment is significant, it does not provide enough funding to cover all costs, so each local Relief Nursery has a strong fundraising strategy for private donations. In addition, each local community where a Relief Nursery is located is required to commit 25% of the operational costs through community matching dollars.

POLICY STRATEGY: Invest in the development of co-located services and supports to streamline access to care.

Aligned and integrated care is critical to access and to creating a positive outcome for families in need of services. Where possible, co-locating IECMH care for families in one setting streamlines capacity for the system to provide services and for families to receive them. IECMH supports can be embedded in existing early childhood settings to maximize existing resources and relationships. Even adult-serving systems can consider how to integrate an IECMH perspective and philosophy, as well as direct IECMH services. The example below from The Children's Center Utah highlights the integration of IECMH clinical services, therapeutic preschool, and Utah Infant-Toddler Courts.

The Children's Center Utah Integrates IECMH Clinical Services, Therapeutic Preschool and Infant-Toddler Courts

The Children's Center Utah, headquartered in West Valley City, is a leader in the state's development of a system for IECMH services and supports. As an integrated clinical setting, The Children's Center Utah provides co-located IECMH clinical services and therapeutic preschool for almost 1,100 families annually across programs. In the past several years, The Children's Center Utah has led the state's launch of the Safe Babies approach through the Utah Infant-Toddler Court Program (U-ITCP). This initiative, paired with an array of IECMH services and supports, is building a trauma-responsive system that prioritizes the mental health and well-being of families with babies and toddlers involved in the child welfare system.

IECMH Clinical Services child and family therapy is offered on an outpatient basis at The Children's Center Utah. Clinical assessment is the first step. This informs a clinical treatment plan, which is developed and monitored with the family's involvement. Family therapy sessions include parents and children together. Treatment modalities may include Attachment and Biobehavioral Catch-up; Attachment, Regulation, and Competency; child-parent psychotherapy; and trauma-focused cognitive behavioral therapy.

Therapeutic Preschool is a specialized approach to serving young children with emotional or behavioral challenges, including those who may have had traumatic experiences. The Children's Center Utah program specifically works with children ages 2 to 5, after they are internally referred by an IECMH professional. Classrooms are staffed by two therapeutic preschool specialists who have IECMH training and expertise. Classroom ratios are much lower than traditional preschool settings, with two preschool specialists to every nine children. There are also up to two volunteers n each room to support the group.

The Utah Infant-Toddler Court Program integrates IECMH into the child welfare process via access to services, mental health consultation, and resources in family team meetings and court hearings. U-ITCP facilitates collaboration between local, state, and national partners to align IECMH practices.

BENEFITS OF THE CO-LOCATED MODEL

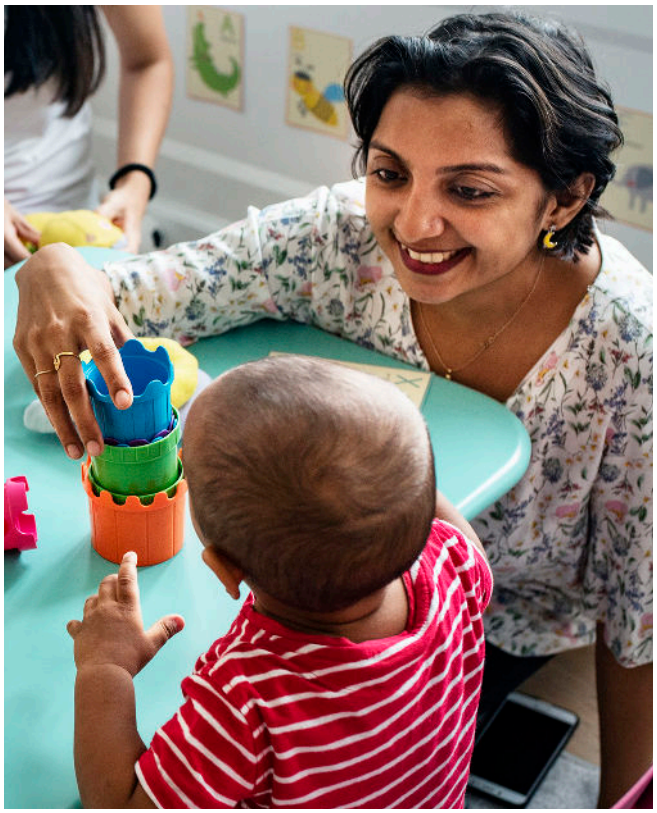
- Coordination and integration of the IECMH clinical team: The Children's Center Utah's unique approach to co-located care for very young children affords families the opportunity to access a specialized clinical team and, if needed, psychological evaluation, psychiatric services, and parenting groups. These services are highly coordinated, working in tandem to support a child's clinical treatment plan and strengthen the parent-child relationship. For example, families enrolled in therapeutic preschool also receive on-site family therapy, which strengthens relationships and attachment and supports children's social-emotional development.

- **Increased opportunities for clinical observation and parent involvement:** Because the preschool program operates on site with IECMH clinical services, the IECMH clinicians can work with parents in observing the children while they attend their therapeutic group. The group rooms include one-way mirrors to allow clinicians to observe; sometimes, parents join in these observations to gain insight into how their child is doing.
- **Reflective supervision for early childhood educators:** An additional benefit includes the provision of reflective supervision for clinical staff, including those in the therapeutic preschool program. This is provided by IECMH clinical supervisors.
- **Space for new innovations:** As a result of its special partnership with the local child welfare agency, the Children's Center Utah is piloting a new position, the family time support specialist, to help with the preparation, logistics, and supervision of in-person sessions with parents and children. These visits support ongoing quality interactions between the children and parents when a child is placed out of home. These visits also provide a way for both children and parents to heal and find positive support in the process. The program is piloting "fostering relationships" to facilitate strong partnerships between foster parents and biological parents and to facilitate positive interactions during the first five post-removal family visits.
- **Integrated workforce supports:** The Children's Center Utah also provides free training and consultation through its statewide IECMH Training and Teleconsultation Program. These consultation services are offered at no cost to providers seeking support related to serving young children and their families. Examples of available consultation services include case consultation, provider collaboration support, referral/resource coordination, reflective supervision, and technical assistance.

Tertiary Prevention

Tertiary prevention approaches are designed for families in crisis who are currently involved in the child welfare system, with babies and toddlers having been removed from their homes. Tertiary prevention strategies offer an opportunity to prevent repeat maltreatment and associated adverse outcomes and/or mitigate the negative outcomes of past maltreatment.[39] Where safe and appropriate, connections with primary caregivers should be prioritized and encouraged, including frequent family time. A range of tertiary services and supports need to be available to families with this level of systems involvement to maximize their chances for healing and recovery.

Tertiary interventions often have a therapeutic element that focuses on strengthening the parent-child relationship and the parent's ability to respond to the child's emotional and developmental needs. Examples of tertiary prevention services that should be available include family-based residential substance use treatment, infant-toddler court teams, parent mentors/parent partners, crisis nurseries, and an array of intensive, evidence-based interventions, such as those outlined in the Title IV-E Prevention Services Clearinghouse.

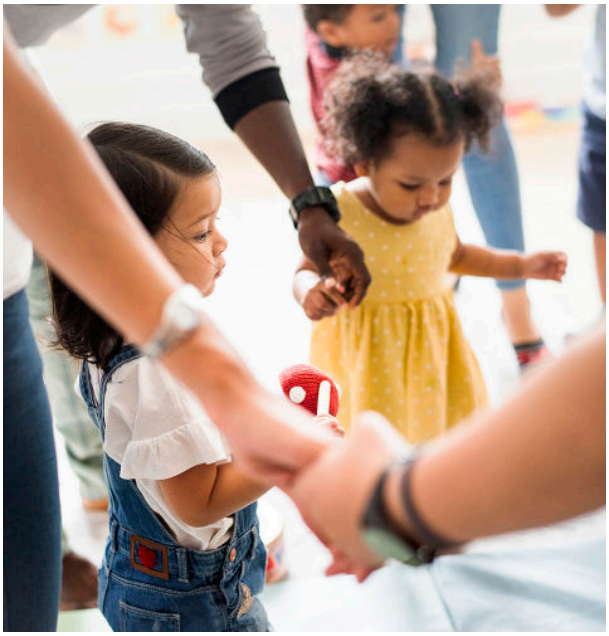


POLICY STRATEGY: Adapt existing early childhood and adult-serving systems to integrate IECMH across the different points of contact with families with young children, including but not limited to those outlined below.

Develop or enhance family-based residential substance use treatment. Family-based residential treatment programs are critical to keeping families together while the primary caregiver participates in intensive substance use treatment services. These programs can prevent a child's removal, which might otherwise occur if a parent needs to attend treatment in a setting that excludes children. Family-based residential treatment programs allow children to live at the program facility with their parents and offer an array of co-located services for the entire family. It is critical for existing family-based residential treatment programs to incorporate IECMH-focused services for parents of very young children, as well as support for program staff. These programs offer an opportunity to embed IECMH services and supports during a critical phase of the family's recovery. Given their role in supporting the healthy development of very young children, adult-serving systems should be trained in IECMH and parent-child attachment relationship concepts.

Implement Infant-Toddler Court Teams. Infant-Toddler Court Teams (ITCTs) are a collaborative practice designed to advance the health and well-being of babies and toddlers under court jurisdiction who are in foster care or at risk of removal from their homes and families. ITCTs are rooted in the Safe Babies™ approach, which puts IECMH at the center of decision making to meet the urgent developmental need of very young children for safe, stable, nurturing, and protective caregiving. ITCTs enhance judicial oversight and practice with more frequent court hearings and engage families with compassion and a healing approach. A key role in ITCTs is the community coordinator, who builds linkages across early childhood systems that increase access to timely, effective, and meaningful services and supports. The community coordinator also plays a pivotal role in providing a consistent and strong voice for the developmental needs of infants and toddlers and in elevating parents' voices in the child welfare process. Evaluations of the Safe Babies approach and other ITCTs have found that children are more likely to reunify with their family and spend less time in out-of-home placement.[40,41, 42, 43]

Implement crisis respite/crisis nurseries. A crisis nursery is a trauma-responsive child care and respite setting for families in distress. The underlying philosophy is that during high-stress or unpredictable situations,



crisis nurseries can provide a safe, temporary place for very young children to receive short-term care and wraparound services. Crisis nurseries provide 24/7 care for children from birth to age 5 on a temporary basis, but there are variations at the program level in length of stay and ages served.

Currently, there are about 60 crisis nurseries operating in the U.S., with each nursery having its own approach or model. One variation in approach can be the length of stay (e.g., daytime only, from 48 to 72 hours, 30 days, or up to 90 days). While crisis nurseries were originally designed to serve those under age 5, some programs now support children up to early adolescence. This expanded age range can allow for sibling groups to be served together. Models are driven by state-level licensing requirements and community needs and are often equipped to serve a range of children with trauma, developmental disabilities, and/or medical concerns.[44] Case management and parent education are common components of the crisis nursery model.

Outcomes linked with crisis nurseries include the prevention of out-of-home placement and reduction of risk for maltreatment.[45] In fact, a study of Illinois' crisis nurseries found that children in the program with child welfare involvement were significantly more likely to reunify with their family than those who never received crisis nursery services.[46] The same study found that such settings are most often used by single parents, largely single mothers. Crisis nurseries are increasingly seen as an approach to preventing foster care placement or facilitating reunification for children already in foster care.

Providence House in Ohio Helps Families in Crisis

Providence House cares for children during a crisis when their parents are unable to do so. This free, voluntary, non-custodial program in the Cleveland, Ohio area provides emergency shelter, direct care, and medical care and monitoring for at-risk children from birth to age 12. Providence House operates two crisis nursery locations where children can stay from 24 hours up to 90 days. One site specifically focuses on children with medical conditions. Up to 30 children can be served at a time, and through a partnership with child welfare, two beds are always reserved for short-term emergency support while a child awaits foster care or kinship care placement.

During a child's stay at Providence House, licensed social workers support parents/guardians through case management, parent education, and aftercare. At admission, adults and children are screened for trauma history, with a certified trauma therapist on staff to support families with appropriate trauma interventions while in the program. Parents/guardians are required to visit their children at least two times per week. The aftercare program—a voluntary, 12-month, post-discharge service—provides concrete supports such as diapers, toys, and household supplies, as well as follow-up contacts and referrals to promote family stability.

A study of the long-term outcomes of Providence House's program concluded that among families served, children were less likely to enter foster care after a stay in the crisis nursery. Families of color were likely to have more success in the program than their white peers and have less foster care involvement following their children's stay. While some children (28%) have multiple stays, the study found that these children were no more likely to enter foster care than the children of families with only one encounter with the program. Another program evaluation found that participating families were more likely than non-participants to experience positive long-term outcomes related to housing, employment, income, and other social determinants of health.

CONCLUSION

Child welfare systems and their early childhood systems partners can continue to grow capacity for IECMH services and supports along the prevention continuum. Child welfare and their family-serving partners should consider how to integrate preventive interventions into their work with at-risk families. Many voices are needed at the tables where systems-level resource decisions are made, including the voices of families with lived experience. Planning 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. Opportunities exist to enact policies and practices that will support the healthy development of very young children and strengthen families—and the time to invest in IECMH services and supports is now.

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