Center for Advanced Studies in Child Welfare

School of Social Work
UNIVERSITY OF MINNESOTA

CW360°

a comprehensive look at a prevalent child welfare issue

Safety   Permanency   Well-Being

Using a Developmental Approach in Child Welfare Practice
Winter 2012

From the Editors (vertical, left margin)

From the Editors

Since 2008, the Center for Advanced Studies in Child Welfare has been producing *CW360°* as an annual publication, released each spring, which provides communities, child welfare professionals, and other human service professionals with comprehensive information on the latest research, policies, and practices in a key area affecting child well-being today. We have enjoyed watching the interest and circulation of the publication grow each year as more and more people in the child welfare community and beyond discover the wealth of resources and information in each issue. This year we are excited to offer our first fall special edition of *CW360°*, co-produced with our partners at the Center for Education and Early Development (CEED) at the University of Minnesota.
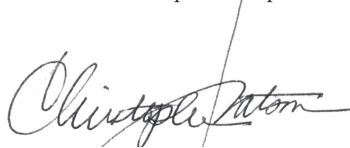
As we have striven to take a multidisciplinary view of the topic in each issue of *CW360°*, there are some challenges we run into again and again. One of these challenges is the recognition that, while there is great progress toward integration of services across systems or spheres of practice in social services, much of the work still occurs in "silos," often to the detriment of the families and children we are trying to serve. Another challenge for child welfare practitioners is the struggle to provide services that are appropriately tailored to the developmental stages of the children we serve, ranging from birth to early adulthood, with those at the very beginning of the spectrum, birth to five year olds, often being the most vulnerable of all. It is the intersection of these challenges that brought our two Centers together to

collaborate on this special edition of *CW360°*.

As in previous editions, *CW360°* is divided into three sections: overview, practice and collaborations, and perspectives. In the overview section, articles focus on key issues from research on early childhood development and maltreatment to federal policy related to children birth to 5 in the child welfare system. The practice section includes articles on evidence-based and promising practices for addressing early childhood experiences of trauma and maltreatment in young children. The collaborations and perspectives section presents articles from a variety of child welfare and early childhood stakeholders, highlighting innovative examples of cross-system collaborations and offering practical suggestions and strategies for system and practice improvements.

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We are excited and honored to partner with The Center for Advanced Studies in Child Welfare on this special issue of *CW360°*, focused on families with children from birth to age five. The mission of the Center for Early Education and Development is to improve developmental outcomes for children through research, training, and outreach, and we welcomed the opportunity to engage in this work specifically focused on children and families whose lives are touched by the child welfare system. Young children are the most vulnerable members of our society, in part because they are completely reliant on adults to care for them. In addition, the fields of developmental science and early care and education have taught us that young children have unique developmental needs

that are dramatically different from those of older children, adolescents and adults. Understanding a young child's unique developmental needs is essential to help the child reach his or her optimal development and to support the family caring for that child, especially under conditions of abuse and neglect. Who better to do this work together then those of us on the front lines of protecting our most vulnerable members of society: social workers, early interventionists, and early care and educators! Therefore, it is our sincere hope that this special issue of *CW360°* can contribute to the bridges we are building between the worlds of developmental science, early care and education, and child welfare.

We invite readers to view the 2011 Minnesota Roundtable on Early Childhood Education, Mobilizing Hope: Using a Developmental Approach in Child Welfare, which was held in early November and featured a number of contributors from this issue, including Tom Dishion, Anne Gearity, Lynne Katz, and Judge Cindy Lederman. Archived video from the Roundtable can be viewed at CEED's website: http://z.umn.edu/2011roundtable

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Development and the Welfare of Children

L. Alan Sroufe, PhD

Development turns at each and every stage of the journey on an interaction between the organism as it has developed up to that moment and the environment in which it then finds itself (Bowlby, 1973).

The perspective of development, so eloquently described by Bowlby above, provides a powerful tool for making sense of human behavior. As an example, the importance of the infant's pointing and other gestures become more meaningful when seen as the precursor of the verbal communication that will follow. Likewise, the self-imposed gender segregation in middle childhood makes more sense when we understand that forming loyal, same-gender friendships and learning peer group norms are the first steps towards developing the complex social networks and intimacy of adolescence. Thus, the behavior of individuals, both competence and maladaptation, becomes more understandable when seen as the outcome of development.

For decades students in the social sciences have been taught that behavior depends on the interaction of genes and environment. However, there is a third influence on behavior that may be most important of all; namely, the child's past developmental history. Individual history, or cumulative experience, affects both the current environment the child is experiencing and the child's reaction to it; in other words, it is not simply that nature and nurture interact, but that children, including their developmental history, play an active role in shaping this interaction. For example, children seek and avoid different experiences, interpret experiences uniquely, and elicit different kinds of behavior from other people. Thus, children with histories

of rejection more often interpret ambiguous actions as implying hostile intent than do children with supportive histories (Suess, Grossmann, & Sroufe, 1992). Children who isolate themselves in the pre-school classroom garner neither the growth enhancing experience of peer interaction nor the same degree of nurturance from teachers.

Recent evidence also makes clear that growth of the brain and even genetic influences are impacted by developmental history. The maturing brain, it turns out, is "experience dependent"; the nature of neural patterns formed depends on the particular qualities of experience of the infant (Stiles, 2008). Research primarily with animals, but beginning with humans, also shows that whether genes are or are not expressed depends on each organism's early experience (Kaffman & Meaney, 2007). In particular, a history of extreme stress affects expression of genes in the central nervous system that impact stress reactivity.

The important role of developmental history is confirmed by longitudinal studies, in which variations in early experience are documented and children are followed into adolescence and adulthood (Sroufe, Egeland, Carlson, & Collins, 2005). Infants having secure attachments to their primary caregivers, for example, later are more empathic, more self-confident, more competent with peers, and better adjusted at school than are children with histories of insecure attachment. They are better able to form trusting relationships as adults and less vulnerable to mental health problems. Likewise, a history of physical, sexual, and/or emotional abuse puts individuals at risk for psychopathology (Egeland, 2009). Such findings have been obtained when controlling for IQ, SES, temperament, and even later experience. Perhaps more striking, studies of continuity and change have shown that early experience is not erased even following developmental change. Thus, for example, rhesus monkeys, having apparently been thoroughly rehabilitated following histories of early deprivation, revert to stereotypic behaviors (i.e., repetitive, functionless activities that frequently interfere with an individual's

typical behavioral repertoire, such as rocking) when placed under stress (Suomi, 1977). On the other side, children who are troubled in preschool, despite having had early supportive care, are nonetheless more likely to rebound from their problems than are troubled preschoolers with less positive histories. So, not only are self-confidence, social competence, and psychopathology outcomes of development, so too is resilience (Sroufe et al., 2005). Resilience is not something some children just have; it is a product of history. Moreover, the same longitudinal research shows that stress, trauma, or adversity in the first five years of life often has more negative consequences than the same negative experiences at a later age (Appleyard, Egeland, van Dulmen, & Sroufe, 2005).

As the opening quote implies, development is cumulative. As one brain researcher puts it: "In short, development does not happen all at once; rather it builds upon itself, often creating as it goes the tools necessary for each successive step in the developmental process" (Stiles, 2008, pp. 380-381). It is in this sense that early experience has special importance. It, of course, does not directly determine all later behavior; rather, it initiates a pathway that sets a direction toward adaptation or maladaptation (Bowlby, 1973). One may use the analogy of building a house. Early experience, the foundation, is not more important than later experience; a house without proper supporting structures or without an adequate roof will surely deteriorate. Still, the foundation is crucial for the overall soundness of the house, and it to an extent constrains what it can become. Since all of the outcomes we wish to promote in children—curiosity, sociability, compassion, high self-esteem, and resilience— are developmental outcomes, it behooves us as a society to insure that each child has an emotionally and cognitively supportive early environment.

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Overview

Opportunities and Challenges in Addressing the Early Years of Children in the Child Welfare System

Esther Wattenberg, PhD

L. Alan Sroufe provides the message: the child's developmental history leads us to clues to present behavior. Neuroscientists, as Sroufe points out, have alerted us to the rapid brain development that occurs in the first years of a child's life. The interaction of genes and the environment, and the developmental history, provide the key to making sense of human behavior. This, then, is the important direction for child welfare: pay attention to the early years of a child's life.

Longitudinal studies have captured the importance of early experience in creating the pathways through which adaptation or maladaptation is directed. Further, concepts and research in attachment, the patterns of the unfolding relationship between the caregiver and the infant, have underlined this importance. Here we have the foundation for life-shaping behaviors such as confidence, competence, optimism, the capacity to develop secure and reciprocal relationships, and the zest for learning. It is this understanding that enlarged the tasks of child welfare, adding "well-being," along with "safety" and "permanency," as guiding principles of the field.

The maltreatment of infants and children leads to harsh consequences. Children with histories of trauma and severe early neglect are likely to suffer a life course of rejection, isolation, failure, and negative self-image. Abused and neglected young children emerge in adult life in social work caseloads of "deep-end" families suffering from poor mental health, substance abuse, and domestic violence.

This act, which influences law, policy, and practice in child protection, for the first time, authorizes state grant funding for the training of caseworkers in early childhood and adolescent development. In the most recent federal legislation authorizing child welfare services, the Children and Family Services Improvement and Innovation Act, there are also new requirements for state standards addressing the developmental needs of children under five.

For example, there is an increased focus on the needs of newborn infants affected by alcohol use during pregnancy. States must now have in effect either a law or a program that addresses those needs, including procedures for referring families to child protective services. States must also report on the number of children referred to child protective services as a result of drug

services including education, nutrition, mental health care, and promoting culturally informed early and continued development of infants.

Even more important than early intervention strategies, the strong body of evidence of the impact of early trauma on lifelong development leads to a critical recognition for the field of child welfare: Once a child under five is reported for maltreatment, a prevention strategy should be invoked to minimize further negative developmental outcomes. But prevention of developmental harm in children experiencing abuse and neglect is not only the responsibility of the child welfare system. Developing a more community-focused system of shared responsibility with the child welfare system for the well-being of children should be a focus of attention.

In conclusion, we must acknowledge "well-being" as an important framework for the child welfare system. While it is more complex than is widely understood ("putting socks on the octopus") only when we begin to truly address child and family "well-being" and the cooperation that it requires between child welfare, health, and education, can we begin to address the "best interests of the child."

Only when we begin to truly address child and family "well-being" and the cooperation that it requires between child welfare, health, and education, can we begin to address the "best interests of the child."

Here we come to a profound understanding: maltreatment in the early years is the source of negative feelings of self, the environment, and relationship to others.

For policy and practice advocates in the field of child welfare, there is support for early intervention as a window of opportunity to grasp and trace the complex narrative of neglected and abused infants and toddlers.

Recognition of the importance of integration of a developmental perspective in child welfare practice can be found in the 2010 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA).

withdrawal symptoms at birth or diagnosis of Fetal Alcohol Spectrum Disorder. These new CAPTA provisions are intended to underline the importance of referring these newborns for early intervention to promote health and well-being.

Child welfare practice strategies for changing the course for children in developmental jeopardy may include:

• A "child find" emphasis for an early recognition of a problematic child in children's mental health and public health;

• A strong connection to Early Head Start programs to provide comprehensive

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Hope Through Action: A Unique Window of Opportunity

ZERO TO THREE

Every seven minutes a baby or toddler in America is removed from his parents' care because of alleged abuse or neglect (U.S. Department of Health and Human Services, 2011). At a time when these children are first exploring the world, when their lives as learners are just beginning, they are learning that the world is a dangerous and frightening place. Their brains are assaulted by stress hormones that can diminish their IQs and social interactions. Their need to find safe, trusting relationships overrides their curiosity. Their future and the future of their communities are compromised.

Early experiences, both positive and negative, have a decisive effect on how the brain is wired (National Research Council and Institute of Medicine, 2000), altering the brain's architecture (see Tarullo, this issue). These changes in the brain give rise to several psychological difficulties—cognitive delays, poor self-regulation, and difficulty in paying attention (Harden, 2007). Maltreated infants and toddlers also struggle with poor self-esteem, behavior control, and attachment formation and may have difficulty showing empathy, controlling their behavior in social situations, and initiating social interaction.

> Reorienting a child welfare system toward a developmental approach requires commitment from policymakers as well as the inclusion of specific knowledge of the science of early child development in the training of child welfare, social service, early childhood, and legal workforces.

However, because of the rapid brain development, the early years also present an unparalleled window of opportunity to effectively intervene with at-risk children (National Research Council, 2000). To be effective, interventions must begin early and be designed with the characteristics and experiences of these infants, toddlers, and families in mind (Harden, 2007). Intervening in the early years can lead to significant cost savings over time through reductions in child abuse and neglect, criminal behavior, welfare dependence, and substance abuse. A study of the cumulative costs of special education from birth to 18 years old found that intervening at birth resulted in lower costs over the course of childhood than services started later in life (approximately $37,000 when services were begun in infancy, 28% to 30% lower than when begun after the age of 6) (Wood, 1981).

Given this early window of opportunity, there are a number of ways that policymakers and practitioners can intervene to improve outcomes for infants and toddlers. Child welfare practices must be focused on child safety and also structured to promote healthy development and the formation of a secure attachment between the child and at least one nurturing adult. A reorientation of thinking is needed to reform approaches to infants and toddlers who come to the attention of the child welfare system at such a developmentally critical time.

An Agenda for Addressing the Developmental Needs of Infants and Toddlers

Every child welfare decision and service should enhance the well-being of infants, toddlers, and their families. Elements of a policy agenda focused on infants, toddlers, and their families should build on what we know about healthy infant and toddler development and the protective factors that help families mitigate the trauma of maltreatment and provide a nurturing environment for young children. Reorienting a child welfare system toward a developmental approach requires commitment from policymakers as well as the inclusion of specific knowledge of the science of early child development in the training of child welfare, social service, early childhood, and legal workforces.

Guiding principles, policies, and practices to address them include the following:

Stable, caring relationships are essential for healthy development. At least one loving, nurturing relationship is the linchpin of positive early development. Relationships

A CALL TO ACTION ON BEHALF OF MALTREATED INFANTS AND TODDLERS

Sponsored by:
American Humane Association
Center for the Study of Social Policy
Child Welfare League of America
Children's Defense Fund
ZERO TO THREE

Overview

with caregivers are the context in which early development occurs. These first relationships that a child forms with adults have the strongest influence on social and emotional development (National Research Council, 2000). Infants and toddlers rely on their closest caregivers for security and comfort. Those who are able to develop secure relationships are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments (National Research Council, 2000). They also show a greater capacity for self-regulation, effective social interactions, self-reliance, and adaptive coping skills later in life (Goldsmith et al, 2004). Child welfare policies and practices should make supporting responsive, secure bonds between the youngest children and their parents and caregivers a central goal. This means maintaining and supporting frequent parent–child contact; minimizing changes in foster placements; using congregate care only where parents and their young children can be cared for together; and promoting permanency for the children within a year of entry into foster care.

Early intervention can ameliorate the consequences of early adversity. Approximately one third of infants and toddlers investigated by child welfare services have a developmental delay (Casanueva, 2008). Data from the National Survey of Child and Adolescent Well-Being indicate that 35% of children from birth to 3 years old involved in child welfare investigations were in need of early intervention services. However, only a small percent (12.7%) of these children were receiving the Individualized Family Service Plans to which they were entitled under federal law (Casanueva, 2008). Meeting developmental needs means routinely screening infants and toddlers for developmental delays and then intervening with necessary services. Infant and early childhood mental health specialists can serve as consultants to staff, birth parents, and other caregivers. They can help address the relationship between baby and parent and between baby and foster parent. Child–parent psychotherapy, the only mental health intervention appropriate for use with infants and their adult caregivers, is a critical mental health service to be able to offer. Often this means training local mental health clinicians to use this approach.

Families and communities must be key partners in efforts to ensure the well-being of every child. The child welfare system cannot do it alone. By working collaboratively, the child welfare, legal, education, judicial, and human services professions can support vulnerable families in their journey away from maltreatment and toward healthy self

sufficiency. This is important during the life of the child maltreatment intervention and after the children reach permanency. At-risk families with young children need to build strong friendships and community connections. Cooperation among all the agencies involved in the families' lives and the families themselves, can link families to community programs like Early Head Start, community schools, faith communities, and Alcoholics Anonymous that will help families succeed after the formal child welfare intervention ends.

Child welfare administration at the federal, state, and local levels must focus on infants, toddlers, and their families in such functions as the delivery of services, data collection, research, and attention to special populations. It is extremely important that we know more about what is occurring with the youngest children in the child welfare system and what works best in addressing their needs. We must acknowledge and respond to their needs in program administration, research, data collection, and analysis, as well as the provision of ongoing services.

Maltreatment and negative foster care experiences can have negative lifelong implications if not properly addressed. Focusing on the developmental needs of infants and toddlers in the child welfare system holds the potential for closing the pipeline to the juvenile delinquency system, school failure, adult criminality, substance abuse, and new generations of abused and neglected children.

This article owes its origins to A Call to Action On Behalf of Maltreated Infants and Toddlers, jointly published by the American Humane Association, the Child Welfare League of America, the Center for the Study of Social Policy, the Children's Defense Fund, and ZERO TO THREE. The full document represents our collective vision of important steps that can and should be taken in policies, programs, and practices to better address the developmental needs of infants and toddlers who come to the attention of the child welfare system. The full document can be downloaded from http://www.zerotothree.org/public-policy/federal-policy/childwelfareweb.pdf

Childcare in the Context of Foster Care: Potential Benefits for Underserved Children

Mary Elizabeth Meloy, MPP

Recent movement in the policy arena has brought the understudied topic of Early Care and Education (ECE) and Child Welfare service coordination into the spotlight, thus acknowledging the shared goals of the two systems that target vulnerable children to reduce risk and promote protective factors within their care-giving environments, including, but extending beyond, the biological family. Indeed, policymakers at the federal level have begun to encourage states to improve collaboration between their early childhood and child welfare systems and build infrastructure to facilitate their collaborative efforts (US-DHHS, 2011). Yet, many questions remain about the use and potential impacts of ECE for foster children, forcing policymakers and practitioners to make these service decisions without an empirical knowledge base.

Ample research has established both the myriad of developmental needs (developmental delays, physical and mental health issues) that affect young foster children (Cicchetti, 2007; Pinderhughes, Harden, & Guyer, 2007) and the potential of high quality childcare and ECE programs to improve the well-being of similarly "at-risk" children (Campbell et al., 2002; Gormley, Phillips, & Gayer, 2008; Reynolds, Temple, & Ou, 2003; Schweinhart, 2004; Phillips & Meloy, in press). Thus, ECE experiences may have the potential to benefit foster children's development.

While foster children do share many qualities with the at-risk samples that have been studied in the ECE and early intervention literature (low-income, minority, special needs), the greatest and most unique challenges to their development are their poor care-giving experiences (abuse, neglect) and disruptions to their care-giving environments as they move in and out of (and within) foster care (Wulczyn, Kogan, & Harden, 2003). Therefore, whether ECE poses benefits or a threat to their development is worth examining and may depend largely on the quality of the experience and the stability of the childcare placement.

Researchers have begun to address this gap by examining predictors and patterns of— and to some extent the outcomes associated with—ECE enrollment for foster children. Much of the current research points to under-utilization of ECE services for foster children. Specifically, foster children in Colorado were less likely to be referred to ECE services than to other services, such as those supported under IDEA (Ward et al., 2009), which was linked to caseworker perception that ECE did not address children's developmental needs. In Illinois, only 11% of foster parents utilized Child Care Development Fund subsidies for their foster children under the age of five, despite categorical eligibility (Meloy & Phillips, under review). Finally, national data from the National Survey of Child and Adolescent Well-being also suggests that foster parents under-utilize childcare, particularly Head Start (Meloy, 2011). This pattern of under-utilization appears to be less true for older children, as evidenced by childcare subsidies being used more frequently for preschoolers in Illinois and the enrollment of most preschool-aged foster children in Oregon (88%) in some form of ECE (Meloy & Phillips, under review; Lipscomb & Pears, in press).

Despite this risk, exposure to Head Start, in particular, has been linked to foster children's language and cognitive development over time (Meloy, 2011) and to fewer transitions while in foster care (Lipscomb & Pears, in press) compared to children experiencing other types of childcare or no childcare at all. Childcare subsidy receipt was also associated with a reduced risk of foster placement disruption over time (Meloy & Phillips, under review). Finally, research out of Miami has demonstrated a potential link between enrollment in accredited childcare centers and foster children's early school success (Kaiser, Katz, Dinehart, & Ullery, 2011). Nonetheless, it is possible that long hours of childcare, frequent transitions between childcare placements and households with fewer resources may actually compound the risks to these children's development.

These initial forays into research at the intersection of ECE and Child Welfare highlight the challenges and opportunities associated with collaboration between these two service systems. Foster parent resources and caseworker beliefs appear to influence foster children's exposure to ECE experiences of varying types; and ECE, particularly Head Start, exposure is associated with their improved developmental and foster placement stability outcomes. While this research has highlighted the potential need to connect more young foster children with quality ECE programs and established a link between ECE experiences and their well-being, many questions remain. Future research aimed at providing a complete picture of the role and impacts of ECE for foster children is essential to achieving these systems' shared goals.

Mary Elizabeth Meloy, MPP, is a doctoral candidate at Georgetown University in Human Development and Public Policy. Her research focuses on the developmental impacts and social support provided by early care and education experiences for children living in poverty, children with special educational needs, and children who experienced maltreatment and child welfare system supervision.

Overview

Overview

Early Intervention for Infants and Toddlers in Child Protection: Updating Public Policy

Marcie Jefferys, PhD

Passing good laws is just one step in improving the public policies that impact our most vulnerable children. The 2003 federal Child Abuse Prevention and Treatment Act (CAPTA) requires children under age three with a substantiated maltreatment report be referred for assessment of their development and need for early intervention services. The law is based on the overwhelming evidence of the higher risk for lifelong harm that results from unaddressed adverse early childhood experiences such as maltreatment. Assuring at-risk children are screened for developmental

been referred, assessed, or receiving services. This year, a coalition of major actors in child welfare and early childhood policy have issued a joint "call to action on behalf of maltreated infants and toddlers" that includes increasing knowledge "about what is occurring with the youngest children in the child welfare system" (American Humane Association et al, 2011, p. 7; Zero to Three article in this issue).

These barriers can be overcome. More can be learned from caseworkers and early childhood staff about their knowledge of, and experiences implementing the law. Linking

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Only one in seven children who are eligible for early intervention services receive them.

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progress as early as possible is a critical early step in averting delays and the rationale for the 2003 CAPTA requirement.

The law has not been an easy one to implement, however. Although it is estimated that half of all young children investigated for maltreatment need early intervention services, the youngest children are less likely than older children to receive services. Overall, only one in seven children who are eligible for early intervention services receive them (National Center for Children in Poverty, 2009). Funding explains some part of these results, but other factors also come into play.

Essential to implementing the law is collaboration across child welfare and early childhood systems, requiring shifts in perspectives from both fields. Although younger children are reported for neglect and removed from their homes at higher rates than older children (Wulzcyn, Barth, Yuan, Harden & Landsverk, 2005), the system has not historically been sensitive to the developmental needs of children at different ages (American Humane Association, et al, 2011). Likewise, the professionals delivering early intervention services usually have little training or experience with families in the child welfare system (Barth, Scarborough, Lloyd, Losby, Casanueva, Mann, 2008). They may especially be lacking training in the social emotional problems that maltreated children often develop (National Center for Children in Poverty, 2009).

At the administrative and policymaking level, few data exist to guide the law's implementation or determine its impact. Adequate policies are not in place at the federal level or in all states to provide information about how many children have

data across state agencies and systems could provide better information for planning services at the child and family level as well as help administrators and policy makers pursue fuller implementation of the law. Cross training in child development and child welfare is happening in some jurisdictions (U.S. Department of Health and Human Services, 2007).

Research and other changes in child welfare policy suggest that the law itself should be revisited. Barth et al. (2008) determined that children whose maltreatment was investigated, but not substantiated, scored as poorly on developmental assessments as those with substantiated maltreatment, suggesting these children should be included in the mandate. The high rate of exposure to multiple risk factors most of these young children experience also suggests that all maltreated children be eligible for early intervention services. If the law is not changed to make them categorically eligible, follow-up processes should be required so that at least all children are tracked through their childhood to catch problems they may develop as they age.

The law should also be updated to reflect changes in other child welfare policies. As more states implement alternative response systems in which maltreatment is not formally determined, fewer children will fall under the referral requirement. In Minnesota, for instance, 70% of families screened in by the child protection system are in the alternative response track (Minnesota Department of Human Services, 2011).

Despite these challenges, the current law is an important step forward. Child welfare workers and early childhood program staff, as well as public health workers, researchers,

advocates, and families impacted by these policies, have an important role to play in improving the law and ensuring its effective implementation. They can also help remind policy makers that these families are often stressed by broader societal and economic factors, including deep poverty, discrimination, and inadequate public welfare programs and policies. Given the high public costs and lost human capital of unaddressed early adverse childhood experiences, effective and well-implemented early childhood and child welfare policies are important for all of us.

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Development of Attachment Relationships in Young Children

Monica Stevens, PhD, Julie Larrieu, PhD, and Charles Zeanah, PhD

The attachment system is a biological system in which children manage feelings of distress or perceived threats by seeking comfort, nurturance, and protection from particular adult caregivers. Attachment relationships form gradually during the first few years of life, and variations in the quality of the attachment relationship result from interactions in which a child experiences the primary caregiver either as a consistent provider of nurturance and security or as

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The most effective treatments of attachment disturbances are those that focus on improving the caregiver-child relationship by enhancing parenting skills, increasing caregiver insight, and improving parental sensitivity to the child.

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undependable or even harsh. Qualitative features of the attachment relationship (e.g., security) are believed to be shaped by these experiences (Dozier et al., 2009).

Individual differences in attachment styles describe the balance between the child's exploratory and proximity-seeking behavior in the presence of an attachment figure. Children who have experienced consistently responsive and warm caregivers develop secure attachments and use their primary caregiver as a base from which to explore their environment and seek comfort and security in response to threat. Children who have experienced inconsistent caregiving may develop anxious, resistant attachment. In response to threat, the child displays intense distress in order to achieve proximity with the caregiver, but because the child does not know what to expect from the inconsistent caregiver, the child is not readily soothed. In response to caregivers who are withdrawn, harsh, or inconsistent, children may develop avoidant attachment relationships. When the attachment is avoidant, the child shows little distress in response to threat, and actively or passively avoids proximity to the caregiver as the child has learned that strong displays of emotion serve to distance the attachment figure (Main & Solomon, 1990). The importance of a secure attachment relationship has been clearly established as a critical component of adaptive functioning, and lacking secure attachment is associated with increased risk of psychopathology, emotional dysregulation, behavior problems, and poor school performance (Bureau, Easterbrooks, & Lyons-Ruth, 2009; Lyons-Ruth & Jacobvitz, 2008; van IJzendoorn, Schuengel, & Bakersmans-Kranenburg, 1999; Moss & St-Laurent, 2001).

Some children, particularly those who have experienced maltreatment or multiple disruptions in their attachment relationship, fail to develop an organized attachment relationship at all. In disorganized attachment relationships, the child lacks a coherent strategy for obtaining comfort and safety from the attachment figure when under threat, often because the caregiver is serving as both the threat and the attachment figure. Research bears out this relation between maltreatment and attachment disorganization (Stronach, et al., 2011). In a meta-analysis of 80 studies, van IJzendoorn and colleagues (1999) found that 48% of maltreated children were classified as having disorganized attachment, versus 17% of non-maltreated children. Furthermore, disorganized attachment has been implicated as a significant risk factor in the development of child and adult psychopathology (Dozier, Stovall, & Albus, 1999; Green & Goldwyn, 2002; Lyons-Ruth & Jacobvitz, 2008). Given the concerning trajectory of children with disorganized attachment relationships and the stability of this pattern, research on effective prevention and intervention of attachment problems is important.

In conditions of severe neglect, even more extreme disturbances of attachment may be noted. Reactive attachment disorder describes lack of attachment relationships in young children who are cognitively capable of forming them. These children do not seek comfort or nurturance from caregivers and exhibit reduced social reciprocity, minimal positive affect, and serious emotion regulation difficulties. Another disorder of attachment, known as indiscriminate/disinhibited, is associated with lack of selectivity in adults from whom comfort and support are sought. Children with this disorder approach unfamiliar adults without hesitation, fail to check back with attachment figures in unfamiliar settings, and are even willing to "go off" with strangers. This disorder has been identified in children who lack attachments, who have disorganized or insecure attachments, or even in children with secure attachments. These disorders are moderately stable over time and associated with functional impairment (Gleason et al., 2011). Because of differences in their phenomenology, course, correlates and relation with patterns of attachment, they are considered distinct disorders. Plans for the DSM-5 include the addition of this disorder as Disinhibited Social Engagement Disorder to distinguish it from Reactive Attachment Disorder (APA, 2010), which will be limited to describing emotionally withdrawn/inhibited behavior.

Well-supported treatments exist for young children at risk for attachment problems, such as Child Parent Psychotherapy (CPP; Lieberman, Ippen, & Van Horn, 2006), the Circle of Security intervention (COS; Hoffman, Marvin, Cooper, & Powell, 2006), and Attachment and Biobehavioral Catch-up (ABC; Dozier et al., 2006). Randomized trials have demonstrated that quality foster care for young, maltreated children, augmented by intervention, may lead to enhanced security of attachment and reductions in disorganized attachments (Dozier et al., 2003; Smyke et al., 2010). These interventions should not be confused with coercive holding therapies, sometimes called "attachment therapies." They lack empirical support, but more importantly, they are dangerous and have led to six deaths (Allen, 2011; Chaffin et al., 2006). The most effective treatments of attachment disturbances are those that focus on improving the caregiver-child relationship by enhancing parenting skills, increasing caregiver insight, and improving parental sensitivity to the child.

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Overview

Effects of Child Maltreatment on the Developing Brain

Amanda Tarullo, PhD

Infants and young children rely on their caregivers to play with them, to comfort them and keep them safe, to teach them about relationships, and to help them cope with scary or confusing situations. This sensitive, responsive caregiving is critical not only for children's immediate safety and happiness, but also to support normal brain development. While some parts of the brain continue to grow and change throughout childhood, the most rapid period of brain development is in the first five years of life. During these early years, the brain does not just develop automatically as if it had an internal clock. Instead, a child's experiences play an active role in shaping the brain's architecture (Black, 1998). By providing sensitive, responsive care, parents help their young children to build connections between brain regions. These neural pathways enable children to learn, pay attention, develop social skills, and manage their emotions.

Unfortunately, harsh or inconsistent care also leaves an enduring imprint on the developing brain, putting children who have experienced maltreatment at risk for physical disease, mental health problems, and substance abuse disorders later (Anda et al., 2006). Specifically, child maltreatment is associated with structural abnormalities in brain regions that control emotions and behavior, which may partially explain links between child maltreatment and adult psychiatric disorders (McCrory, De Brito, & Viding, 2010). For example, the corpus callosum, which links the left and right hemispheres, has been found to be smaller in maltreated children than in non-maltreated children (De Bellis, et al., 2002). There can also be abnormalities in the prefrontal cortex, which manages emotional and cognitive functioning (Carrion, et al., 2009; De Bellis, et al., 2002), and the cerebellum, which is involved in learned fear (De Bellis

& Kuchibhatla, 2006). These abnormal brain structures may lead to emotional and behavioral problems. For instance, among children experiencing physical abuse, the orbitofrontal cortex, which is involved in regulating emotions, is smaller, and this brain abnormality is related to parent and child reports of difficulties with social functioning (Hanson, et al., 2010). Child maltreatment often leads to posttraumatic stress disorder and other psychiatric diagnoses, and it can be challenging to determine whether brain abnormalities are due to the maltreatment itself, or to associated psychiatric disorders, or to both (Hanson, et al., 2010). The specific effects on brain structure and function also depend on the type of adversity the child experiences (e.g., physical abuse, sexual abuse, or witnessing violence) and the child's age (McCrory, et al., 2010).

Child maltreatment alters the brain's perception and interpretation of facial expressions. A study measuring brain electrical activity found that children who have experienced physical abuse have a stronger brain response to angry faces and voices, and they are more distracted by these anger cues compared to non-abused children (Shackman, Shackman, & Pollak, 2007). Also, when shown ambiguous facial expressions, these children are very sensitive to even slight signs of anger (Pollak & Kistler, 2002). These children live in an environment where an angry face or voice can signal imminent danger of physical abuse, so it may be adaptive for their brains to be very vigilant to

signs of anger. However, it is easy to imagine how this heightened vigilance to anger could be maladaptive in other settings such as daycare or school (Shackman, et al., 2007), putting children at risk for anxiety or conduct problems.

Young children's physiological stress systems are immature at birth and therefore vulnerable to maltreatment and neglect. From infancy through preschool, children depend on sensitive, responsive caregivers to help maintain the normal daily rhythm of the stress hormone cortisol, and to protect the developing brain from being exposed to too much cortisol (Gunnar & Donzella, 2002). By the end of the first year, children with sensitive, responsive parents show no cortisol increase to a stressful experience like getting immunizations, even though they cry: their parents' presence buffers them from stress hormone elevations (Gunnar & Donzella, 2002). When parents are not sensitive and responsive, however, toddlers do show cortisol

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By providing sensitive, responsive care, parents help their young children to build connections between brain regions. These neural pathways enable children to learn, pay attention, develop social skills, and manage their emotions.

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responses to stressful experiences. Over time, chronic stresses such as abuse, neglect, and multiple foster care placements can distort the child's daily stress hormone rhythms, so that cortisol levels are either too high or too low (Fisher, Gunnar, Dozier, Bruce, & Pears, 2006). When evaluating intervention programs, it is critical to consider both behavioral and neurobiological outcomes. For example, when children with abnormal cortisol levels were placed in an intensive foster care intervention program, which provided extensive support and training to foster parents, the children's cortisol became more normal, whereas children in regular foster care placements continued to have abnormal cortisol rhythms (Fisher, et al., 2006). Such findings offer hope that intensive intervention programs to improve the quality of care young children receive may help to normalize some aspects of brain function.

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Child Maltreatment: Risk and Resilience in Ages Birth to 5

Anne Shaffer, PhD

A primary goal of the child welfare system is to protect and recover the well-being of children exposed to adverse circumstances, such as child maltreatment or neglect. In efforts to protect children from adversity, researchers and practitioners have paid much attention to the definition and identification of different types and forms of child maltreatment, including physical abuse, sexual abuse, psychological abuse, and physical and emotional neglect. These efforts are of immense practical importance in establishing and guiding standards for mandated reporting and other intervention decisions relevant to Child Protective Services. Efforts to identify and distinguish among types of maltreatment and neglect are also relevant to understanding child and adult outcomes that can differ according to the type(s) of maltreatment experienced. Relatedly, research and practice in child welfare has focused on delineating other aspects of maltreatment that can affect the development of problems or recovery following the experiences, such as the timing and duration of maltreatment, the relationship of the child to the perpetrator of the maltreatment, and maltreatment severity. This is particularly relevant when considering maltreatment in the first five

years, as early maltreatment has been associated with some of the most detrimental outcomes. Taken together, this research has done much to increase the scope of child maltreatment prevention and intervention efforts in the decades following Kempe's seminal publication regarding "battered child syndrome," which begat the increased awareness of child abuse as a concern to public health and welfare.

In contrast, less attention has been paid to defining and identifying what it means for a child to be doing "well" in their environment. Child welfare professionals are well-prepared to judge when a child's environment is abusive or neglectful, or if a child is showing signs of maladjustment. However, child welfare professionals may benefit from learning the latest research on promoting resilience. These questions have long been the domain of developmental psychology; thus, the application of a developmental perspective to child welfare work can inform efforts to identify factors that can both protect children from harm and enhance well-being in children exposed to adversity such as maltreatment. In particular, developmental research on risk and resilience has updated and broadened notions of what it means to
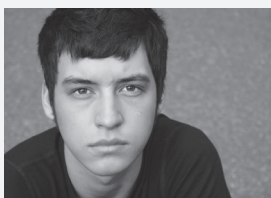
be exposed to conditions that increase the likelihood of negative outcomes, and what factors in a child's life and environment can protect a child from risky experiences such as maltreatment, to support and promote positive development (Cichetti, 2004; Shaffer, Egeland, & Wang, 2010).

While the fact that child maltreatment is a risk factor for later maladapation is not a surprise to child welfare professionals, developmental research on risk can still shed light on important concepts that are relevant to the well-being of maltreated children. For example, developmental research has long recognized that rarely does a single risk factor exert effects in isolation; instead, risk factors tend to accumulate in the lives of children. Child maltreatment and neglect tend to co-occur with other risk factors in families, such as poverty, intimate partner violence or neighborhood violence, parenting stress, and parental mental health problems or substance abuse. Thus, child maltreatment is particularly harmful to children not only because the act(s) are harmful but also because the wider environmental and contextual stress on their caregivers further deprive them of typical/adaptive caregiving that is crucial for supporting healthy development.

Overview

With the identification of risk comes the acknowledgment that some children continue to do well despite their exposure to risk or adversity. This developmental phenomenon has been the subject of extensive investigation under the umbrella term "resilience." Resilience is an inherently developmental concept—that is, resilience is not a trait or a static characteristic of a person, but an outcome of the combination of risk and protective factors present in a child's life that influence the course of development toward either positive adaptation or maladaptation. In this way, "resilience" indicates that a child is doing well (i.e., developing competently) despite having experienced significant risk or adversity (Masten, 2001). Although defining maltreatment as a condition of risk or adversity is something in which child welfare professionals are extensively prepared, it can be more challenging to identify how and in what ways a child is "doing well."

A key point related to resilience that developmental research has clarified is that competence, or "doing well," is more complex than simply an absence of psychopathology or problems. Furthermore, competence is multidimensional, and in child development, domains of competence can include behavioral, emotional, social, and cognitive aspects. In the birth to five age range, the development of competence in these domains is largely governed by the attachment relationship, and attachment security can be disrupted in cases of maltreatment or neglect. Furthermore, achieving school readiness is a salient aspect of development by age five, and poorer educational outcomes are frequently observed in maltreated and especially neglected children. This may be directly related to specific domains of competence that are salient in the first five years, including emotional and behavioral regulation, and executive functioning; all areas that maltreated or neglected children can show impairments. Understanding and identifying the developmental domains of competence that underlie the development of later goals such as school readiness can support effective prevention or intervention efforts and steer maltreated or neglected children back toward positive adaptation.

Resilient children, who are doing well despite experiences of adversity such as maltreatment, inevitably have protective factors that are present in their lives and operating to buffer or offset the impact of negative experiences in some ways. Ultimately, this application of a developmental perspective, and in particular an understanding of predictors of resilience, can be of greatest benefit to child welfare in ways that use this information to steer the developmental course back toward well-being for children who have been maltreated or neglected. It is important to note that no specific protective factor or set of protective factors is a "magic bullet" that can protect against any conditions of harm; instead, it is the combination and balance of risk and protective factors over the course of development that collectively tips the balance toward positive adaptation or maladaptation. Still, to the extent that protective factors can be reliably identified, these findings can guide prevention and intervention work in child welfare.

As with risk factors, protective factors can be present at the individual level, family level, or in the broader social context of a child. Examples of protective factors that can promote resilience among children who have experienced maltreatment or other adversity are secure attachment, high IQ, emotion regulation, and school engagement. Some of these factors are less developmentally relevant to children in the birth to five age period, such as school engagement, but are listed as suggestions of protective factors to which children can be steered as they reach middle childhood in order to facilitate later positive adaptation. Other protective factors, such as IQ, may seem less open to change but can be supported in children who show these strengths. And factors such as emotion regulation highlight the fact that these abilities are nurtured in the birth to five period through sensitive and responsive caregiving. Thus, from a child welfare perspective, decisions about child placement that keep these factors in mind will ultimately support the development of child wellbeing. This, ultimately, is the goal in adopting a developmental approach to issues facing the child welfare system.

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Red Flags: Parent-Child Relationship

If persistent difficulties are noted in the domains listed below, a referral for more intensive treatment may be indicated.

- **Parent and child have difficulty connecting.** Child does not respond to parent's presence. Parent is unable to engage or play with or set limits for child. Parent infrequently talks to child or holds child's hand. Parent and child have frequent miscommunications or parent says he or she does not know how to relate to the child.

- **Parent consistently fails to protect the child,** allowing child to touch, eat, play with, or climb on dangerous objects.

- **Parent is consistently cold or hostile to the child.** Parent uses hard tone or offensive words or uses unnecessary force. Parent threatens to hit the infant or calls the child names.

- **Parent attributes malignant motives to child's behavior.** Parent may say the child deliberately makes him or her angry by waking up at night or that the infant will turn out to be a mean troublemaker "just like his dad."

For the complete Minnesota Infant Mental Health Tip Sheet on "Guidelines for Referral: Red Flags," authored by Carol Siegel and Ana Pratt, visit CEED Publications online at http://www.cehd.umn.edu/ceed/publications/tipsheets/

Overview

Improved Child Safety with the Nurturing Parenting Program and the Potential for Cost Savings to Child Welfare

Erin Maher, PhD, Lyscha Marcynyszyn, PhD, Rhenda Hodnett, PdD, and Tyler Corwin, MA

Casey Family Programs collaborated with Louisiana's Department of Social Services to evaluate their statewide implementation of an evidence-informed parenting education program. The Nurturing Parenting Program® (NPP) for Infants, Toddlers and Preschoolers is built on the principle that knowledge and empathy are the foundation of responsive parenting. Theoretical underpinnings of the program include an understanding of behavior as influenced by earlier experiences. Cognitive-behavioral, psycho-educational, and family-centered approaches are used to develop positive parenting skills. Caregivers participated in a 16-week, group-based program that was supplemented by home visits in some instances. Caregivers focused on self-awareness and empowerment, empathy for their children's needs, child development, discipline, emotional communication, behavioral skills, family routines, and decision-making to promote child safety.

not have been able to control for all the characteristics of the caregivers and their families that could be associated with both participation levels in NPP and maltreatment. Nonetheless, these results suggest that moving to evidence-informed parenting education, such as NPP, may improve safety outcomes for children and reduce future child welfare involvement for families who have had previous contact with the system.

Results of a cost savings analysis from the perspective of the child welfare department show a benefit-to-cost ratio of .87. That is, in the four-and-a-half year time frame following participants in the first two-and-a-half years of program implementation, the state child welfare agency could recoup at least 87% of the costs of delivering the NPP assuming average-to-high attendance levels. These savings stem from the direct costs associated with observed reductions in repeat maltreatment.

are needed to promote use and spread of programs with documented effectiveness. Louisiana's policy shift toward evidence-informed programming, its statewide implementation and evaluation of the NPP, and the NPP's potential to reduce ongoing child welfare involvement may have relevance for other jurisdictions interested in similar programmatic transformations of child welfare services.

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Program participation is associated with fewer short-term allegations and fewer longer-term substantiated incidences of maltreatment.

The study consisted of 528 caregivers with children under six who had child abuse and/or neglect allegations. Administrative data on child welfare involvement combined with survey data on caregiver's demographic characteristics and parental attitudes were used to measure the association between program attendance and likelihood of subsequent maltreatment.

Results demonstrate that level of participation in the NPP was associated with a reduction in short-term allegations and longer-term substantiated child maltreatment incidences (Maher, Marcynyszyn, Corwin, & Hodnett, 2011). The more sessions caregivers attended, the more child safety improved, as measured by a recurrence of maltreatment reports.

- Six months after the program's conclusion, caregivers who attended more sessions were significantly less likely to be re-reported for child maltreatment.

- Two years after participating, caregivers who attended more sessions were significantly less likely to have a substantiated maltreatment incidence.

In summary, program participation is associated with fewer short-term allegations and fewer longer-term substantiated incidences of maltreatment. However, one limitation of the study is that we may

Some program costs, such as supervision and non-personnel costs (e.g., rent) were not included. However, we also did not include savings stemming from other outcomes associated with the prevention of maltreatment including medical costs (hospitalizations, chronic health conditions, doctor visits, prescriptions), non-medical costs (judicial and criminal services, special education), and lost productivity (lost earnings) (Corso & Lutzker, 2006). If these savings were included, our benefit-cost ratio would be substantially higher. In addition, we did not include savings attributable to reductions in maltreatment from other child-serving agencies or systems, such as Medicaid. In sum, this cost analysis demonstrates the potential of the NPP for producing long-term savings to child welfare agencies. These savings could then be reinvested into additional prevention strategies and programs.

In child welfare, parenting education interventions serve families who are trying to keep their children from entering out-of-home care or who are seeking reunification. But, the use of evidence-informed or evidence-based parenting education programs is scarce. This examination is one step along a continuum to establish the NPP as a cost-effective program to better serve the child welfare population. Rigorous evaluations of this and other parenting education models
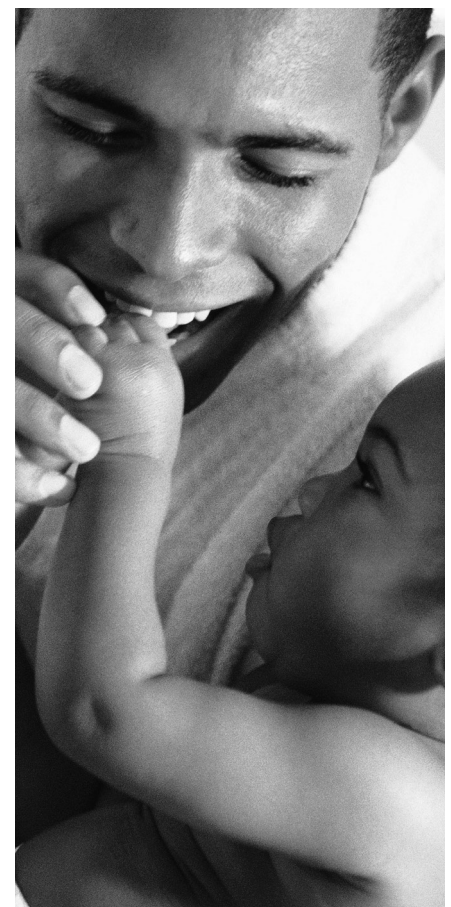
Developmental Repair

Anne Gearity, PhD, LICSW

Developmental Repair (DR) is an intervention model that emerged from community mental health practice with aggressive and disruptive young children at Washburn Center for Children in Minneapolis, MN. It is also a "state of mind" shift necessary to help children struggling with effects of early disruptions of care, including significant behavioral, cognitive and social/relational difficulties. DR integrates principles of developmental psychopathology and resilience, understanding children's risks and also supporting protection drawn from both internal resources and experiential opportunities in the present that increase children's capacities for repair and new learning.

At the core of DR is an assumption that young children learn about the world through their primary caregivers. For children whose early caring experiences have been unreliable or even endangering, their perceptions are often compromised by intense arousal and painful assumptions that no one will help. We *join* children, to provide regulating support that they have not received or have not been able to use. We become interested in their experiences and offer them relationships that provide this active regulating partnering that is a prerequisite or self-regulation.

Because these children are not infants, it is also important to understand their earlier experiences, and how these experiences have impacted their development, and influenced their perception of others, and sense of self. These perceptions often *color* their relational expectations, and to respond with strategies that bridge, instead of exacerbating, their isolation. Perceptions also compromise children's ability to accurately *read* others' intentions and social/emotional messages. As we join these children, we also *read* social/relational exchanges, and help them better interpret what is happening between them and us. This repairs their ability to organize relational interactions in ways that keep them connected. We also describe their *relational fears,* so that they can discern how interactions can feel and work differently.

When this process of repair works, then emotion self-regulation increases. Many of the children (and the adults who have interacted with them) confuse arousal and fear as anger, further confusing and restricting children's ability to recognize and modulate a wider range of emotions. Our interventions help children tolerate and contain these complex and intense feelings so they can gradually feel more self-regulated and self-aware.

It is only when children can modulate

Photo credit:Lawrence Michael Photography

intense stress arousal and feelings that they can then act with more planning and intention. Self-control, better described as effortful control, is a developmental achievement that presumes enough relational reliability so that children can register others' expectations and rules. Effortful control requires trust in basic social contingencies that promise reciprocal regard and supports self-awareness and positive self-protection.

As an intervention model at Washburn, DR is a (half) day treatment program; children attend school or community programs during the other half-day. An important component of DR is helping children participate in their natural social contexts. Many of these children have already become alienated from peers, and have adopted maladaptive behaviors that perpetuate social estrangement. Helping children practice social norms encourages *other-understanding (empathy)* and inclusion, and complements work on self-regulation. Developmental Repair works to build capacities that are necessary for better functioning, and support resilience. Some children continue to have vulnerabilities (anxiety, post-trauma symptoms, depression, attentional and learning difficulties) that require more specific interventions. But interrupting social alienation and disruptive functioning, and restoring children's ability to use adults for regulation and *making sense* of experiences, must occur first.

DR recognizes that when children change, they function differently in their families. Sadly, many of their parents have similar histories and are impacted by their own traumas and regulatory deficits. Helping these parents address their children's developmental needs is challenging because of their own vulnerabilities, especially when the dangers

that have caused developmental damage persist. Because of these intergenerational patterns and traumas, interventions that focus on parental insights or change inadvertently lose children's critical developmental window. By starting with repair of children's capacities, we can support their improved functioning in the family and in the community, and mobilize protective factors that help children keep moving forward.

In this way, DR recognizes the normative progression that allows all children adapt, and intentionally helps children at risk access *pathways* that promote self-regulation and prosocial learning. DR as a paradigm shift has been applied to school, child welfare and mental health interventions. Repair is imperative to interrupt cycles of maltreatment and maladaptation.

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To make this shift in our intervention paradigms most accessible, the manual for Developmental Repair (and the references and research that informs and supports our work) is available at no cost at the Washburn website: www.washburn.org

Attachment and Biobehavioral Catch-up

Mary Dozier, PhD, and Kristin Bernard, MA

Young children involved with the Child Welfare System are at increased risk for a number of problematic outcomes. Even as infants, such children are often biologically and behaviorally dysregulated. For example, maltreated children often show blunted patterns of cortisol production across the day (Bernard, Butzin-Dozier, Rittenhouse, & Dozier, 2010; Fisher; van Ryzin, & Gunnar, 2011) and have difficulty controlling their attention, behavior, and emotions (Jungmeen & Cicchetti, 2010; Pears, Fisher, Bruce, Kim, & Yoerger, 2010). Thus, it is especially important that foster and birth parents behave in nurturing and synchronous ways to enhance children's self-regulatory capabilities. Without coaching, though, such caregivers are rarely in a position to provide the therapeutic care needed. Attachment and Biobehavioral Catch-up (ABC: Dozier & Infant-Caregiver Lab, 2011) is a 10-session parent-coaching program that is designed to help caregivers learn to behave in nurturing and synchronous ways.

The ABC Intervention targets three issues:

1. Young children who have experienced adversity especially need nurturing care, but often behave in ways that fail to elicit nurturance (Stovall & Dozier, 2000; Stovall-McClough & Dozier, 2004). When they feel distressed, young children in foster care often act as if they do not need their foster parents or as if their foster parents cannot soothe them. The ABC Intervention is designed to help foster and birth parents see that children need nurturance even if it is not apparent.

2. When young children experience early adversity, they are especially at risk for becoming dysregulated biologically and behaviorally (Bernard et al., 2010; Fisher et al., in press). One way that this dysregulation is seen is in disruptions in the diurnal production of cortisol, a steroid hormone that regulates the stress response system. The ABC Intervention seeks to enhance children's self-regulation by helping caregivers behave in very synchronous ways. Specifically, parents are encouraged to follow their children's lead and take delight in their efforts.

3. Young children who have had difficult early experiences especially need caregivers who are not frightening or intrusive if they are to develop trusting relationships and adequate regulatory capabilities (Dozier, Stovall, Albus, & Bates, 2001). Our intervention is intended to help parents and caregivers learn to behave in ways that are not frightening or intrusive.

> **The ABC Intervention is designed to help foster and birth parents see that children need nurturance even if it is not apparent.**

The ABC Intervention is implemented through 10 sessions in parents' homes with caregivers and children present. Although the intervention is manualized, parent coaches must be highly attentive to parents' and children's behaviors during the sessions that relate to intervention content. Parent coaches provide feedback to parents "in the moment" by describing their nurturing, synchronous behaviors, and non-frightening behaviors (e.g., "When he banged those blocks together, you banged blocks together."), how these behaviors relate to ABC targets (e.g., "That's a great example of following the lead."), and why these behaviors are important for their children's development (e.g., "When you follow his lead, that helps him develop a sense of control over his environment and supports the development of his regulatory abilities."). In addition to positive comments that celebrate what the parent is doing well, the parent coach offers suggestions and gently challenges the parent to consider alternative responses when they are struggling to promote the three ABC targets. This ongoing feedback from the parent coach helps parents notice and modify behaviors during the sessions. Given that session discussion and in-the-moment feedback specifically and exclusively address the three targets (i.e., nurturance, synchronous interactions, and non-frightening behavior), the ABC intervention represents a very targeted approach for children who have faced early adversity.

Through randomized clinical trials, we have found that the ABC intervention is

effective in helping children develop more secure and organized attachments to their parents (Bernard, Dozier, Bick, Lewis-Morrarty, Lindheim, & Carlson, in press). Of the children whose parents received the ABC intervention, only 32% showed disorganized attachments, as compared with 58% of the children whose parents received the alternative intervention. Enhancing organized attachment may be particularly important given that disorganized attachment is associated with problematic long-term outcomes, such as externalizing behavior problems (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010) and dissociative behavior (Carlson, 1998).

The children whose parents received the ABC intervention also showed more normative cortisol production than children whose parents received the alternative intervention (Dozier et al., 2006). These results are exciting in demonstrating the power of a relatively brief parent coaching intervention to affect both biological and behavioral functioning of children.

Attachment and Biobehavioral Catch-up is a short-term intervention targeting three parenting behaviors critical to children's development of behavioral and biological regulation following early adversity. Randomized clinical trials provide exciting evidence of the ABC intervention's efficacy in helping children develop more secure, organized attachments and better biological regulation. Ongoing research will examine additional outcomes as children get older (e.g., disruptive behavior, social competence), mediators and moderators of intervention effectiveness, and fidelity as the intervention is disseminated.

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Practice
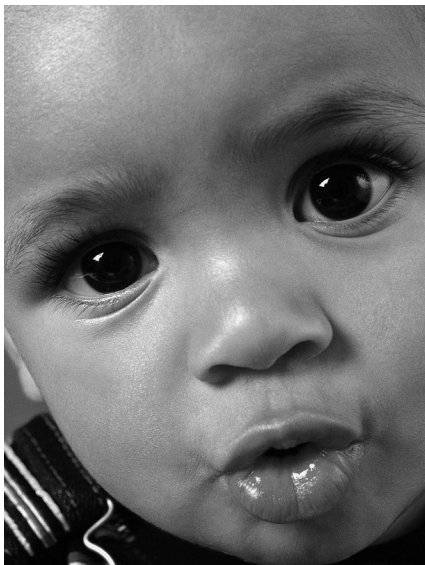
The "Family Check Up" in Early Childhood: A Public Health Intervention to Prevent Long-term Behavioral and Emotional Disorders

Kevin J. Moore, PhD, Thomas J. Dishion, PhD, and Daniel S. Shaw, PhD

Young children with significant disruptive or oppositional behavior may account for a majority of adolescents who develop severe conduct problems (e.g., Dishion and Patterson, 2006; Shaw & Gross, 2008). Moreover, research has shown that it now makes sense in public policy to target high risk families of infants and toddlers with interventions that can facilitate their movement from higher risk trajectories towards more positive developmental pathways. The Family Check Up (FCU) was developed as a home visiting intervention for early childhood (Dishion & Stormshak, 2007; Shaw, Dishion et al., 2006) for this purpose.

One of the key principles of a public health focus is to design interventions that reach as many individuals as possible on the continuum of risk within a community (Kellam, 1990). Intervening during developmental transition points optimizes cascading long-term benefits and reduces risks for children as they grow older. With such an approach, even relatively small effects, over time, can have large and significant outcomes (Biglan, 1995). One of the most effective strategies for a public health focus is to embed empirically supported interventions in services contexts that reach a large number of children and families (Hoagwood & Koretz, 1996). The FCU in early childhood was designed to fit within the service delivery system of Women, Infants and Children Nutritional Supplement programs (WIC), but could also be adapted into Early Head Start or other community-based programs that promote home visiting and support for parenting, such as the child welfare system.

The FCU in early childhood is a brief, three-session intervention to motivate family management practices using a menu-driven, family-choice model, designed to enhance the impetus to change during a key developmental transition point in the development of conduct problems. The early childhood FCU is designed to motivate caretaker engagement with an individually selected array of interventions, based on an empirically validated family management curriculum called Everyday Parenting (Dishion, Stormshak & Kavanagh, 2011). The services that are linked with the FCU range in intensity from brief sessions on positive behavior support, limit setting and relationship building; to frequent sessions over time covering all family management skills, based on parent training procedures (e.g., Forgatch & Patterson, 2010; Kazdin,

2010; Ziller & Eyberg, 2010). The FCU is designed to be provided in family homes using a home visiting model, but it can be delivered in other community-based settings, such as pediatric offices, schools, community mental health or Head Start centers, or the child welfare system. A fuller description of the intervention methods, components and procedures is contained in previously published work (Dishion & Stormshak, 2007; Dishion, Stormshak and Kavanagh, 2011).

The first randomized control trial was a pilot study with 120 mother-son dyads screened to be at risk for early starting conduct problems (Shaw, Dishion, Supplee, Gardner & Arnds, 2006; Gardner, Shaw, Dishion, Burton, & Supplee, 2007). The results demonstrated that FCU was effective in increasing positive maternal involvement and in reducing the disruptive behavior in the boys. These significant outcomes were accomplished with a mean number of 3.26 sessions. Following this pilot study, the Early Steps Multisite intervention trial was begun. This was a randomized study of 731 economically disadvantaged families and their 2- to 3-year-old toddlers, who were also screened based on the presence of socioeconomic, family, and child risk. The families were again recruited through WIC.

Initial results found improvements in observations of caregiver positive parenting, which promoted decreased CP as reported by mothers at ages 3 and 4 (Dishion, et al., 2008). This increase in positive behavior support was also related to improvements in children's school readiness (Lunkenheimer, Dishion, Shaw, Connell, Gardner, Wilson, & Skuban, 2008). Moreover, the intervention effects were highest among families reporting the most severe levels of problem behavior at age 2. Additional findings have shown that families with different types of

sociodemographic risk are no more or less likely to be responsive to the intervention, with the exception that caregivers with less education are more responsive to the FCU than more educated parents (Gardner, Connell, Trentacosta, Shaw, Dishion, & Wilson, 2009; Shaw, Dishion, Connell, Wilson, & Gardner, 2009).

Overall, findings on the Early Steps FCU suggest that this brief, family-centered intervention can be equally effective in reaching the most distressed and most disadvantaged families, compared to those who are more advantaged. A brief, theory-driven intervention that pays particular attention to parent motivation and provides family-centered assessment and feedback while giving families choices in the type of intervention can increase positive parenting, reduce maternal depression and child problem behavior, and increase school-readiness in at risk populations of toddlers. Results from two randomized trials suggest that the FCU has the potential to disrupt the early emergence of both emotional and behavioral problems.

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Practice

Best Practice Across the Child Welfare System of Care: Cultivate Integrated Behavioral and Systems Connections

Lynne Katz, EdD

"I have never heard of infant depression. I would say this will not be the case for Joshua. It is somewhat unfortunate that he had to change caretakers, as the previous MFC parent was doing a great job with him, but since he has transitioned there have been no issues and no signs of 'infant depression.' From my understanding Joshua isn't old enough for a diagnosis of depression."
-Communication from Clinical Social Worker to Early Intervention Specialist (2011)

The statement above demonstrates the importance of having a licensed professional trained in child development and infant mental health on every team making decisions about what is in the best interest of the child in the child welfare system. It is not reasonable to expect a clinical social worker, with little training in child development and infant mental health, to identify possible depression and connect baby Joshua and his parents to an evidence-based intervention program focusing on the known risk of depression for this not yet one year old over his separation from his mother. It is time to expand how we define best practice expectations for those of us working in our child welfare system. At a minimum the following four components could become central to our changing perspective:

- Understanding of the developmental milestones of children from infancy through young adulthood and the impact of risk and harm on developmental trajectories.

- Understanding that our solutions to repair harm must be developmentally appropriate and evidence-based to truly make reasonable efforts resulting in positive long-term outcomes for families.

- Willingness to learn about, understand and integrate into our thinking the perspectives of other professionals working on the case so that an integrated case process can be defined, measured and connected to family outcomes.

- Acceptance of the fact that practice change is a slow process across organizations, systems, and frontline and supervisory staff, and that implementation research

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It is time to expand how we define best practice expectations for those of us working in our child welfare system.

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can inform and systematically guide the process on all levels.

But how do we get there? In Miami-Dade County, FL the Miami Child Well-Being CourtTM Model (MCWBC) is a driver of change. (1) Core components of the MCWBC Model include:

- Judicial leadership – 'science-informed' judging

- Cross-systems partners who possess a declared readiness for change

- Collaborative court processes

- Centrality of the parent-child relationship and child development is evident in court hearings and out of court case activities

- Experienced staff chosen are open to expanding their roles/ready to change their practice around the needs of the child

At the frontline of the Miami Safe Start Initiative (2) dependent children, ages infant-three, were enrolled in a specialized Early Head Start collaborative program with the Juvenile Court. Not only did specially trained infant mental health clinicians from the University of Miami's Linda Ray Intervention Center provide mental health consultation support to the classroom teachers, social workers, and caregivers serving the children; but also, the children and their parents participated in an evidence-based intervention, Child-Parent Psychotherapy, at the Center. On one occasion, the court hearings for families enrolled in the project were held on the EHS site after school, so that the parents would have easier access to their court process. Professionals from both arenas engaged in discussions around the holistic developmental needs of the child, the child-parent relationship and the case plan development, targeting reduction of risk to the child and increased safety. EHS staff was schooled in ASFA timelines and concurrent case planning. Training across disciplines—

legal, clinical, early childhood—brought the players closer to understanding and integrating each others' agendas. Outcomes for the Miami Safe Start families in Early Head Start included improvements from pre to post treatment in the areas of behavioral responsiveness, emotional responsiveness, and reduced intrusive behaviors of the parents.

The use of the evidence-based intervention was central to producing positive outcomes for the families. Unfortunately, the importance of evidence-based programs (EBPs) had still not entirely permeated our child welfare system of care (SOC). For example, Research and Reform for Children in Court conducted a survey at the 2009 Miami Regional Dependency Conference to learn how much the members of the child welfare community knew about EBPs. Although 88% of the 209 survey respondents were unable to define evidence-based practice, 87% believed that evidence-based practices resulted in "better outcomes." Sixty percent believed that evidence based practices "improved collaborative decision-making," and 52% agreed that "the Court thinks they are better programs" (Lederman, Gomez-Kaifer, Katz, Thomlinson, & Maze, 2009).

Criteria developed by the National Implementation Research Network (NIRN) also helped us to determine which aspects of cross-systems best practice were impacted by the project. The NIRN's mission is to close the gap between science and service by improving the science and practice of implementation in relation to evidence-based programs and practices. Using their criteria, we found evidence of change in adult professional behavior across disciplines, and changes in relationships across the stakeholders emerged as well. It was a win-win for the practitioners and the families.

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Practice

Parent Training Program Holds Promise for a Child Welfare Population

Lyscha Marcynyszyn, PhD, Erin Maher, PhD, and Tyler Corwin, MA

This article presents the results of a mixed methods evaluation involving staff and 24 caregivers at two agencies in New York that used The Incredible Years (IY) for the first time (Marcynyszyn, Maher, & Corwin, 2011). The IY demonstrates effectiveness in improving child behavior and parenting skills in a dozen randomized trials and is listed by several registries as being evidence-based. However, it has not yet been established as an evidence-based program specifically for a child welfare (CW) population. Casey Family Programs conducted this evaluation to increase the use of evidence-based programs in CW, in part, through understanding implementation challenges faced by community agencies and subsequent adaptations.

In general, the IY series of programs addresses multiple risk factors associated with the development of conduct disorders in children. The IY Parent Training Program focuses on enhancing parenting skills, knowledge of child development, positive child behavior, and parent-child relationships. The program was delivered by two group leaders in groups of 6 to 12 caregivers for two hours weekly over 16 to 20 weeks. It included discussions, problem solving, skills training, role play practice, and DVD vignettes of parent-child interactions. Following the intervention, caregivers reported:

- Lower levels of parenting stress. For many families, the change in scores before and after the intervention represents a clinically significant reduction in stress. For example, 56% of caregivers experienced clinical levels of parental distress prior to participation in The Incredible Years compared to 25% after.

- Increased empathy toward their children. Empathy was the only one of five dimensions on a parenting attitude scale that showed a significant difference before and after participation. Lack of empathy is one risk factor associated with parents who maltreat.

- More family and overall support after participation.

In addition, staff reported that caregivers were more aware of behaviors that were defeating their parenting and showed increased understanding and acceptance of positive discipline approaches. Staff also said that caregivers established more routines, decreased fighting in the home, and had stronger emotional connections with their children. Participants agreed that group

leaders were sensitive and knowledgeable, strength-based and empowering, culturally competent, and encouraging of caregivers' relationships with others.

Implementation Challenges and Adaptations

Of all the challenges, covering the material in the allotted time was the most common. Time concerns, presented barriers to successful program completion in different ways, including: some participants moved more slowly through the assignments, weekly sessions ran long and overlapped, and program tailoring meant excluding some topics. The program developer noted that such challenges are not atypical for first-time use of programs like the IY. It is expected that high-risk families will take longer to master program concepts, and so more time may be needed. Given this, both agencies increased the number of weeks allotted for the program during their second implementation.

Group leaders also indicated that the DVD vignettes did not represent a broad range of ethnic and socioeconomic diversity, and this seemed to pose a barrier to participant engagement. During the course of program implementation, the updated version of the IY was released with more diverse vignettes.

Group leaders also shared the challenges associated with implementing certain parenting techniques within a CW population. One leader recalled a situation when a mother ignored her child's acting out behavior during tantrums, which led to a neighbor calling both the police and CPS. This indicates that the context in which parents reside may or may not be conducive to implementing all of the IY parenting

strategies. Another leader noted caregiver difficulties using time outs in an overcrowded apartment.

In order to achieve the maximum benefit from the IY program, certain program aspects were tailored, emphasized, or removed due to parents' culture or environment. Some of the program adaptations were fairly straightforward (e.g., holding meetings in person when phones were unavailable); yet other adaptations were more subtle and complicated, given socio-cultural barriers (e.g., encouraging "self-praise" for parents who were unaccustomed to receiving positive feedback). Parents' varying levels of emotional connections with their children also influenced caregivers' capacity to use the parenting strategies. Recognizing and addressing these barriers early is crucial to the successful program implementation. Webster-Stratton and Reid (2010) describe specific strategies for adapting the IY with fidelity for families involved in the CWS.

Evaluating the implementation and outcomes of an evidence-based program in CW settings is an initial step toward addressing the gap between research and practice for improving the well-being of children and families involved with CW.

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The Effect of the Safe Babies Court Teams Project on Time to Permanency: A Summary of Evaluation Findings

Kimberly L. McCombs-Thornton, PhD

Safe Babies Court Teams Project

ZERO TO THREE (ZTT) developed the Safe Babies Court Teams Project (formerly known as the Court Teams for Maltreated Infants and Toddlers Project) to address the developmental needs of young children in the child welfare system. In the Court Teams model, a judge works with a community coordinator to convene representatives from the local child welfare system, legal system, and service providers to form the court team. The court team develops a plan to implement the initiative in their community. Each site serves families of children under age three at time of entry into foster care. The model includes monthly case reviews for each family, referral to child-focused services such as developmental screenings, child-parent behavioral health services, and other activities specialized to the local community. The ZTT national office provides on-going training and technical assistance, resource materials, and monitoring and evaluation activities. ZTT also works with interested judges and communities to secure funding. Twelve Court Teams sites have been funded to date.

Evaluation of the Safe Babies Court Teams Project

One of the long-term goals for the ZTT initiative is to reduce time to permanency. This study uses data from the four initial court teams sites (n=298 children) to compare to a nationally representative sample of children in foster care drawn from the National Survey of Child and Adolescent Well-Being (NSCAW). The comparison group (n=511) uses the same criteria for selection as Safe Babies Court Teams, namely those under that age of three at first entry into foster care. Propensity score analysis and survival analysis are used to study the effect of the program on time to permanency. Interviews were also conducted with the community coordinators

> The model includes monthly case reviews for each family, referral to child-focused services such as developmental screenings, child-parent behavioral health services, and other activities specialized to the local community.

to begin to understand how the initiative effects time to permanency.

Time to permanency is measured in two ways for this study. First, it is measured as how much time passes before a child is discharged from foster care. This is the definition nearly always used in other studies of time to permanency. This is known as "official" permanency in this study. The second definition is based on the child's perspective. ZTT suggests that young children may not be aware of the date of a judge's decision, but they are certainly aware of a move from one home to another. Time to permanency is, therefore, also measured as how long it takes before a child moves into what ultimately becomes the permanent

home. This is called "move in" permanency in this study. For example, let's suppose a child is removed from the mother and placed with the grandparent on day one. If the mother's parental rights are terminated and the grandmother becomes the permanent caregiver, then the child moved into what became the permanent home on day one (move in permanency) though the time to be officially discharged from foster care was much longer. The effect of the Safe Babies Court Team Project is assessed separately on both measures of time to permanency.

Findings

The ZERO TO THREE Safe Babies Court Teams Project has a significant effect on how quickly children exit the foster care system. ZTT cases exit foster care one year earlier on average than a nationally representative group of children from the NSCAW longitudinal survey. When we control for group differences, we find that ZTT children leave foster care nearly 3 times as fast as the comparison group. The program did not have a significant effect, however, on how quickly children are placed in what ultimately becomes the permanent home.

To begin to understand how the ZTT program accelerates time to permanency, the study next considered the effect of the initiative on types of exits from foster care. Young children typically exit foster care in one of four ways: reunification, adoption, relative guardianship, or non-relative legal guardianship.(U.S. Department of Health and Human Services, n.d.) Other research shows that reunification usually requires much less time in foster care than adoption. The effect of the program on time to permanency is in fact explained somewhat by differences in types of exits. Reunification was the most common type of exit for ZTT children while adoption was the most typical for NSCAW. However, the analysis also found that ZTT children spent much less time in foster care regardless of the type of exit. Of children who were reunified, ZTT cases exited foster care 8 months faster on average. Among those who were adopted, ZTT children left foster care

10 months sooner on average. Of children who reached permanency with a relative guardian, ZTT cases exited foster care 3 to 4 months faster on average. And lastly, among children exiting to a non-relative guardian, ZTT children left foster care an average of 10 to 13 months quicker. (McCombs-Thornton & Foster, 2011)

While the data show the program does have a real effect on how quickly children exit foster care, the statistical analysis does not explain how the program speeds up the process. Interviews with the community coordinators were used to begin to identify key program activities related to time to permanency. Findings from the qualitative analysis suggest that the parents' decision to comply with the child welfare service plan is at the center of the permanency process. The ZTT Safe Babies Court Teams Project works to accelerate time to permanency by directly influencing the parents' decision to comply with the service plan as well as supporting the social support network (which in turn supports the parents) and encouraging the child welfare system to locate services for parents and children. While interviews with the community coordinators focused on all components of the Safe Babies Court Teams model, two parts of the intervention – the judge and the monthly case reviews -appear to be essential for moving cases more swiftly through the permanency process.

Many examples of how the judges used the power of the bench to try to directly motivate parents emerged in the interviews. When the parents were complying with the service agreement, judges were quick to give praise and encouragement. On the other hand, parents who were not following through on accessing required services often received a strong reprimand from the judge. According to the community coordinators, all judges also appear to be aware of the Adoption and Safe Families Act (ASFA), the federal legislation designed to decrease time children linger in foster care. There is no federal enforcement of ASFA. Instead, ASFA is enacted at the local level. Judges differ in their approach to meeting ASFA's requirements. For instance, the site with the quickest time to permanency has a judge who requires the service team to make a final recommendation on permanency by the six month mark. The site with the longest time to permanency has a judge who appears to be cautious in making sure the parents have every opportunity to comply before their rights are terminated. In other words, while the judge plays a key in role moving cases to permanency, judges also appear to differ across the sites in their role as timekeeper.

In addition to the judicial role, the monthly case reviews surfaced as an important factor in time to permanency. The monthly case reviews generally take the form of court hearings across the sites, though some also include family team meetings in the case review process. Monthly case reviews universally work to keep all on task.

Appearing in court often means that parents and case workers alike were more likely to act quickly on finding services or following through on other court orders. Procrastination could lead to upsetting the judge. The monthly case reviews also provide a frequent opportunity for the judge, attorneys, and child protective services to keep track of whether or not the parents are complying with the service plan and, therefore, the direction the case is heading. The community coordinators all believe this process leads to a quicker permanency decision.

Conclusion

The ZTT Court Teams initiative is shown to have a significant impact on how quickly children exit foster care. These findings provide support for the project as an evidence-based model. Future evaluation efforts will consider other long-term outcomes as well.

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Practice

Promoting First Relationships

Susan Spieker, PhD, Jean Kelly, PhD, and Monica Oxford, PhD

Promoting First Relationships (PFR; Kelly, Zuckerman, Sandoval, & Buehlman, 2003; 2008) is a manualized training curriculum that aims to promote strengths-based behaviors of service providers, who in turn work with families to improve family and child outcomes through service provision.

PFR training advances specific consultation strategies: Joining, Positive Feedback, Instructive Feedback, Reflective Questions and Comments, and Instruction with Handouts. The PFR program consists of a 10-week intervention that is delivered in the home of the family. Each week has a theme for discussion, an activity which includes videotaping or viewing and reflecting on a videotaped session, and time for "joining." Joining is described as checking in with the parent, listening to their concerns, and establishing a positive, supportive relationship. Each session includes at least two handouts, one with the content area covered that day and one titled "Thoughts for the Week" which asks parents to think about a topic discussed during the session and apply it to their relationship with their child. During the 10 weeks, the provider videotapes parent-child interaction five times and alternates every other week with watching the video with the parent as an opportunity for reflective observation. One video session involves a brief, in-home separation and reunion, and four involve play and a brief teaching interaction between parent and child. When the parent and provider watch the previous session on video, they reflect about the needs of both the parent and the child, and the provider helps the parent "enter the mind" of the child to develop greater empathy and understanding of the child's needs and feelings. The provider also helps the parent identify her own feelings and needs around parenting. Reflective observation during video feedback is one of the most potent elements in the intervention.

The positive results of the PFR training program have been supported by quasi-experimental studies. In a pilot study of staff working with families in a transitional housing shelter (Kelly, Buehlman, & Caldwell, 2000), participating in PFR training improved staff attitudes toward children and parents, expanded staff knowledge of relationship-focused content, and changed actual observed staff behavior with families such that it became less directive, more positive, and more supportive of the parent-child relationship. In another evaluation (Kelly, Zuckerman, & Rosenblatt, 2008) service providers who work with young children (birth to three) with disabilities

Table 1. Providers are trained to deliver the following weekly content to families:

Week	Theme-Discussion/ Handouts	Activity	Thoughts for the Week
1	Attachment Behaviors Social & Emotional Needs of Babies	Videotape Play Session & PFR Video Relationships	Your child's attachment behavior
2	Health Relationships & Meeting the Emotional Needs of Children	Reflective Observation	Your child's social and emotional needs
3	The Path to Trust and Security & Baby Communication (cues)	Videotape Play & Baby Cue's Video	Understanding your baby's cues
4	Challenging Behaviors & Staying Connected	Reflective Observation	What behaviors or situations are challenging?
5	Repair in relationships, when things go wrong.	Videotape Play & Memory of a Strong Emotion	Circle of repair in your life?
6	Social and Emotional Needs & one's own family history	Reflective Observation & "Stress Triggers"	What are your stress triggers?
7	Playtime and Teaching your Child	Videotape Play Session	Playing with your child
8	Encouraging cooperation	Reflective Observation	Encouraging cooperation
9	Behaviors, Feelings and Needs	Videotape Play Session	Behaviors, Feelings, Needs
10	Closing, Celebration of Gains	Reflective Observation	

and their families were trained in PFR. After training, providers used more positive, instructive, and reflective behavior to coach mothers during dyadic interaction. As a result, parents became more growth fostering in their interactions with their young children, more contingent, and showed more overall responsiveness and sensitivity with their children. Additionally, children became more responsive and contingent with their mothers. Both studies support our model of change. Staff members began to engage in supportive relationships with the parents so that, in turn, the parents could better support their children.

Currently, PFR is being evaluated in two federally-funded randomized control trials of relevance to child welfare and other human service professionals. One study (Spieker, Principal Investigator) involves training community mental health providers to deliver PFR in home visits to caregivers (birth, kin or foster) of toddlers in state dependency, starting within 2 months of a change in placement. Analyses of data from this study are being finalized and are congruent with the results of the quasi-experimental studies

above. The second study (Oxford, Principal Investigator) trains social workers to work with parents who recently had child protective service referrals for their toddlers. This study is still in recruitment.

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Implementing Evidence-based Services with Families in the Child Welfare System in Washington State: The Incredible Years

Kimberlee Shoecraft, MSW

For the past four years I have been fortunate enough to be part of bringing evidence-based programs (EBPs) to children and families served by the child welfare system in Washington State. The Washington State legislature began specifically funding evidence-based parenting programs for Children's Administration in 2006. Families and children are currently receiving programs intended to increase child safety in the home and encourage positive parenting skills, such as Homebuilders, Parent-Child Interaction Therapy, Functional Family Therapy, SafeCare, and Incredible Years. I have been facilitating Incredible Years parent groups and training new group leaders in these programs for the past four years.

The Incredible Years programs that have been implemented with the child welfare population in Washington State are the preschool parent program, the toddler parent program, and the baby program. Across these programs, we are able to provide continuous service to parents of children ages birth to 8 years. Each program focuses on key developmental tasks of young children and how parents can support their young children and strengthen their relationships through child-directed play, social and emotional coaching, praise, and positive attention in achieving these milestones. Parents become aware of the developmental needs of their children, so a situation like mom having to ask her two-year-old to keep her hands off the television five times in a row becomes more understandable and less frustrating. Parents also learn to see their children in a more positive way when they understand child development principles and are better able to place realistic expectations on their young children. I have had many parents over the

years express much less frustration with their young children after learning that many of the challenging behaviors children exhibit are developmentally appropriate. In addition, I have had the pleasure of co-facilitating many Incredible Years groups over the past four years, as well as providing clinical consultation and supervision for many group leaders around Washington State. From these people, I have heard many accounts of how Incredible Years is changing the lives of the children and families being served by the child welfare system. Families are referred to Incredible Years in order to prevent out-of-home placement of their children or to facilitate their children being returned to their care after placement into the foster care system. Occasionally, I have had a foster parent and/

Parents also learn to see their children in a more positive way when they understand child development principles and are better able to place realistic expectations on their young children.

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or relative caregiver join our groups.

In the summer of 2010, a group of birth parents and two foster parents began an Incredible Years baby group. The baby group protocol was planned to be 8 weeks, but after completing this group we realized more time was needed to adequately cover the topics and practices. I would strongly recommend extending the baby program for 10-12 weeks. In this group there were a combination of parents who had their babies in their care and parents whose babies were residing in foster care. In order to attend the baby group, though, the baby must be present with the parent in group; the baby group is an interactive parenting program. So, in

some cases, babies were transported to group by their caregivers or their social workers. In this group a couple of the foster parents were invited to stay for the group. These two foster parents participated and contributed to the group in ways that facilitated a positive and collaborative relationship between the foster parent and birth parent in order to provide the best care for the baby. They were able to discuss routines and caretaking issues in order to provide for more continuity of care for the baby. I observed them develop a better understanding of each other, which helped to open the door for more positive feelings towards foster parents and birth parents in our group by all group members. Each of these families had different outcomes for their babies. One of the mothers had her baby

returned to her care, and the foster parent continues to support her by providing child care and parenting help. The other mother decided to have her baby's foster parent adopt her daughter in an open adoption process. Both of these parents learned about their baby's needs developmentally and emotionally in the Incredible Years group, as well as developed a relationship with their baby's foster parent, which allowed them to make safe and healthy decisions for the ongoing care of their infants. I received several comments from the birth and foster parents who completed the program saying how appreciative they were of each other's contributions to the group. I am hopeful that in the future we will be able to move to a more collaborative caregiving model for children being served by the child welfare system in order to improve safety and developmental outcomes and expedite permanency for young children.

Kimberlee Shoecraft, MSW, has worked for 8 years in Washington State's Department of Social and Health Services with the child welfare population. She has led numerous Incredible Years baby, toddler, and preschool BASIC groups since 2007. She can be reached at Shoeck@u.washington.edu.

Collaborations & Perspectives
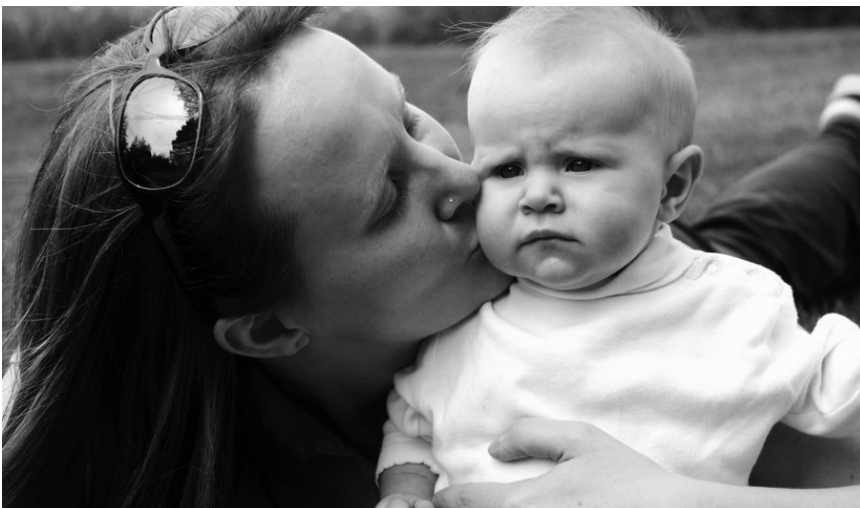
The Need for Better Coordination Across Systems: A Foster Care Family Perspective

As told to Nikki Kovan, PhD

We were called by child protection asking us if we would foster Hope because we were family members. Once we agreed to be foster care parents, we had less than a week before she was brought to our house. We had to get ready for a newborn and go through the training offered to foster care parents all in that short time. The initial training was on car seat safety, SIDS/Shaken Baby Syndrome, and foster care orientation, there was nothing on the special needs of a newborn born in crisis. She was four weeks old when we got her, and addicted to methadone and heroine and we were given no training on how to deal with that. We were not told that Hope was eligible for early intervention services. We went to a meeting with the social worker team two days before we got her, but that was about going over the placement plan, a little about the visitation schedule (which ended up to be more than was discussed), and a chance to meet the parents and their social worker, Hope's social worker and the guardian ad litem. We were given no information about Hope's special needs or services available to her.

Those first few months were very difficult and we had little to no support. Hope was a newborn with such significant issues and we knew nothing about taking care of children with those issues. Hope cried a lot, mostly because of the drugs in her system. Once a month, Hope's social worker made a short visit. He rarely asked questions, and was mostly checking on Hope's safety I suppose. He was difficult to get a hold of and wasn't good at returning messages. The guardian ad litem would also come once per month, and we would talk about the supervised visits between Hope and her parents and the impending court dates. We often got the sense during these visits that the system was more worried about protecting the rights of the parents than what was in the best interest of the child. I'm sure her social worker had so many kids on his caseload, and Hope seemed mostly fine and safe, but we needed training on what to expect with a child with these special needs and how to best help her. We got through those first few months though; then, when she was 7 months old, she was given back to her biological parents. We were devastated because we knew that they weren't ready and that Hope would likely be neglected and maltreated again.

At 18 months old, Hope was returned to us. This time, when she came to us, she had some significant social-emotional behavior issues, including aggressive behavior towards herself, but mostly toward us. We started calling her social worker a lot and asking for help for all of us. We would just hear "let me make a call…," but then we wouldn't hear back. We got the early intervention referral after a couple of months, and had to wait on her mom to sign off on the referral. Finally, a team of people from an early childhood special education program from our school district were involved in her case. Hope was evaluated in the birth to three category, and qualified for help. She would have qualified for early intervention services from birth because she was born addicted to Heroin. We started receiving home visiting services and early intervention for Hope. It was such a huge relief to be heard and to have professionals, who had seen these issues in other children in her situation, confirm that she did have social-emotional behavior issues not typical for her age. We could finally start working toward effective methods to make a difference in her life. It was helpful for us to hear, "you're doing great and doing the right things, or try doing this and it may help in that situation." They also brought sensory toys and books to read to her, helping her to express herself differently. We were invited to monthly play group events, and received suggestions for outings, which helped our whole family feel supported.

Overall, the county workers alone didn't seem to have what was necessary to make the biggest difference for Hope. It seemed like their hearts were willing but their hands were tied. The judge did not allow us to speak on Hope's behalf when she was seven months old, even though we were the ones working with Hope everyday and had regular contact with her parents through supervised visits. She only asked Hope's social worker if the foster parents' concerns were addressed, and the social worker said yes, even though they weren't! If I could change just one thing about the foster care system, it would be to have the judges, the social workers, and the early interventionists all work together and to listen to the voice of the foster care families. Hope is living with a family who is trying to adopt her now, but you can still see the scars of what she went through in those critical first months. Hope is a third generation foster care child and we hope her new family can help her break the cycle.

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Collaborations & Perspectives

Collaborations & Perspectives

Home Visiting with Families at Risk for Maltreatment: Using Assessment Tools to Help Educate Caregivers

Mariah Hofmeister, MSW, LICSW

As budgets shrink and case loads expand, cI worked with a home visiting program that served families at risk for almost three years. In working with this program, I met with at-risk families on a weekly basis, beginning when the child was 1-2 weeks old. Working with families with this frequency enabled me to form a great relationship with these mothers (and sometimes fathers) and babies. The program is designed to work with the parents and children weekly during the child's first year, bi-weekly the second year, and monthly the third year. As part of the home visiting, we administered a developmental screener, the Ages and Stages Questionnaire (ASQ), every four months, beginning when the child was four months old. Starting when the child was one year old, we administered the Ages and Stages Questionnaire—Social-Emotional (ASQ-SE) every six months. I always did these assessments along with the parents and children, explaining as I went. Because I had such a great relationship with these families, the assessments were always part of that relationship, and were not threatening to the parents. The parents seemed to enjoy them, as many of them happily discovered that their children were on track developmentally. When their child was not on track, the parents were able to learn about this early on, so that they could either work on these skills themselves, or have a professional come into their home to help them work on these skills.

In administering the ASQ during that first year, there were often one or two categories where the child scored below average, or lower than the other areas. This was used to inform both the parents and me of the skills that the child needed to develop. Once we learned of a deficit, I would encourage the parents and talk to them about what they could do to help the child in that area. We would focus our next visits on this deficit. In almost all cases, this would improve, and on the next ASQ the child would score within normal range for this category. When the child's deficit was significantly below average for their age, I was able to refer to outside services, including Occupational Therapy, Physical Therapy, and Speech Therapy. This gave the child access to

these services early on in their lives, increasing the chances that they would catch up with their peers in this area while they were still an infant or toddler.

There is not a manual that all parents receive regarding developmental milestones, and if there was, not all children would fit into the manual since everyone develops at a different pace. Most parents do not know what their child should be doing at a certain age. These assessment tools helped the parents understand what was developmentally appropriate, and if their child fell into the average range compared to other children. It also helped bring it to their awareness when it did not.

Once the child was a year old, I started using the ASQ-SE, which was helpful in learning about the child's behaviors and whether the behaviors were maladaptive. When the behaviors were maladaptive, I could talk to the parents about this right away. Knowing this early on helped me, as the home visitor, know what the child was doing and how the parents were reacting, so that I could help them learn about toddler behaviors, and discuss ways of helping their toddler with these behaviors. This tool and conversation helped the family to gain more knowledge and skills around parenting, including the use of more positive parenting behaviors and fewer coercive or negative

> This tool, along with the ongoing relationship and home visits, helped the parents gain a better understanding of normal child development, and also gave them the support and tools to deal with the challenging behaviors that young children display.

parenting behaviors, possibly contributing to fewer instances of abuse and neglect. This tool, along with the ongoing relationship and home visits, helped the parents gain a better understanding of normal child development, and also gave them the support and tools to deal with the challenging behaviors that young children display. In my experience, administering assessments and discussing child development on an ongoing basis can prevent child abuse and neglect from occurring.

In the three years that I worked in the Healthy Families program, none of the families that I worked with ever became involved in child protection. These families had to be at-risk for child protection involvement to be in this program. These families developed the skills, knowledge, and support necessary to be "good enough" parents. Using the ASQ and ASQ-SE assisted me in helping these families understand where their child was on the developmental pathway which allowed them to provide what their children needed to be happy, healthy, well-adapted children.

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Using Science to Make Healing Decisions in Juvenile Courts

Judge Cindy S. Lederman

Dependency judges across the United States have the most rewarding, yet agonizing, jobs in the American justice system. We preside over hundreds of cases each week, making important decisions in a matter of moments. And in those moments, we can actually change the course of a human life. We try to maintain dignity and humanity in the proceedings while working with the most impoverished families. As students of human behavior and experts in human suffering, we try to develop some expertise in promoting healing, although we have only been trained in the law. We realize that the children and families we see in court have come to us as a last resort when everyone and everything has failed them. The children enter our doors precisely because they have been deprived of a healthy attachment to a caregiver, the most important keystone of child development. They do not have empathetic, nurturing, and responsive caregivers; they have been harmed by those who are supposed to love and protect them. The parents we see have to learn to regulate their child's behavior without hitting the child and be taught to praise their children. They have not asked for help and have not entered our courtrooms voluntarily (Lederman, 2011). Many are truly puzzled about why their children have been removed, insisting that they have been good parents. We have a tremendous responsibility not to fail them or their children, as too many others already have.

Unfortunately, the many decision-makers in family and juvenile law and mental health remain largely ignorant of decades of child development research. Child custody decision-makers, especially judges, and child development researchers rarely intersect; therefore, the opportunity for one to learn from the other is almost nonexistent (Kelly & Lamb, 2000). Bridging the chasm between research and practice is essential if we are to meet our legal mandate and moral responsibility to facilitate the healing of children and families. Every decision in child welfare cases has a clinical as well as legal component, and ignoring the effects of a decision on the wellbeing and health of a child can be harmful. Judging in dependency court is the most complex kind of jurisprudence because knowing and applying the law is rarely enough. We cannot make custody and visitation decisions in a developmental black box (Shonkoff & Bales, 2011). And we cannot do it alone.

Changing human behavior and attempting to heal those who have been harmed requires collaboration with experts in mental health, substance abuse, early intervention, child care, parenting interventions, and so many other fields. The courtroom must be a forum where experts are welcome, their testimony is valued, and they feel that the information they impart to the court assists the court in making a better informed decision. The court, the attorneys, and the experts must work together as a team. There is also a quotidian educational opportunity when everyone learns together from the presence and testimony of experts in court.

In our book, *Child Centered Practices for the Courtroom and Community: A Guide to Working Effectively with Young Children and their Families in the Child Welfare System*, Lynne Katz and I introduced a metaphor for the role of the judge working with other professionals in juvenile and family courts. Two prominent research psychologists, sitting in the courtroom and observing a long morning docket, described the role of the judge as equivalent to that of a conductor of an orchestra. The judge is actively involved in overseeing and coordinating the professionals working together in the courtroom, each performing a distinct role but working together in concert. The ultimate goal is to bring the unique voices, expertise, knowledge, and information to the judge who puts it together in a way that produces the most informed decision on behalf of children and families. Each professional has a different role to play in the orchestra or the courtroom, but the combination is what creates the majesty of the piece of music or facilitates the goal of healing.

Breaking the intergenerational cycle of child maltreatment will never be achieved in a courtroom filled with lawyers and the law, alone. It is only when we value the contribution of science, research, and clinical expertise as much as we cherish the law that our courtrooms can be a forum for lasting healing.

Judge Cindy S. Lederman has served in the Miami-Dade Juvenile Court since 1994, including 10 years as Presiding Judge. Her work with maltreated infants and toddlers has resulted in the Miami-Dade Juvenile Court Early Childhood Initiative, which has been replicated with Congressional funding and formed the basis for the national Court Teams for Change Project operated by Zero to Three.

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Collaborations & Perspectives

White Earth Early Childhood Program

Barb Fabre and Mary Leff, LICSW

The White Earth Ojibwe Reservation is located in northwestern Minnesota and contains three Minnesota counties—Mahnomen, Becker and Clearwater—covering 36 townships. The Reservation includes fertile rolling prairie and rich timberland with a large number of beautiful lakes. Its name comes from the unique white clay found underneath its black soil. The White Earth Reservation is governed by the Reservation Tribal Council, whose Education Division oversees the White Earth Child Care/Early Childhood Program, a federally funded program through ACF/Child Care Development Fund.

The total population within the reservation boundaries is 9,188. Enrollment for the White Earth Reservation is approximately 19,500 members. The WE Child Care/Early Childhood Program (WECC/ECP) serves over 374 children through center-based and in-home child care settings and through the Child Care Assistance Program. There are seven school districts with connections to Pre-K within its boundaries, two Head Start Programs, a tribal ECFE program, a tribal early intervention program, and a Tribal Health Program.

The mission of the WECC/ECP is to help our children succeed by providing high-quality, culturally-based child development support, services, outreach, and advocacy for children, families, child care providers, and community on or near the White Earth Reservation. Under the guidance of the Program Director and Community Outreach/Early Childhood Coordinator, the WECC/ECP has been on a continuum of growth through learning and listening to our families, our communities, our schools, and our community organizations. The program has been able to be creative with shared ideas and funding from our community partnership, which has brought collaborations with larger state and federal entities, as well as public and private nonprofit organizations. The key to the success of the WECC/ECP programming is innovation, energy, and sharing. These partnerships have brought the development of a strong a sense of community action around families to work together to solve problems.

Due to the large number of children in out-of-home placements and in the court system, the WECC/ECP began working with the White Earth Tribal Court staff, which included Judge Anita Fineday and White Earth Indian Child Welfare Program staff. An initial meeting with Judge Fineday and ICW resulted in a mutual agreement that there needs to be a solid connection and relationship between the court system and early childhood service providers, to help children and families who are in the court system to have access and support with child development, parenting, and screenings. Through this partnership, the WECC/ECP was invited to regular drug court staffing meetings to help make referrals and provide early childhood services as needed to those families.

It was also evident that there needed to be a dedicated staff person to help coordinate services to children and families in the court and child welfare systems to ensure follow-up on referrals and utilization of assessment/screenings and parenting support services. This partnership began to look for funding for a Coordinator position.

In the meantime, the WECC/ECP wrote and received funding to start a Parent Mentor Program to help support parents who have lost their children and are working to get them back, who are at risk of losing their children, or who are first-time parents who want to ensure they are on the right track. The Parent Mentor Program works closely with the tribal courts and ICW on referral and cases. The Parent Mentor Program has been hugely successful and in demand. Parent Mentors develop positive relationships with at-risk families in order to help support them and to help the parents/caregivers to become their children's best advocate.

The WECC/ECP has become the early childhood resource for the White Earth Reservation and continues to work on issues that support children and families. In 2011, the Minnesota Children's Defense Fund named the WECC/ECP a Star of the State because of the successes of its initiatives and programming. We know that families are constantly having to deal with overwhelming issues when they live in rural and high poverty areas such as ours, and we make a difference by providing intervention and prevention services through culturally relevant and on a consistent basis.

Photo credit: Ivy Vainio

A community survey and visioning process was conducted by the WECC/ECP and West Central Initiative six years ago, to put a process into motion to help give the people a voice and a direction to solve problems together. From that, came a list that WECC/ECP uses as a base for programming (but is not limited to):

- Increased community library services
- Increased opportunities and incentive for parent participation in their children activities and readiness for school
- Increased community events for families
- Parent mentors to help our families with advice and resources
- Increased access to oral health services for all families and their children
- Hotline for community members to report crimes in their communities without fear of retribution, and increased opportunities to have positive interactions with community police officers
- Increased information on good family nutrition
- Development of a user friendly local early childhood resource guide for parents

The WECC/ECP will remain strong because of its community strength and will continue to advance the idea of all children ready for school through our efforts around prevention, intervention and support for all children and families.

Barb Fabre is Director of the White Earth Child Care/Early Childhood Program.

Mary Leff, LICSW, coordinates the White Earth Early Childhood Initiative for the White Earth Child Care/Early Childhood Program, funded by the McKnight Foundation.

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- How can I help my baby or toddler to move around?
- How can I help my child to be more considerate?
- How can I help my child understand death?
- How can I help my young child to become a reader?
- How can I survive these temper tantrums?
- How can I teach my child responsibility?
- How can parents and caregivers support a baby's healthy development?
- How can trauma affect my young child?

- How do I get to know my newborn?
- Is It normal for children to be afraid?
- Is It okay to leave her home alone?
- Is my child ready for kindergarten?
- Is this stress? What can I do?
- What can I do about sibling rivalry?
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- What is meant by "infant mental health"?
- What should I teach my child about money?
- What's going on in my baby's brain?
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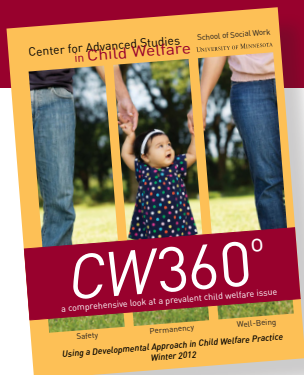
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