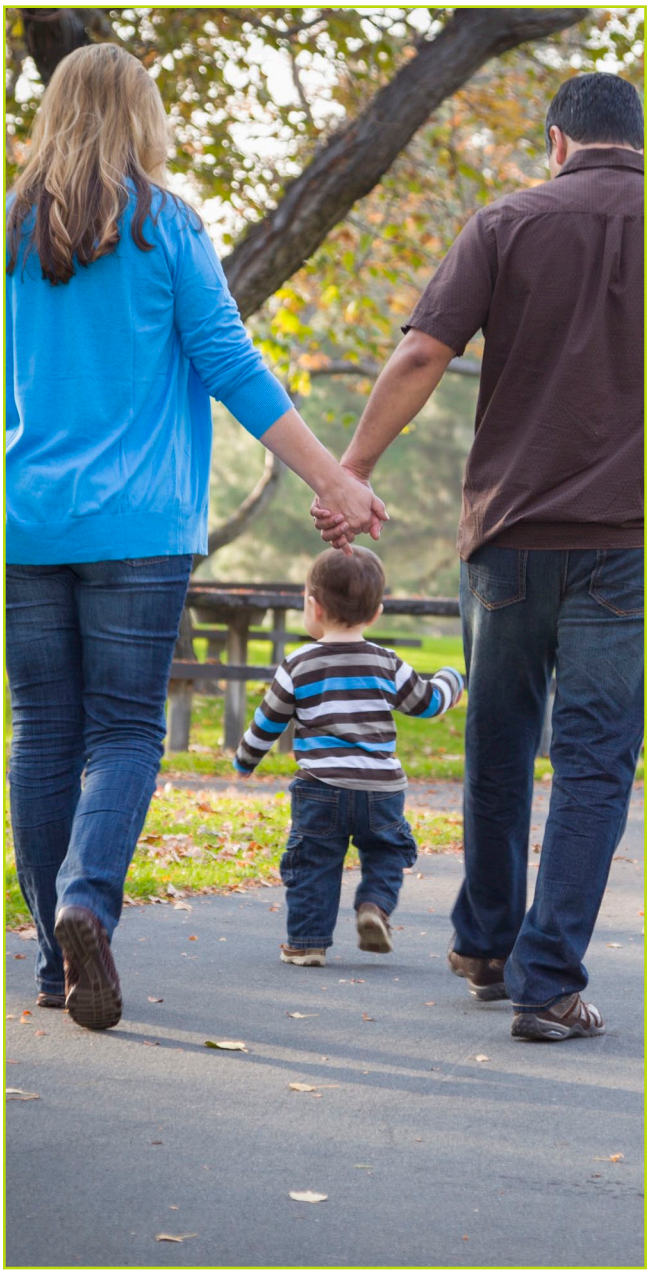
Changing the Course for Infants and Toddlers



A Survey of State Child Welfare Policies and Initiatives

September 2013

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

Child TRENDS®

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About Us

ZERO TO THREE is a national, nonprofit organization that provides parents, professionals and policymakers the knowledge and know-how to nurture early development. The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. Child Trends is a nonprofit, nonpartisan research center that studies children at all stages of development, striving to improve the lives and prospects of children and youth by conducting high-quality research and sharing the resulting knowledge with practitioners and policymakers. ZERO TO THREE and Child Trends worked together to design the survey, analyze responses, and draft this report.

Executive Summary and Key Findings

The harsh reality of maltreatment in the form of abuse or neglect looms in the lives of thousands of infants and toddlers: almost 200,000 children under the age of three come into contact with the child welfare system every year.[1] For young children, this threat arises at a crucial time in life, when early experiences are shaping the brain's architecture into a foundation for learning, health, and future success. Maltreatment chemically alters the brain's development and can lead to permanent damage of the brain's architecture.[2] The developmental risks associated with maltreatment (such as cognitive delays, attachment disorders, difficulty showing empathy, poor self-esteem, and social challenges) are exacerbated by removal from home and placement in multiple foster homes.[3]

Although the first years of life are a time of great vulnerability, they also present an opportunity to intervene early to prevent or minimize negative effects. Through high-quality, timely interventions focused on the unique needs of infants and toddlers, the developmental damage to very young children who have been maltreated can be significantly reduced.[4] It is critically important that child welfare policymakers and administrators understand the impact of maltreatment on infants and toddlers, so that they can systematically implement interventions and services that best meet the needs of these very young children.

The *Survey of State Child Welfare Agency Initiatives for Maltreated Infants and Toddlers*, conducted from September 2012 to March 2013, asked state child welfare agency representatives to respond to questions regarding the policies and practices that guide their work in addressing the needs of infants and toddlers who have been maltreated. Questions were included pertaining both to infants and toddlers in foster care and to infants and toddlers who have been "maltreated": for whom a report of abuse or neglect has been substantiated by the child welfare agency or for whom an alternative/differential response has produced a determination that the child has experienced maltreatment.

The survey's goal was to identify and share innovations in policy and practice, and highlight key challenges, gaps, and barriers that child welfare agencies across the country face in meeting the needs of very young children who have experienced maltreatment. Forty-six states participated in the survey. Three broad themes emerged from analysis of survey responses:

1 Few states have policies that differentiate services or timelines for infants and toddlers versus older children.

Although most child welfare agencies do have an array of policies and practices aimed at promoting the overall health and well-being of all maltreated children in general, this lack of differentiation means that the unique developmental needs of infants and toddlers may not be met in many key areas. While state policies applying to children of all ages—such as encouraging placement with kin, promoting children remaining in their first out-of-home placements, and utilizing concurrent planning—do promote stability for young children, their implementation may not account for the urgency of the developmental needs of maltreated infants and toddlers specifically. The rapid developmental changes in the infant and toddler years, together with the importance of attachment with critical adults in promoting healthy development, call for differentiating key policies that affect foundational aspects of children's development. Such policies include more frequent visitation with birth parents, swift timelines between screenings and services for health and developmental concerns, greater involvement of birth parents in services for themselves and their young children, and more frequent case reviews, court hearings, and case worker visits.

Key survey findings:

- Thirty-one states do not routinely hold case reviews, permanency hearings, other court hearings, or family group decision-making meetings on a more frequent or expedited basis for infants and toddlers in foster care, as compared to other age groups.
- Nine of the 40 states that dictate the frequency of face-to-face visitation between birth parents and their children in foster care require more frequent visitation for infants and toddlers in care compared to older children.

2 Relatively few states have implemented promising approaches to meeting the unique developmental needs of infants and toddlers.

There are several promising approaches that can help address the needs of infants and toddlers who have experienced maltreatment. These include: appropriate timeframes for health and developmental screenings and timely referrals to specialists; greater frequency in infant-toddler foster care case reviews and hearings; required training for all levels of agency staff, foster parents, court personnel, and biological parents about the developmental needs of infants and toddlers; multi-system collaborations with other agencies that serve infants and toddlers and their families; more frequent face-to-face visits with birth parents for infants and toddlers; and polices prohibiting the placement of young children in congregate care except in situations where parents and their young children can be cared for together. These approaches are discussed in greater detail in the body of the report. With the exception of multi-system collaborations, these policies are limited in number and not universally available across or even within states. A more systemic approach to addressing the developmental needs of very young children could help states identify specific policies or components they wish to implement.

Although the examples detailed in the key survey findings below are promising ways to meet the needs of maltreated infants and toddlers, the survey found that most of these policies are not being implemented in a majority of states.

Key survey findings:

- Just over half of responding states (26 out of 46) have policies requiring that referrals to specialists be made within a specific timeframe once a health or developmental concern is identified. Identified timeframes range from two to 60 days. Only nine states require that these referrals occur within one week.
- Only three states (Alaska, Hawaii, South Dakota) require training on developmentally-appropriate practices for infants and toddlers who have been maltreated for all child welfare staff, including case workers, supervisors, administrators, and other staff.
- Forty states have policies requiring concurrent planning, but only 14 reported that concurrent planning begins "immediately," "as soon as possible," or "within 24 hours" of placement outside the home.

3 Given growing awareness about the needs of very young children stemming from neuroscience and child development research, child welfare agencies have a long way to go in aligning policies and practices to ensure that the unique needs of infants and toddlers are met.

Infusing research into practice is complex and can take time, but the evidence is clear about the resulting harm when the development of infants and toddlers who have experienced maltreatment is not supported. As awareness grows regarding developmental needs and specific policies and practices that can address them, states should focus particularly on two important areas. The first is reaching all maltreated infants and toddlers, rather than only those in foster care, with developmentally-oriented policies and practices. Young children who are not removed from their homes are just as vulnerable to developmental problems as those who are.

The second is providing supports to meet the often-complex needs of birth parents, including secondary trauma, to increase the chances of successful reunifications. The survey identified specific barriers to accessing services for both children and parents. These include lack of services in certain areas of the state, low number/quantity of service providers, and waiting lists. These barriers could be greatly reduced by taking the needs of maltreated infants and toddlers and their birth families into account in the adjustment and creation of policies and funding streams, and by providing additional training to the many groups of professionals and caretakers who work with and make decisions about maltreated infants and toddlers.

Key survey findings:

- About two-thirds of responding states have policies requiring adherence to visit/screening schedules (physical health/immunizations, dental health, mental/behavioral health, and developmental) for children in foster care. Fewer states, less than one-third, have policies requiring adherence to such schedules for all maltreated infants and toddlers, including those who are not in child welfare custody.
- No states reported that training is required for birth parents on how and when to seek early intervention services for young children who may have one or more developmental delays or disabilities under Part C of the Individuals with Disabilities Education Act (IDEA), and only three states require training for court personnel on Part C requirements and developmental delays.
- The majority of states do not have policies that require that health, mental health, and substance abuse-related supports be offered to all parents of maltreated infants and toddlers involved with the child welfare system.
- Of the 40 states with policies that dictate the frequency of face-to-face visits between birth parents and their children in foster care, only one state requires daily visitation and only 12 states require visitation at least once a week.
- With the exception of a few services, most states reported a greater availability of post-permanency supports for adoptive parents and children who are adopted, compared to birth parents and their children upon reunification.

Introduction

Early childhood is a critically important period in a child's life, and early experiences can greatly affect a child's overall health and well-being. Research has documented special developmental challenges that can emerge for very young children who have experienced abuse or neglect.[5]

Early and sustained exposure to abuse and neglect can influence the physical architecture of the brain, preventing infants and toddlers from fully developing the neural connections that facilitate later learning.[6] The maltreatment of an infant or toddler can have a traumatic effect on his health and development. Infants and toddlers need responsive and consistent caregivers for healthy development. When a young child is removed from his parents, he has a heightened risk of cognitive delays and faces challenges making and building new relationships.[7]

Although children of all ages can be victims of abuse or neglect, infants and toddlers are particularly vulnerable to maltreatment and its effects. This makes federal data on child maltreatment especially concerning: children ages zero to three experience abuse or neglect at disproportionately high rates—representing nearly 27 percent of all maltreatment victims in FY 2011, despite comprising only 16 percent of the overall child population.[8] In addition to experiencing maltreatment at high rates, infants and toddlers represented 31 percent of all children entering foster care in 2011.[9]

While early childhood is a time of great vulnerability, it is also a time of great potential for interventions to prevent or minimize negative effects that are much more difficult to alter later in life.[10] Early and appropriate interventions can help minimize lasting damage caused by abuse, neglect, and placement in foster care. By understanding the developmental risks, identifying delays early, and linking infants, toddlers, and their families and caretakers to appropriate interventions, outcomes for maltreated infants and toddlers can be improved.

Having reliable data and information about existing state policies and initiatives to address the needs of maltreated infants and toddlers and their families is a crucial step in strengthening overall supports and services. In 2011, Congress enacted the Child and Family Services Improvement and Innovation Act, which calls on states to describe in their state child welfare plans how they promote permanency for and address the developmental needs of young children in their care. The new federal requirement, coupled with emerging research on the critical developmental period of birth-to-age-three—including rapid brain development and knowledge of the profound negative effects of maltreatment on these children—creates a timely opportunity for a national dialogue on the importance of developmentally-appropriate policies and programs to

both prevent and respond to abuse and neglect among very young children.[11]

This report presents findings from a national survey of states and the District of Columbia regarding the policies and practices that guide child welfare agencies' work in addressing the needs of maltreated infants and toddlers. Forty-six states participated in the survey. The goal of the survey was to identify and share innovations in policy and practice, and highlight key challenges, gaps, and barriers that child welfare agencies across the country face in meeting the needs of very young children who have experienced maltreatment.

About the Survey

The *Survey of State Child Welfare Agency Initiatives for Maltreated Infants and Toddlers* was conducted between September 2012 and March 2013. The survey was designed through a collaborative process between ZERO TO THREE and Child Trends and underwent several stages of review with outside experts and state pilot testers.

Following the design of the survey, the survey materials were mailed to each state's child welfare director or lead administrator in September 2012. Data gathering and data analysis were conducted between October 2012 and March 2013. The survey instrument, which was accessible online, can be found in Appendix A. The survey included 47 questions, which were organized into **six main topic areas relevant to the health, well-being, and permanency outcomes for infants and toddlers** in the child welfare system, including:

1. Assessments and services for maltreated infants and toddlers and their families
2. Infants and toddlers in foster care and their families
3. Post-permanency services for infants and toddlers in foster care and their families
4. Training in early childhood development and developmentally-appropriate practice
5. Data collection and analyses
6. Additional initiatives targeting maltreated infants and toddlers and their families

Variances among states and by county

The survey documents the structure of child welfare systems. Thirty of the participating states have child welfare systems that are state administered. Fourteen states have child welfare systems that are county administered, state supervised. One state described its child welfare system as city run, and another state described the structure as a hybrid: state administered in certain counties and city administered in major cities. Appendix C has state-specific information.

Twenty-six of the 47 survey questions allowed states to select "it varies by county" or "yes, but only in some parts of the state." Even those states with state administered systems had some variance by county. Most of the questions with this option provided states with the opportunity to explain or describe the variation. As this report discusses specific questions, rationales for that variance and details about its impact on states are also shared as appropriate.

Definitions provided in the survey

In considering the "**policies**" that your state has in place, please consider policies that exist in law, agency regulations, and other written policy guidance.

When responding to questions about "**infants and toddlers**" on this survey, please consider children aged 0 to 3 years. However, we welcome information about any initiatives, programs, or policies specifically directed at certain age groups within this population (e.g., a program specifically for 0-1 year olds) or a broader early childhood age group (e.g., a program for children 0 to 4, or specifically for 3 to 4 year olds), and have included space at the end of the survey where these descriptions can be provided.

When responding to questions about children who have been "**maltreated**," please consider children for whom a report of abuse or neglect has been substantiated by the child welfare agency, or for whom an alternative/differential response has produced a determination that the child has experienced maltreatment (which may be a "victim" finding, or a comparable term used in your state).

When responding to questions about infant and toddlers in "**foster care**" on this survey, please consider any children who are in the custody of the state or local child welfare agency. These children may be in a variety of out-of-home placements, including non-relative or relative/kin foster homes, shelter care homes, group homes, institutions, or hospitals.

In recognition that states often define terms differently, respondents were provided with definitions of key terms to guide their interpretation of the questions both in the beginning of the tool and throughout the survey as appropriate. See the survey in Appendix A for the definitions provided to respondents. Appendix B lists and describes the various federal laws that were referenced throughout the survey.

Forty-six state child welfare agencies participated in the survey.[i] After each state agency submitted initial answers, the research team reviewed submissions for any inconsistent interpretations of questions or responses that required clarification through follow-up contact. Follow-up discussions occurred between January and March 2013, after which the complete data set was analyzed and a final report prepared.

It is important to note that many questions asked states specifically about policy requirements, not whether or how the policy is being implemented. Therefore, the implementation of identified policies is not the focus of this report.

i AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MA, MI, MN, MO, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, VT, VA, WA, WV, WI, WY

Summary of Results

Section I. Assessments and Services for Maltreated Infants and Toddlers

The first section of the survey asked states about the physical health, mental health, and developmental needs of infants and toddlers. Young children involved with the child welfare system are more likely than children in the general population to have lower IQ scores, language ability, and school performance.[12] Early identification of health and developmental needs and swift connection to appropriate services is particularly important for maltreated infants and toddlers.

Assessments and treatment of children's health, mental health, and developmental needs

Identifying and addressing developmental issues early, especially for an age group where development occurs rapidly and for a population so vulnerable to developmental problems, can reduce the need for special interventions later. In addition, research shows that infants and toddlers for whom abuse or neglect is substantiated, but who remain at home with their parents, are as likely to have developmental problems as those placed in foster care.[13] Of particular concern is the effect of maltreatment on social and emotional development and the need for mental health responses appropriate to infants, toddlers, and their parents together.

Overall, states have policies requiring adherence to physical health/immunizations, dental health, mental/behavioral health, and developmental assessments and screening schedules for young children in foster care; however, as displayed in Figure 1, fewer states have policies requiring adherence to those same screening schedules for all maltreated infants and toddlers.

Figure I: Number of states with policies that require adherence to health/ developmental visit or screening schedules

	Physical Health/ Immunizations	Dental Health	Mental/ Behavioral Health	Developmental Monitoring/ Screening
Adherence to visit/screening schedule required only for infants and toddlers in foster care	**33**	**32**	**27**	**30**
Adherence to visit/screening schedule required for all maltreated infants and toddlers	**12**	**10**	**8**	**14**
Varies by county	**0**	**0**	**4**	**0**

Only seven states require assessments for all maltreated infants and toddlers in each category: Alabama, Georgia, Hawaii, Indiana, Oregon, Texas, and West Virginia.

In addition to reporting who is required to receive screenings, states also reported about the types of screening/visitation schedules required. A vast majority of states (43) reported using the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) visit/screening schedule, the American Academy of Pediatrics (AAP) visit/screening schedule, or the American Academy of Pediatric Dentistry visit/screening schedule for at least one category of required screening.

When a screening identifies potential health or developmental problems, it is important that infants and toddlers are quickly referred to specialists so that interventions can begin as soon as possible. **Twenty-six states reported that they have policies requiring that referrals be made within a specific timeframe, and an additional state does so in some counties. However, only nine states require a referral within one week of identification.** Five of the nine states require referrals be made within two business days or 48 hours (New Hampshire, South Carolina, Texas, Washington, West Virginia). Of the remaining 14 states that require referrals within a specific timeframe, one requires referrals within ten days, one within two weeks, eight within 30 days, and two within 60 days; the other states vary depending upon the type of referral, or are determined on a case-by-case basis.

Forty-two states reported that they have policies or practice guidelines specifically promoting the involvement of birth parents in evaluating the health of infants and toddlers in foster care. States promote such involvement in a variety of ways, including:

- Interviewing birth parents about their child's health (39 states);
- Routinely discussing the outcomes of health care visits or assessments (e.g., doctor recommendations or screening results) with birth parents (36 states); and
- Routinely including birth parents in health care planning discussions (which could include physical, mental, dental, or developmental health) (35 states).

States were asked about routinely provided mental health services for maltreated infants and toddlers. Infant mental health was defined as follows: *Infant-early childhood mental health (I-ECMH), sometimes referred to as social and emotional development, is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.* **The mental health services states most frequently reported that they routinely provide include: guidance to foster parents to help children make the transition before and after visits with birth parents (33 states); parent-child relationship assessments (28 states); and providing children in foster care with a keepsake from their birth parents' home (25 states).** One state example of mental health services comes from Louisiana, which provides infant mental health services through Infant Mental Health Teams. These teams provide comprehensive services to children, ages zero to 60 months, whose families

are involved with the child welfare agency due to maltreatment or who have been prenatally exposed to drugs or alcohol.

States are exploring the use of medical homes for maltreated infants and toddlers; however, **only four states have policies requiring that infants and toddlers in foster care have a medical home** (Idaho, Kentucky, Oregon, Texas). Twenty-one states reported using medical homes either statewide (six states) or in some areas of the state (15 states). Nine states reported that they are working to initiate or expand the use of medical homes. Because maltreated children are so likely to experience developmental delays and medical problems, it is critical that they have access to a medical home, including consistent primary care from a pediatrician who comes to know the child and family.

Definition of medical home provided in the survey

When children have a medical home, all aspects of pediatric care can be managed by one consistent pediatrician who knows a child's family and their medical history. This includes well-child visits; immunizations; screenings and assessments; patient and parent counseling about health, nutrition, safety, and mental health; and supervision of care. In addition, when appropriate, a pediatrician can also refer a child to specialized health care providers and early intervention services while coordinating care with other programs and services. The AAP has identified seven desirable characteristics of a medical home: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Please see www.medicalhomeinfo.org for more information.

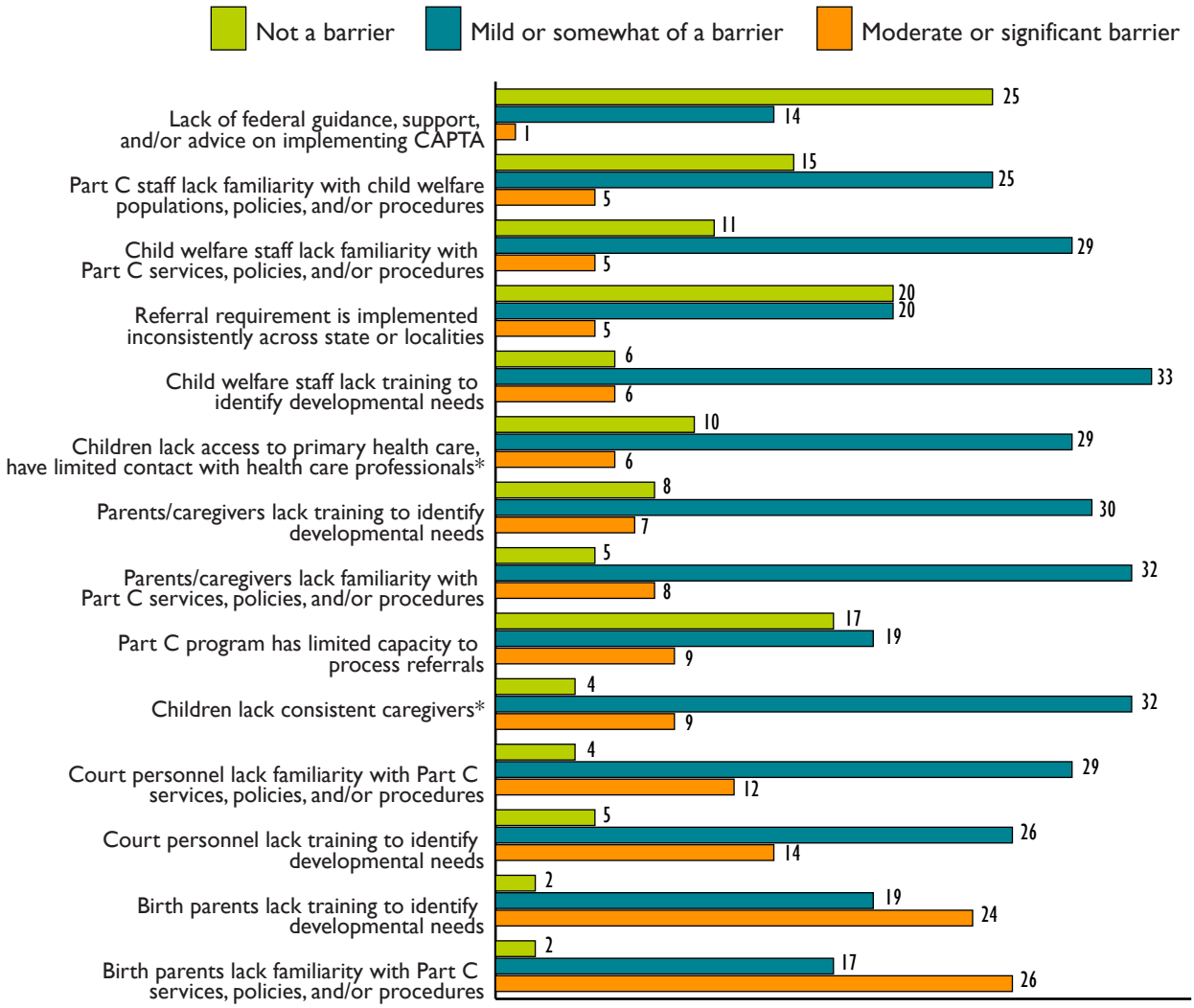
Child Abuse Prevention and Treatment Act (CAPTA) and referral to Part C of the Individuals with Disabilities Act (IDEA)

In addition to the health screenings described above, the Child Abuse Prevention and Treatment Act (CAPTA) requires states to develop a procedure for referral of all children under age 3 involved in a substantiated case of child abuse, neglect, or illegal drug exposure to early intervention services under Part C early intervention of IDEA. Recognizing the vulnerability of babies in the child welfare system and the importance of detecting developmental problems early, these two federal laws require states to have procedures for screening and, if necessary, referring young children for early intervention evaluation and services. Little is known about implementation of this requirement across states.

In 26 states, the Part C agency conducts the CAPTA-required screenings for maltreated infants and toddlers; seven states reported that a contracted agency or other organization conducts screenings; three states reported that the child welfare agency conducts screenings; and nine states responded "other" or that "it varies by county."

The survey identified a range of barriers that child welfare agencies face in implementing the requirements under federal law for referring maltreated infants and toddlers to early intervention services (made available through Part C of IDEA). As illustrated in Figure 2, the items **most frequently identified as "moderate" or "significant" barriers were birth parents' lack of familiarity with Part C services, policies, and/or procedures, and birth parents' lack of training to identify developmental needs.** Just over half of states described these barriers as moderate or significant.

Figure 2: Number of states that reported barriers to CAPTA-Part C implementation

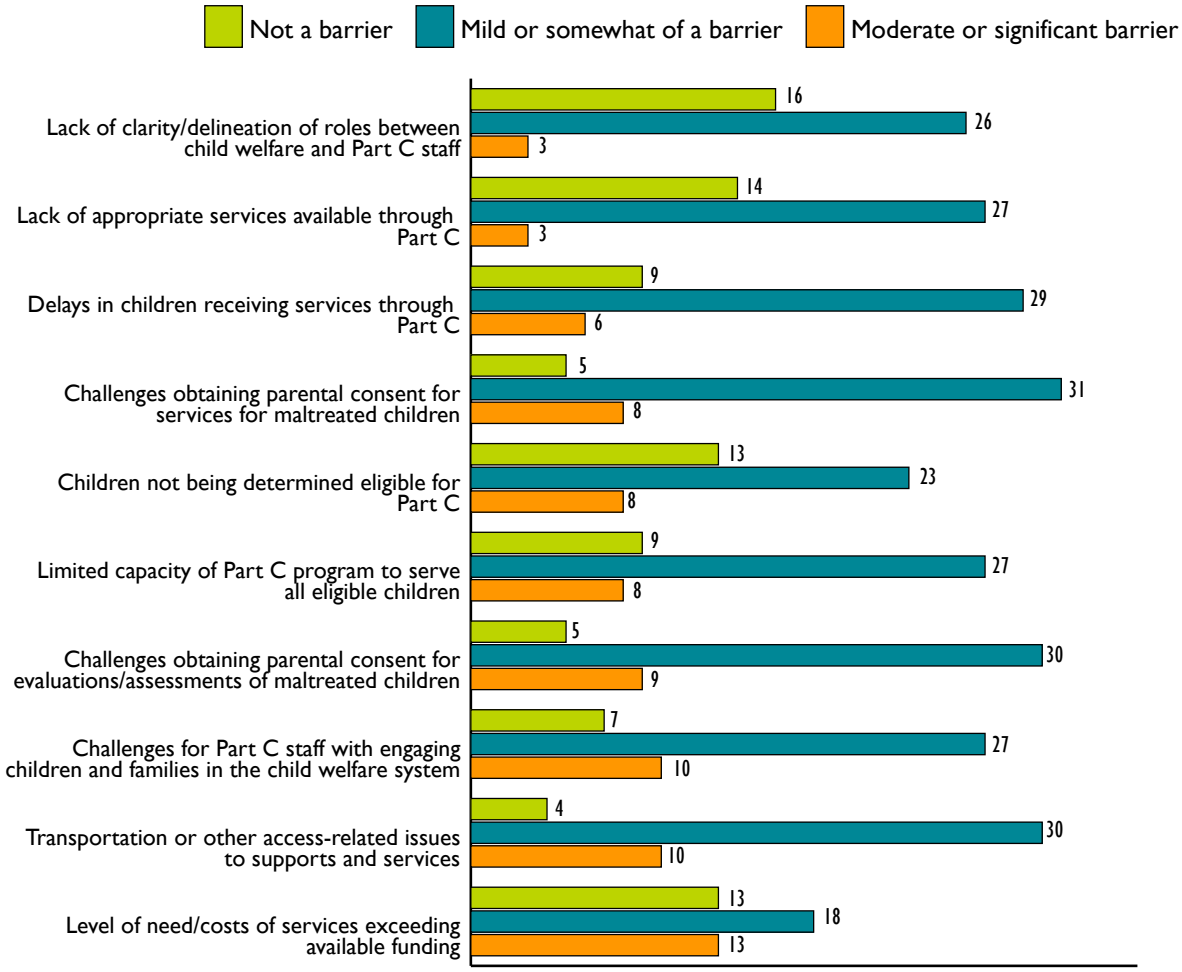


Iowa, Rhode Island, and North Dakota described mechanisms for reaching out to birth parents in an effort to reduce these barriers. Iowa sends a letter of referral for services to all families with substantiated cases. Rhode Island redesigned its medical consent form to encompass early intervention services. North Dakota created an informational handout for birth parents. All three states identified birth parents' lack of familiarity with Part C and birth parents' lack of training to identify developmental needs as moderate or significant barriers.

The survey also asked respondents to identify barriers to children and families' receiving services from Part C (Figure 3). The following were the **barriers states most-frequently identified as moderate or significant: level of need/costs of services exceeding available funding (13 states), challenges for Part C staff with engaging children and families in the child welfare system (10 states), and transportation or other access-related issues to supports and services (10 states).** Although these were more-frequently identified as moderate or significant than other barriers, only a minority of states identified them as such: a majority of states responded that these were not barriers at all, or were very mild

barriers. Barriers most commonly reported as "not at all a barrier" or a "very mild barrier" were lack of clarity/delineation of roles between child welfare and Part C staff (33 states) and lack of appropriate services available through Part C (29 states).

Figure 3: Number of states that reported barriers to children receiving Part C services



As identified above, states are struggling with barriers to implementing CAPTA requirements on many fronts. State child welfare agencies shared examples of how they have addressed some of the barriers to coordinating and delivering Part C early intervention services, including:

- Leaders in child welfare and Part C engaging and collaborating to implement requirements of federal/state/local laws (36 states);
- Formal information-sharing about each system's policies/procedures (i.e., Part C and child welfare) (28 states); and
- Clear delineation of roles/responsibilities of Part C and child welfare staff (24 states).

Although birth parents' lack of familiarity with Part C was identified as a barrier for 26 states, **no states reported that training is required for birth parents of maltreated infants and toddlers on how and when to seek services for young children under Part C.** Only three states (Alabama, Texas, West Virginia) require training for court personnel on Part C requirements and developmental delays. Minnesota is taking a multi-agency approach to improving implementation. The state is working with its Part C early intervention agency to craft a data-sharing agreement, which would allow the state to analyze rates of referral by Minnesota's Temporary Assistance for Needy Families (TANF) and child welfare programs to the Minnesota Department of Education's early learning screening and early childhood special education programs.

Services and supports for parents of maltreated infants and toddlers

Young children's development is shaped by the close relationships they have with important adults in their lives. Parents of children in the child welfare system often face a plethora of challenges—sometimes stemming from their own childhood trauma—that must be addressed before they can nurture their children and better meet their needs and, where children have been placed in foster care, be reunified.[14] Supports provided to birth parents can play an important role in helping parents to address their problems and achieve timelier reunification with their young children. The survey probed states about policies requiring services and supports to birth parents, as well as barriers to receiving services and methods to reducing those barriers.

Most often, policies do not require that health, mental health, and substance abuse-related screenings and supports are offered to birth parents of maltreated infants and toddlers in all cases. As illustrated in Figure 4, the most commonly reported screenings and supports required by policy for parents of maltreated infants and toddlers in all cases are domestic violence screening (17 states), followed by substance abuse screening (12 states), and priority for substance abuse treatment when substance abuse is identified (12 states). Thirty-one states do not have policies requiring a physical exam to detect any underlying issues that may contribute to maltreatment or a neuropsychological assessment to assess parents' abilities and capacities. It is important to note that these questions are limited to what state policy requires. Therefore, this report therefore cannot draw any conclusions about whether or how implementation is taking place.

Figure 4: Number of states with policies that require screenings and services for birth parents of maltreated infants and toddlers

	In all cases	In some cases	Don't specify	Varies by county
Domestic violence screening	17	12	14	3
Substance abuse screening	12	15	18	1
If substance abuse identified: Priority for substance abuse treatment services	12	10	19	5
If substance abuse identified: Referral to substance abuse treatment programs with demonstrated effectiveness	10	10	22	4
If substance abuse identified: Participation in comprehensive family-based substance abuse treatment	3	10	28	5
A psychological assessment to assess any mental health issues (including for postpartum depression, traumatic stress)	5	16	23	2
If mental health issues identified: Referral to mental health services with demonstrated effectiveness	8	13	23	2
A physical exam to detect any underlying issues that may contribute to maltreatment	5	10	31	0
A neuropsychological assessment to assess their abilities and capacities (including for fetal-alcohol exposure and resulting deficits)	2	11	31	2

The survey also asked about services that are routinely provided to birth parents of infants and toddlers in foster care (see Figure 5). The most commonly reported service was parenting education (39 states), followed by participation in therapeutic interventions or services provided to the child (28 states). The least-frequently reported service was providing parents with information about secondary trauma and strategies for coping with and managing their own stress or trauma histories (18 states).

Figure 5: Number of states that routinely provide services to parents of infants and toddlers in foster care

	Routinely provided	To the parent from whom the child was removed	To mothers	To fathers	To both mothers and fathers
Parenting education (including training on child development and the impact of trauma) using approaches developmentally appropriate for the age of the child(ren), and which have demonstrated effectiveness addressing the specific parenting issues identified for this parent	**39**	**17**	**0**	**0**	**22**
Participation in therapeutic interventions or services provided to the child (e.g., dyadic therapy, Parent-Child Psychotherapy)	**28**	**12**	**0**	**0**	**16**
Mentoring by foster parents	**21**	**13**	**0**	**0**	**8**
Information about secondary trauma and strategies for coping with and managing their own stress or trauma histories (when applicable)	**18**	**9**	**0**	**0**	**9**

All respondents identified at least one barrier as "somewhat of a barrier" to providing services to birth parents of maltreated infants and toddlers. The most frequently identified moderate or significant barriers to services for parents of maltreated infants and toddlers were:

- lack of services in certain areas of state/unequal geographical distribution of service (33 states);
- low number/quantity of service providers (29 states);
- waiting lists (24 states);
- transportation to services (23 states);
- difficulty engaging fathers (22 states); and
- lack of child care (17 states).

In order to reduce barriers, states most commonly reported making interpreters available at service providers (36 states), followed closely by providing or reimbursing for the costs of transportation to services (35 states). Other common steps were providing financial assistance for services (31 states) and developing father-specific programs (30 states).

Several states described unique supports for parents of young children. Hawaii's Attachment and Biobehavioral Catch-up Intervention, offered through Enhanced Healthy Start, is a 10-week program that teaches caregivers how to have positive interactions with their children. Illinois is using its recently awarded Title IV-E grant to implement enhanced assessments for children birth to 3 in Cook County. Those children in the treatment group determined to be in need of services to address issues of trauma and attachment will be referred to evidence-based treatments, including Child-Parent Psychotherapy and Nurturing Parents education programs. New Jersey has recently adjusted its policies to make it easier for teen moms in foster care to keep their infants in their placements, including a new board rate for foster parents.

Partnerships and collaborations to support maltreated infants and toddlers and their families

Federal law requires some cross-system collaboration, such as between child welfare and early intervention services, but most states reported interagency collaborations that extend beyond those required. As outlined in Figure 6, states identified resources and agencies with which they shared formal or informal links; these links are extremely common across states. **Over 40 states identified links with at least ten other service agencies or public entities:** adult mental health services, infant/early childhood mental health services, public assistance programs, Part C early intervention agency, home visiting services, early learning and development programs, substance abuse treatment programs, domestic violence services, family court, and community resources that help families build informal support systems. The least commonly linked entity, with only 18 states reporting, was between the child welfare agency and immigrations and customs enforcement.

Figure 6: Number of states with linkages between child welfare and other entities/resources

Resources	Number of states selecting
Domestic violence services	**44**
Family court (court with jurisdiction over child abuse and neglect cases)	**44**
Part C early intervention agency	**44**
Community resources that help families build informal support systems (incl. the faith community)	**43**
Public assistance programs (incl. Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Children's Health Insurance Program (CHIP), and Low Income Home Energy Assistance Program (LIHEAP))	**43**
Substance abuse treatment programs	**43**
Early learning and development programs (e.g., Early Head Start)	**42**
Home visiting services	**42**
Law enforcement agencies	**41**
Adult mental health services	**40**
Infant/early childhood mental health services	**40**
Health services (e.g., pediatricians, dentists, AAP)	**39**
Intellectual disabilities services (for parents)	**33**
Criminal justice system (in cases of incarcerated parents)	**32**
Immigration and customs enforcement (in cases of detained parents)	**18**
Other	**6**

When ranking collaborations, states identified the strongest links as those between the child welfare agency and the Part C early intervention agency, followed by those between the child welfare agency and the agency providing public assistance. Several states also mentioned collaboration and partnership with a state early learning council or other interagency body.

West Virginia reported a notable strong connection with the Coalition Against Domestic Violence, which reviews and provides input on child welfare policy. Members of the Coalition conduct trainings for all child welfare staff, which include the impact of domestic violence on the development of young children, and how domestic violence can impact children even if they have not been physically harmed.

Case reviews, court hearings, and family group decision-making for infants and toddlers

Infants and toddlers grow and develop at an astounding rate. During these critical early months and years, while development is occurring at such an accelerated pace, the frequency and timing of foster care reviews and hearings is important so that concerns can be identified and addressed as quickly as possible. To ensure that efforts are being made to keep young children's development on track, oversight of child welfare cases involving infants and toddlers needs to account for the fact that their development progresses so rapidly and that they have unique needs around forming and maintaining close, trusting relationships.

In alignment with federal laws, the most commonly reported frequency for case reviews is every six months; for permanency hearings is every 12 months; and for other court review hearings is 13 months. The majority of states do not specify in policy how frequently family group decision-making should take place. Only Hawaii holds any of these proceedings more than once a month.

Most states (31) reported that they do not routinely hold any proceeding on a more frequent or expedited basis for infants and toddlers in foster care as compared to other age groups. Four states routinely hold case reviews more frequently (Colorado, Hawaii, Kansas, Rhode Island); six states routinely hold permanency hearings more frequently (Arizona, California, Colorado, Iowa, Rhode Island, Vermont); three states routinely hold court review hearings more frequently (Colorado, Hawaii, Kansas); and only two routinely hold family group decision-making more frequently (New Mexico, Rhode Island). Six states (Arkansas, Colorado, Kansas, Missouri, Ohio, Oregon) reported that there was variance by county.

States that do hold hearings more frequently were asked to describe how the frequency differed for infants and toddlers. Arizona expedites the initial permanency hearing for children under age 3. Oregon describes great variances in practice between counties, highlighting a county where the judge holds monthly hearings for all children under age 3. In Rhode Island, reviews are held more frequently as a way to facilitate faster reunification and greater involvement with biological parents. One court in Texas assigns all infant and toddler cases to the same judge.

Stability, attachment, and permanency for infants and toddlers in foster care

States reported a wide array of services available to infants and toddlers in foster care, including those that have the potential to nurture attachments between young children and their families and caregivers. The survey questions were designed to identify services and supports particularly relevant to promoting strong and secure attachments in acknowledgement of the growing body of early childhood development research highlighting the importance of healthy attachments. The transitions that ensue when a child is placed into foster care can pose significant challenges with respect to caregiver attachments for very young children.[15]

Most states reported one or more policies related to foster care placement that have the potential to support stable attachments for all children in foster care. These policies also benefit infants and toddlers in foster care. **Most states promote placement with kin and encourage interaction with birth families for all children in foster care.** A vast majority, 43 states, have a preference given to kin/relative placements (when they are appropriate) for infants and toddlers in foster care. Two states do not have a preference for kin/relative placements, and in one state the preference varies by county. **Forty states have polices requiring that concurrent planning be undertaken for children in foster care, but only 14 states initiate concurrent planning immediately, "as soon as possible," or within 24 hours of placement outside the home.**

Definition of concurrent planning provided in the survey

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

In Texas, concurrent planning begins as soon as the child is placed into state custody. If a child is under age 2, the worker is required to consult with relevant professionals to determine the skills or knowledge that the parents should learn or acquire to provide a safe placement for the child. The worker discusses this with the parents and ensures that those skills and abilities are incorporated into the service plan as appropriate. Staff are also instructed to consider the need for therapeutic visits between the child and the child's parents to be supervised by a licensed psychologist or another relevant professional, to promote family reunifications and to educate the parents about issues relating to the removal of the child.

Thirty-nine states have policies or practice guidelines that specifically promote keeping children in their first out-of-home care placement throughout their foster care tenure. Strategies for doing so include: placing children with relatives when appropriate, placing children with siblings who are also in care, carefully matching a foster child to a foster family, and providing supports for the foster family once the placement is made. Ohio mentioned a practice specific to young children, wherein social workers and foster parents can also receive early childhood-trauma-based trainings to help promote a more stable placement.

When a transition to a new placement is required, 20 states require a transition plan and 11 states require higher-level review for the placement change. Eleven states described other protections in place, including family team meetings (five states), documentation of the rationale for the transitions (three states), case conferences (one state), guardian ad litem notification (one state), and court notification after two placement transitions (one state).

Other policies to protect the stability and attachment of all children in foster care include:

- Thirty-three states have foster families who mentor birth parents;
- Thirty states have foster/adoptive families who maintain contact with birth

families after reunification or adoption; and

- Sixteen states require pre-removal conferences before a child is removed from the home.

In addition to these policies, which benefit all children in foster care, the states were probed about some initiatives specific to infants and toddlers. Twenty-four states reported having a differential response system throughout the entire state, with seven additional states having a differential response system in parts of the state. States that answered affirmatively were asked if they could use differential response in referrals of infants and toddlers. **Infants and toddlers are eligible for differential response services in all but four of the 31 states that utilize differential response in at least part of the state.**

Definition of differential response provided in the survey

States with differential response (also known as alternative response) procedures offer both traditional investigations and assessment alternatives to families reported for child abuse and neglect, depending on the severity of the allegation and other considerations.

Six states have a specific policy prohibiting the use of congregate care settings (e.g. group homes, treatment facilities, intake shelters) for children under a particular age. Of those states, the District of Columbia and Hawaii prohibit congregate care for children under the age of 12, Wyoming under the age of 11, Michigan under the age of ten, and Kansas and Nevada under the age of six. **Seventeen states[ii] reported policies requiring special authorization—such as commissioner-level or director sign-off—or special circumstances to place an infant or toddler in congregate care. An additional six states[iii] reported having no specific policy in place but reported that in practice they do not place infants and toddlers in congregate care except under special circumstances.** These special circumstances included placing children with parents in treatment facilities, placing infants or toddlers with a parent under age 18, placing children with older siblings, or meeting medical needs that require a higher level of care.

Fourteen states have policies that allow for termination of parental rights on shorter timeframes than would typically be the case for infants and toddlers who will not be reunified with their birth parents. Only ten of those have that policy across the entire state (Colorado, Delaware, Florida, Hawaii, Illinois, Iowa, Louisiana, Missouri, New Jersey, Rhode Island). **Only one state (Michigan) has a policy of more frequent caseworker visits for infants and toddlers in foster care than for other age groups in the entire state. Six states do so in some areas of the state.** Thirty-nine states reported that they do not have more frequent caseworker visits for infants and toddlers than for other age groups.

ii The 17 states reporting a requirement of special authorization include: AK, AZ, CA, FL, GA, IL, IN, LA, MD, MS, NJ, NY, OK, TN, RI, WA, WI

iii The 6 states include: NC, ND, OH, OR, TX, VT. North Dakota reported not having a policy in place that prohibits congregate care, but that congregate care is not even available for children under age 6 and that no facilities are licensed for children of that age.

Parent and sibling visitation for infants and toddlers in foster care

In order to keep ties with primary caretakers as strong and stable as possible, it is crucial that infants and toddlers in foster care have frequent contact, as close to daily as possible, with their birth parents. Research has shown that frequent visitation increases the likelihood of reunification, reduces the time in out-of-home care, and promotes healthy attachment.[16] Forty states reported having polices that dictate how frequently face-to-face face visitation between children in foster care and their birth parents should occur in at least part of the state. Only six states do not have a policy in place. Figure 7 summarizes state responses of how often face-to-face contact should occur. **Of the 40 states with policies that dictate the frequency of face-to-face visits, only Alaska requires daily visitation and only 12 states require visitation at least once a week.**

Figure 7: Number of states with policies that require face-to-face visitation between birth parents and infants and toddlers in foster care

Frequency required	Number of states selecting
Daily	**1**
At least once a week	**12**
At least every two weeks	**4**
At least monthly	**13**
Other (please specify)	**10**

Description of other:
- When agency resources allow, visitation shall be scheduled at two-week intervals, unless the court has specified another visitation arrangement.
- Policy gives recommendations, but flexibility is also considered.
- Weekly suggested; based on case.
- Three times per week and for appointments as appropriate.
- Case-by-case determination.
- As often as possible.
- Required the day after placement and weekly for the first month. After that, monthly visits with the majority of the visits in the home/facility where the child resides.
- "Frequent" visits—The increase or decrease in frequency is dictated by the court with recommendations from the Department through the case plan, CASA, defense attorneys and service providers.

Only nine of the 40 states requiring face-to-face visitation in their policies differentiate frequency for infants and toddlers in foster care verses other age groups. Twenty-nine of those states do not differentiate for young children (two states did not answer). Of the nine states that distinguish visitation schedules for younger children in foster care, all reported more frequent visitation for young children.

States were asked about several other visitation and placement supports for infants and toddlers in foster care. As shown in Figure 8, **only 13 states routinely provide visit-coaches or other relationship-supporting approaches during visits between parents and their infants or toddlers.** In Texas, staff regularly consider the need for therapeutic visits between the child and the child's parents to be supervised by a licensed psychologist or another relevant professional to promote family reunifications and to educate the parents about issues relating to the removal of the child. **A majority of states (40) have policies that invite/encourage birth parents to participate in routine activities, such as doctors'**

appointments and birthday celebrations. Similarly, 44 states routinely place infants and toddlers in foster care with their older siblings.

Several states mentioned initiatives to promote more frequent visitation or supported visitation. New Jersey and Hawaii mentioned additional training for staff. Texas developed a working group to establish better policies and Arkansas developed a "sibling report" to monitor placement of children with their siblings. Iowa described the Family Interaction Initiative, which encourages frequent interactions between parents and their young children. Oregon is using its Title IV-E waiver on an enhanced supervision of visitation program, which will increase the number of visits to three times per week. The focus on the program is building a bond between parents and their young children.

Figure 8: Number of states with visitation supports

	Yes	No	It varies by county
Are infants and toddlers in foster care routinely placed with their older siblings (who are also in foster care)?	**44**	**1**	**1**
Do policies require that parents (when appropriate) are invited/encouraged to participate in routine activities (e.g., doctor's appointments, birthday celebrations) for infants and toddlers in foster care?	**40**	**5**	**1**
Are visit-coaches or other relationship-supporting approaches routinely provided for visits between parents and their infants and toddlers in foster care?	**13**	**20**	**13**

Section 3: Post-Permanency Services for Infants and Toddlers in Foster Care and Their Families

After a child achieves permanency through reunification, adoption, or permanent guardianship, many states continue to provide a variety of supports to both the child and the family. While a child is awaiting permanency, many states require that post-permanency plans be developed to lay out the supports, plans, and schedules that will assist the child and family in building a safe and permanent home. Thirty-three states have policies requiring the child welfare agency develop a post-permanency plan for reunification; 28 states require one for adoption; and 20 states do so for guardianship. **Ten states reported that they do not have policies requiring any post-permanency plan for infants and toddlers.** States reported the following components of post-permanency plans:

- Identification of supports/ facilitators for successful reunification or adoption/ guardianship (34 states);
- Service plans (32 states);
- Identification of barriers to successful reunification or adoptiondis/guardianship (30 states);
- Trial home visits (30 states);
- Timeframes (30 states);
- Safety plans (29 states);
- Schedule of visitation with siblings (if applicable) (24 states); and
- Schedule of visitation with non-custodial parent (if applicable (20 states).

Figure 9 summarizes post-permanency supports routinely offered to parents. As the table illustrates, **with the exception of a few services, most states reported a greater availability of post-permanency supports for adoptive parents compared to birth parents upon reunification or to legal guardians upon guardianship.** The only exceptions are material supports and follow-up visits with child welfare agency staff. **Most states also reported a greater availability of services and supports to adopted children compared to children who are reunified with their birth parents or who gain permanency through a legal guardianship.**

Figure 9: Number of states that routinely offer post-permanency services and supports to parents

	Post-reunification	Post-adoption	Post-guardianship	Varies by county
Respite care	9	18	7	10
Support groups	15	30	19	11
Linkages with community-based services	38	39	34	6
Information and referral	39	40	36	6
Educational support/advocacy	27	28	24	7
Mental health services	27	32	24	8
Material supports (e.g., income support, job training, health care coverage, housing assistance)	23	22	20	10
Assistance with locating/paying for residential treatment	10	13	8	10
Follow-up visits/communications with child welfare staff (e.g., home visits, or mentors for some period of time)	32	18	12	4
Written agreements for open relationships between birth and foster/adoptive parents or legal guardians	5	19	8	6
Other	1	3	3	0
Health care services (e.g., pediatricians, dentist, occupational therapists)	29	34	29	8
Mental health services	30	39	32	10
Early learning and development programs (such as Early Head Start)	33	35	34	9
Part C early intervention services	34	37	33	10
Other	1	3	3	1

Section 4: Training in Early Childhood Development and Developmentally-Appropriate Practice

Front-line caseworkers play a significant role in identifying developmental concerns and requesting supports for infants and toddlers and their families. **Only eight states reported that their child welfare agencies employ staff dedicated to working with, or specifically assigned to work with, maltreated infants and toddlers.** Five of those states only employ such staff in some areas of the state.

A variety of additional stakeholders play a role in the lives of maltreated infants and toddlers, including court personnel, foster parents, birth parents, and health and mental health professionals. In the majority of states, professional training on developmentally appropriate practices for maltreated infants and toddlers is offered

or required to a cross-section of individuals, including practitioners who regularly interact with maltreated infants and toddlers as well as family members and others. States are most likely to require training for front-line child welfare staff (25 states). Less than half of states require training for child welfare supervisors (18 states), foster parents (22 states), and adoptive parents or kinship guardians (15 states), though all but six states at least offer training to these groups. **Only three states (Alaska, Hawaii, South Dakota) require training on developmentally appropriate practices for maltreated infants and toddlers for all child welfare staff, including case workers, supervisors, administrators, and other staff.** Figure 10 details the number of states with policies requiring that training be "required," "offered," or "neither offered nor required" for different groups.

Figure 10: Number of states that require or offer training on developmentally appropriate practices for maltreated infants and toddlers

	Required	Offered	Neither required nor offered
Front-line child welfare staff (e.g., caseworkers)—regardless of the age of children on their caseload	25	15	6
Foster parents	22	18	6
Child welfare supervisors	18	22	6
Adoptive parents/kinship guardians	15	23	8
Part C early intervention providers	13	15	11
Home visiting providers	12	16	11
Kinship care providers	8	29	8
Early care and education providers	7	23	10
Other child welfare agency staff	5	30	9
Child welfare administrators	4	31	9
Attorneys, judges, and other court staff	4	26	11
Health care providers (including pediatricians, occupational therapists, etc.)	3	21	13
Mental health providers	3	22	12

States were asked what the training comprised. A list of examples was provided for states including: infant/toddler development, recognizing developmental delays, cultural competence, supporting families, and trauma-informed. Generally, states repeated one or more of the examples provided for them, though a few unique innovations were described. The District of Columbia and Georgia both offer online learning components for their staff. Tennessee has five centers of excellence, which provide education and hands-on training experiences for practitioners on topics including parent-child interaction therapy. Washington is training staff on the dynamics of attachment and separation and placement.

Section 5: Data Collection and Analysis

States collect much data related to infants and toddlers: demographic data including characteristics of infants and toddlers who have experienced abuse and/or neglect, such as age, sex, race/ethnicity, maltreatment type experienced, and characteristics of infants and toddlers entering foster care—such as time in care, episodes in care, placement settings, siblings in care, and reason for entering care—are being collected across nearly all states. Figure 11 summarizes the types of data collected by states. **Data gaps exist, such as frequency of contact between infants and toddlers in foster care and their siblings (including face-to-face visits, phone calls, and overnight or weekend visits), and training (type and frequency) for professionals and caregivers involved with maltreated infants and toddlers.**

Children ages zero to three represented 27 percent of all maltreatment victims in 2011 despite comprising only 16 percent of the overall child population.[17]

Although the majority of states are collecting data related to infants and toddlers, **over half of respondents, 25 states, do not analyze disaggregated data within the maltreated infant/toddler population. Twenty-one states reported that they analyze the disaggregated data; however, only 10 of those states analyze all data elements.**

Figure 11: Number of states that collect data related to maltreated infants and toddlers

	State-wide	Only in certain areas	Not collected
Characteristics of infants and toddlers entering foster care, such as time in care, episodes in care, placement settings, siblings in care, reason for entering care	**46**	**0**	**0**
Characteristics of infants and toddlers who have experienced abuse and/or neglect, such as age, sex, race/ethnicity, maltreatment type experienced	**45**	**0**	**1**
Frequency of permanency hearings for infants and toddlers in foster care	**43**	**0**	**3**
Frequency of case reviews/administrative reviews for infants and toddlers in foster care	**42**	**0**	**4**
Permanent placements of infants and toddlers from foster care by race, sex, and age (including reunifications with parents, relative guardianships, adoption)	**42**	**0**	**3**
Infants and toddlers who have a physical disability	**37**	**0**	**9**
Infants and toddlers who have a developmental disability (e.g., autism, cerebral palsy)	**35**	**0**	**11**
Frequency of contact between infants and toddlers in foster care and their parents (including face-to-face visits, phone calls, overnight or weekend visits)	**30**	**0**	**16**
Infants and toddlers who have a chronic, on-going illness (e.g., asthma, diabetes, sickle cell anemia)	**26**	**4**	**16**
Services received by infants and toddlers who have experienced abuse and/or neglect	**25**	**3**	**17**
Infants and toddlers referred to Part C, including how many are eligible and how many receive services	**25**	**3**	**17**
Services referred for infants and toddlers who have experienced abuse and/or neglect	**24**	**4**	**18**
Frequency of contact between infants and toddlers in foster care and their siblings (including face-to-face visits, phone calls, overnight or weekend visits)	**22**	**1**	**22**
Training (type, frequency) for professionals and caregivers involved with maltreated infants and toddlers	**17**	**3**	**25**

Discussion

The *Survey of State Child Welfare Agency Initiatives for Maltreated Infants and Toddlers* sets the stage for understanding how states are currently supporting young children and where opportunities to expand supports exist. Although maltreated infants and toddlers are at heightened risk of developmental delays and are over-represented in the foster care population, research has shown that strong supports and swift intervention can improve outcomes for these children.[18] Child welfare agencies that understand early childhood development and the specific concerns of this population can have a significant impact on these young lives. Through an analysis of survey responses, three clear themes emerged, which are discussed in this section.

Few states differentiate services or timelines for infants and toddlers

Young children develop, change, learn, and grow at a rapid pace, and timeframes for services, reviews, and referrals must be quick enough to identify and address needs before they are exacerbated. Courts and child welfare agencies must be poised to respond to service needs quickly and make sure the path to permanent and stable connections is smooth for these very young children. In spite of the need for timeliness, of the 26 states with polices setting timeframes for referrals to specialists when potential health and developmental problems are identified, only nine of those states require the referral occur within one week. Similarly, most states (31 states) responded that that they do not routinely hold case reviews, permanency hearings, court review hearings, or family group decision-making meetings on a more frequent or expedited basis for infants and toddlers. Although case workers may be able to help identify health and developmental issues in a timely manner, 39 states do not have policies that require more frequent case worker visits for infants and toddlers in foster care.

The survey showed that states are generally not differentiating between the infant and toddler foster care population and other age groups of children in foster care. This inclusion of infants and toddlers in the general foster care population is particularly

noticeable in policies related to foster care placements. The survey responses showed that many states have policies that benefit all children: encouraging or giving preference to kinship placements (43 states), promoting the first out-of-home placement (39 states), and beginning concurrent planning immediately, as soon as possible or within 24 hours of removal (14 states). Many states also reported offering the mentorship of birth parents by foster parents (33 states) and routinely placing children with their siblings when appropriate (44 states). Although all of these policies can and do benefit foster children of all ages, they may be more beneficial if tailored to the age of the child. In particular, special care and knowledge must be undertaken for very young children. Infants and toddlers grow and develop at such a rapid pace that timely intervention plays a significant role in improving outcomes. Policies and practice must be developed and implemented with this consideration in mind.

In addition to categorizing young children in foster care in the same way as older children in foster care, the survey showed that training in early childhood development and developmentally appropriate practices is not usually required for the adults who live with and work with maltreated infants and toddlers. Many of the barriers identified by survey respondents to infants and toddlers and their parents receiving services—such as challenges in securing parental consent and eligibility determination issues—point to the need for stronger training for case workers, parents, foster parents, and court personnel. Surprisingly few states—only three—require all their child welfare staff to be trained on developmentally appropriate practices for maltreated infants and toddlers.

All staff who interact with maltreated infants and toddlers and provide input into their case plans need to understand their needs and development. Additionally, professionals who interact with maltreated infants and toddlers as a subset of the foster child population may need additional training on the specific risks and needs associated with maltreated infants and toddlers. Although many more states offer such training to their child welfare staff, related professionals, foster parents, kinship caregivers, and court personnel, follow-up research is needed to learn whether or not these stakeholders are taking advantage of the training and how deep the training goes into infant and toddler development.

Although states have several promising approaches to meeting the needs of maltreated infants and toddlers, relatively few states have implemented such approaches

As mentioned above, many states do have policies in place that benefit all children in foster care, including infants and toddlers. In addition, some promising policies and approaches which distinguish infants and toddlers from other children in care did emerge through survey responses. Both federal and state policymakers need to understand how these policies can play a particularly positive role in the lives of very young children.

Prohibition in policy for the placement of young children in congregate care except in situations where parents and their young children can be cared for together. Young children need a secure and stable attachment with a caregiver for their early development. Congregate care settings for young children deprive them of the individualized attention they need to cope with the trauma of their removal. Only six states have

an explicit prohibition in their policies for all infants and toddlers (and other young children). Although 17 states do have policies that require special authorization for the placement of young children in congregate care settings, such polices leave the door open for such placements that are most often not in the best interest of very young children. States with no specific policy in place may have a practice of not placing infants and toddlers in congregate care, as was indicated by six states. An example of a special circumstance is when the only option for keeping a mother and a young child together would be placement into congregate care.

Frequent visitation between birth parents and infants and toddlers in foster care. Removing an infant or toddler from her parents can be incredibly disruptive to her development. Due to their developmental timeline, infants and toddlers need consistent, nurturing relationships to develop into fully functional adults. Frequent and consistent contact is essential if young children are to develop and maintain strong, secure relationships with their parents. Research has shown that frequent visitation (e.g., multiple times each week) increases the likelihood of reunification, reduces the time in out-of-home care, and promotes healthy attachment.[19] The survey responses showed that few states' policies provide the frequency of visitation that infants and toddlers need. Policies that require more frequent visitation, ideally daily visitation, between infants and toddlers in foster care and their birth parents are critical to protecting a young child's attachment to her parents. Only Alaska reported a policy of daily visitation, and that policy is only available in some jurisdictions in the state. Although nine states do differentiate by providing more frequent visitation for birth parents and infants and toddlers in foster care, none of those states differentiate in policy.

Child welfare agencies have a long way to go, but they also have useful tools to help them get there

Although there are promising policies that recognize the unique needs of infants and toddlers, these policies appeared infrequently across states. Not only are these promising policies not available in every state, states with promise in one area may not have strong policies to improve the outcomes of young children in other areas. States need support in understanding how their own policies and practices are impacting the health and development of infants and toddlers.

It is also critical for states and policymakers to be aware of the needs of those maltreated infants and toddlers who remain in their parents' homes but have a substantiated case of abuse or neglect. Fewer states have policies requiring adherence to a visit/screening schedule for health and developmental screenings and assessments for maltreated infants and toddlers as a group than for those in foster care. However, many of these at-risk children have the same health and developmental issues as those

in foster care. Less than a third of states require developmental screenings for all maltreated infants and toddlers and less than one in five states require mental health screenings for all maltreated infants and toddlers. By not identifying and addressing the needs of all maltreated infants and toddlers, these children face significant threats to their cognitive and social development.

The survey responses show that states are not fully addressing the complex needs of birth parents. Parents who maltreat or abuse their own children are often victims of abuse or maltreatment themselves.[20] This "secondary trauma" can play a significant role in the lives of birth parents. The polices and related services that birth parents need to overcome their own trauma, mental health, substance abuse, and domestic violence issues are often not being provided regularly across states. Only 18 states routinely provide information about secondary trauma and offer strategies for coping with and managing this history. Over two-thirds of states do not have policies that require a physical exam for parents, to address any physical issues that may be contributing to the maltreatment. Only two states require a neurophysiological assessment for parents to assess their abilities and capacities. Policies in slightly more than a third of states require domestic violence screenings and slightly less than a third require substance abuse screenings for parents. Without addressing these issues, it is difficult for them to become the parents that their young children need them to be.

States also lack clear policies related to services to improve the interaction between birth parents and their children. Although states tend to promote involvement of birth parents in evaluating the health of infants and toddlers in foster care, nearly half of states identified birth parents' lack of training to identify developmental needs as a moderate or significant barrier to implementing CAPTA requirements. No states are providing training for birth parents about how and when to seek services for their infants or toddlers. Only 13 states routinely provide visit-coaches or other relationship-supporting approaches during visits between birth parents and their infants and toddlers in foster care across the whole state. Although 33 states offer mentoring by foster parents to birth parents, less than half of states routinely provide such mentoring. Birth parents need more consistent supports in caring for, playing with, and promoting the healthy development of their young children.

One-third of infants who achieve reunification with their birth families later re-enter the child welfare system.[21] It is significant that, in spite of this statistic, it is more common for states to routinely offer post-permanency supports for adoptive parents and guardians than for reunified birth parents. According to the survey's findings, more states routinely offer post-permanency services and supports to adopted children than reunified children. Birth parents need broader support from the child welfare system both before and after reunification is achieved.

Resources for states

States eager to better meet the needs of maltreated infants and toddlers can begin now. Tools like ZERO TO THREE'S *A Developmental Approach to Child Welfare Services for Infants, Toddlers and Their Families: A Self-Assessment Tool for States and Counties Administering Child Welfare Services* can assist states in gauging where they have strengths and where there is room to grow. It is important that multiple stakeholders, including those from child welfare, mental health, health, courts, early care and education, home visiting, and Part C are involved in conducting these assessments. True collaboration between these agencies and within each agency itself can assist young children and their families by ensuring coordinated case plans and services, leading to smooth and robust services for this high risk group. Both federal and state policymakers can use tools like *A Call to Action on Behalf of Maltreated Infants and Toddlers*—a collective vision of ZERO TO THREE and other leading child welfare and early childhood development organizations—for concrete ideas about how to move forward.

In a similar effort, Casey Family Programs developed a brief, *Making the Case for Early Childhood Intervention in Child Welfare: A Research and Practice Brief*, which sets out to examine the types and availability of intervention approaches for families with young children who are involved with child welfare.[22]

The authors hope that this analysis of the *Survey of State Child Welfare Agency Initiatives for Maltreated Infants and Toddlers* will help states better understand the many positive steps they can take as they work to address the needs of the youngest children in their care.

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Appendix A: Index of state policies and practices to support the development of young children

The ZERO TO THREE Policy Center, a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers, and Child Trends, a nonprofit, nonpartisan research center that studies children at all stages of development, worked together to design the survey and analyze responses. During the course of this collaboration, based on both organizations' knowledge and expertise in early childhood development and the child welfare system, several key policies and practices stood out as particularly significant for fostering the healthy development of maltreated infants and toddlers. These areas are displayed in the table on the following pages, with a landscape of state responses. The five states that did not participate in the survey (Connecticut, Maine, Mississippi, Montana, Utah) are not included in the index. "I/T" refers to "infants and toddlers."

The Index is structured as follows:

1. Assessments and services for maltreated infants and toddlers

2. Case reviews, court hearings, and family group decision-making

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

Assessments and services for maltreated infants and toddlers

	AL	AK	AZ	AR	CA	CO	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	MD	MA	MI	MN	MO
Policy requires health/immunization assessments for all maltreated I/T	X									X	X			X					X			X	
Policy requires dental health assessments for all maltreated I/T	X									X	X			X					X				
Policy requires mental/behavioral health assessments for all maltreated I/T	X									X	X			X								X	
Policy requires developmental monitoring/screening for all maltreated I/T	X			X						X	X			X				X				X	
Policy requires referral to specialists within one week of health or developmental problem identified for I/T in foster care				X											X			X					

	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	VT	VA	WA	WV	WI	WY	ALL
Policy requires health/immunization assessments for all maltreated I/T											X	X	X				X		X		X			12
Policy requires dental health assessments for all maltreated I/T											X	X					X		X		X			10
Policy requires mental/behavioral health assessments for all maltreated I/T											X						X				X			8
Policy requires developmental monitoring/screening for all maltreated I/T									X		X	X					X		X		X	X		14
Policy requires referral to specialists within one week of health or developmental problem identified for I/T in foster care			X						X					X			X			X	X			9

Case reviews, court hearings, and family group decision-making

	AL	AK	AZ	AR	CA	CO	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	MD	MA	MI	MN	MO
Policy requires more frequent case reviews for I/T in foster care						X					X					X							
Policy requires more frequent permanency hearings for I/T in foster care			X		X	X									X								
Policy requires more frequent court review hearings for I/T in foster care						X					X					X							
Policy requires more frequent family group decision-making for I/T in foster care																							
Policy requires more frequent case worker visits for I/T in foster care																					X		

	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	VT	VA	WA	WV	WI	WY	ALL
Policy requires more frequent case reviews for I/T in foster care													X											4
Policy requires more frequent permanency hearings for I/T in foster care													X					X						6
Policy requires more frequent court review hearings for I/T in foster care																								3
Policy requires more frequent family group decision-making for I/T in foster care					X								X											2
Policy requires more frequent case worker visits for I/T in foster care																								1

Stability, attachment, and permanency for infants and toddlers in foster care

	AL	AK	AZ	AR	CA	CO	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	MD	MA	MI	MN	MO
Policy specifically promotes keeping I/T in 1st out of home placement			X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X		X
States reported concurrent planning begins immediately, as soon as possible, or within 24 hours of removal				X									X	X							X		
Visit coaching or other relationship-supporting approaches routinely provided								X			X	X		X	X	X							X
Mentoring by foster families routinely offered to birth parents						X		X	X	X	X	X	X		X	X	X	X	X	X			X
Policy prohibits congregate care for children under age 6								X			X					X					X		
Policy dictates visitation with parents for I/T in foster care occurs more than once a week		X	X	X			X	X			X		X				X				X		X
Training on developmentally appropriate practices for maltreated I/Ts required for all child welfare agency staff		X									X												
Child-parent psychotherapy routinely provided	X					X		X	X					X				X	X				X

Stability, attachment, and permanency for infants and toddlers in foster care (continued)

	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	VT	VA	WA	WV	WI	WY	ALL
Policy specifically promotes keeping I/T in 1st out of home placement	X		X	X	X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X	X	39
States reported concurrent planning begins immediately, as soon as possible, or within 24 hours of removal			X	X		X		X						X			X	X			X	X	X	14
Visit coaching or other relationship-supporting approaches routinely provided	X			X			X									X		X			X			13
Mentoring by foster families routinely offered to birth parents				X				X		X				X		X			X				X	21
Policy prohibits congregate care for children under age 6		X																					X	6
Policy dictates visitation with parents for I/T in foster care occurs more than once a week				X							X		X						X			X	X	16
Training on developmentally appropriate practices for maltreated I/Ts required for all child welfare agency staff															X									3
Child-parent psychotherapy routinely provided				X		X							X	X		X					X			14

Appendix B: Survey of State Child Welfare Agency Initiatives for Maltreated Infants and Toddlers

Survey of State Child Welfare Agency Initiatives for Maltreated Infants and Toddlers

Instructions and Overview

Thank you for participating in this national survey, which aims to gather and share information about state policies and practices that guide child welfare agencies' work in addressing the needs of maltreated infants and toddlers. The survey is being conducted by ZERO TO THREE (www.zerotothree.org), a national, nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers, and Child Trends (www.childtrends.org), a nonprofit, nonpartisan research center that studies children at all stages of development.

The survey is organized into six sections:

Section I. **Assessments and Services for Maltreated Infants and Toddlers and their Families**
Section II. **Infants and Toddlers in Foster Care and their Families**
Section III. **Post-Permanency Services for Infants and Toddlers in Foster Care and their Families**
Section IV. **Training in Early Childhood Development and Developmentally-Appropriate Practice**
Section V. **Data Collection and Analyses**
Section VI. **Additional Initiatives Targeting Maltreated Infants and Toddlers and their Families**

Completing and Submitting the Survey: The survey can be completed electronically by providing responses directly in this document, which is a writeable PDF file. Upon completing the survey, please send it as an attachment by email to Kerry DeVooght at kdevooght@childtrends.org. We anticipate that the survey will take approximately 60-90 minutes to complete. Although the instrument may appear lengthy, we have attempted to minimize the burden by developing most questions in a multiple choice format—which typically results in questions that may seem longer, though they will likely require less time to complete. Additionally, we have included many definitions and descriptions throughout the survey that are designed to assist your understanding of the questions, but may also result in the survey appearing more extensive. However, we hope that these factors actually make the instrument less time-consuming and easier to complete.

Survey Results: The results of this survey will be shared with each of the survey respondents in advance of publication. In addition, a final report will be published and made available to interested stakeholders.

Helpful Tips

Key Definitions and Terms: Because states often define terms differently, throughout the survey we have included definitions or descriptions of important terms in textboxes with purple headings. **Please read these descriptions carefully**, as they will assist you in responding accurately to the questions and will help to enhance comparability across states.

As you proceed through the survey, you will notice that some questions ask about whether particular activities are **required** by policies, or are **specifically promoted** by policies or practice guidelines. These terms are

Questions? Please contact Kerry DeVooght at Child Trends: kdevooght@childtrends.org; 202-572-6135

important as they help to distinguish whether a policy in your state simply *allows* something to take place, versus whether a policy or practice guideline explicitly instructs the agency (or another entity) to do or provide something, or to diligently attempt to do so. When questions ask whether policies or practice guidelines in your state *specifically promote* something, please only respond affirmatively if the policy or guidance language clearly states that the particular activity in question should be prioritized or attempted. Similarly, when questions ask if something **typically** or **routinely** occurs in your state, please only answer affirmatively if the particular activity or procedure is the norm; that is, only if it almost always occurs. These terms will help to distinguish whether something *can* or *does* happen on occasion in your state versus whether it is standard practice for it to occur.

Finally, we understand that the terms "**policies,**" "**infants and toddlers,**" "**maltreatment,**" and "**foster care**" may have differing definitions across states (or even in various jurisdictions within your state). For the purposes of this survey, please use the following definitions to guide your responses throughout the survey:

DEFINITION: "POLICIES"
In considering the "**policies**" that your state has in place, please consider policies that exist in law, agency regulations, and other written policy guidance.

DEFINITION: "INFANTS AND TODDLERS"
When responding to questions about "**infants and toddlers**" on this survey, please consider children aged 0 to 3 years. However, we welcome information about any initiatives, programs, or policies specifically directed at certain age groups within this population (e.g., a program specifically for 0-1 year olds) or a broader early childhood age group (e.g., a program for children 0 to 4, or specifically for 3 to 4 year olds), and have included space at the end of the survey where these descriptions can be provided.

DEFINITION: "MALTREATMENT"
When responding to questions about children who have been "**maltreated**," please consider children for whom a report of abuse or neglect **has been substantiated by the child welfare agency**, or for whom an alternative/differential response has produced **a determination that the child has experienced maltreatment** (which may be a "victim" finding, or a comparable term used in your state).

DEFINITION: "FOSTER CARE"
When responding to questions about infant and toddlers in **"foster care"** on this survey, please consider any children who are in the custody of the state or local child welfare agency. These children may be in a variety of out-of-home placements, including non-relative or relative/kin foster homes, shelter care homes, group homes, institutions, or hospitals.

Questions?

We would be happy to answer any questions you have regarding the survey. Please do not hesitate to contact Kerry DeVooght at kdevooght@childtrends.org or 202-572-6135. Thank you in advance for your time.

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i. Please enter contact information for the individual primarily responsible for completing this survey, or the individual we should contact with any questions about your survey responses.

Name: _____
Job Title/Position:_____
Agency:_____
Mailing Address:_____
Email Address:_____
Phone Number:_____

ii. How is your state's child welfare system structured? (please choose one)

- ◯ County administered, state supervised
- ◯ State administered
- ◯ Other (please describe)

I. Assessments and Services for Maltreated Infants and Toddlers and their Families

Questions 1-7: Assessing and Addressing Children's Health, Mental Health, and Developmental Needs

1. **The table below is designed to gather information about any specific schedules that are used in your state for health/developmental visits or screenings for maltreated infants and toddlers. We understand that your policies around visits and screenings may vary depending on a maltreated child's status with the child welfare agency (e.g., in foster care versus remaining at home in the birth parents' custody). Therefore, we have provided a distinction between these two groups in the table.**

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

	Adherence to visit/screening schedule required *only* for infants and toddlers in foster care	**Adherence to visit/screening schedule required for all maltreated infants and toddlers (incl. those who are not in child welfare agency custody)**	**Varies by county**
Physical Health & Immunizations	☐	☐	☐
Dental Health	☐	☐	☐
Mental/Behavioral Health	☐	☐	☐
Developmental Monitoring/Screening	☐	☐	☐

2. **If you indicated that adherence to a visit/screening schedule is required, please name or describe the type of schedule(s) used.** (e.g., the American Academy of Pediatrics or American Academy of Pediatric Dentistry's recommended schedules, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) framework, or a state- or county-developed schedule)

Physical Health & Immunizations:

Dental Health:

Mental /Behavioral Health:

Developmental Monitoring/Screening:

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3. Do policies or practice guidelines in your state specifically promote the involvement of birth parents in evaluating the health of <u>infants and toddlers in foster care</u>?

- ◯ Yes
- ◯ No
- ◯ It varies by county *(Please explain/describe the variation in the text box below)*

3a. If yes, how do your policies specifically promote birth parents' involvement? *(Select all that apply)*

- ☐ Birth parents are interviewed about their child's health
- ☐ Birth parents are routinely invited to health care visits, screenings, assessments
- ☐ Birth parents' attendance and participation in health care visits, screening, and assessments is facilitated (e.g., providing transportation)
- ☐ Outcomes of health care visits or assessments (e.g., doctor recommendations or screening results) are routinely discussed with birth parents
- ☐ Developmental milestones are reviewed with birth parents (e.g., using the Ages to Stages tool or other similar materials)
- ☐ Birth parents are routinely included in health care planning discussions (which could include physical, mental, dental, or developmental health)
- ☐ Other (*please specify*):_____

4. Do policies in your state require that referrals to specialists be made within a specific timeframe when potential health or developmental problems are identified for maltreated infants and toddlers?

- ◯ Yes
- ◯ No
- ◯ It varies by county *(Please explain/describe the variation in the text box below)*

4a. If yes, within what timeframe of the determination of potential health or developmental problems must referrals be made?

- ◯ Within 1 week
- ◯ Within 2 weeks
- ◯ Within 30 days
- ◯ Other *(please specify)*:_____

REFER TO THIS DEFINITION FOR QUESTION #5: "INFANT-EARLY CHILDHOOD MENTAL HEALTH"
<u>Infant-early childhood mental health (I-ECMH),</u> sometimes referred to as social and emotional development, is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.

5. **What services are routinely provided in your state to meet the mental health needs of maltreated infants and toddlers?** *(Select all that apply)*

- ☐ Parent-child relationship assessments
- ☐ Therapeutic visitation
- ☐ Parent-child psychotherapy
- ☐ Parent-child interaction therapy
- ☐ Guidance to foster parents to help children make the transition before and after visits with birth parents
- ☐ Providing children in foster care with a keepsake from their birth parents' home (e.g., a stuffed animal, recording of their parent singing or reading aloud, a comforter or item of clothing with the parent's scent on it)
- ☐ Other *(please specify)*:
- ☐ It varies by county *(Please explain/describe the variation in the text box below)*

REFER TO THIS DEFINITION FOR QUESTION #6: "MEDICAL HOMES"

When children have a **medical home**, all aspects of pediatric care can be managed by one consistent pediatrician who knows a child's family and their medical history. This includes well-child visits; immunizations; screenings and assessments; patient and parent counseling about health, nutrition, safety, and mental health; and supervision of care. In addition, when appropriate, a pediatrician can also refer a child to specialized health care providers and early intervention services while coordinating care with other programs and services. The AAP has identified seven desirable characteristics of a medical home: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Please see www.medicalhomeinfo.org for more information.

6. **Are "medical homes" used in your state for maltreated children?**

- ◯ Yes, in all areas of the state
- ◯ Yes, but only in some areas of the state
- ◯ No

6a. If yes, do policies in your state require that infants and toddlers in foster care have a medical home?

- ◯ Yes
- ◯ No
- ◯ It varies by county *(Please explain/describe the variation in the text box below)*

7. **Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, to assess and address the health, mental health, or developmental needs of maltreated infants and toddlers.**

Questions? Please contact Kerry DeVooght at Child Trends: kdevooght@childtrends.org; 202-572-6135

Questions 8-12: Child Abuse Prevention and Treatment Act (CAPTA) and Referral to Part C of the Individuals with Disabilities and Education Act (IDEA)

REFER TO THIS DEFINITION FOR QUESTIONS #8-12: "CAPTA" AND PART C OF THE INDIVIDUALS WITH DISABILITIES AND EDUCATION ACT (IDEA)
The next series of questions asks about the requirement of the **Child Abuse Prevention and Treatment Act (CAPTA)** for children under age 3 with a substantiated case of abuse, neglect, or illegal drug exposure to be screened for developmental delays and referred to the Part C early intervention agency. CAPTA is the key federal legislation addressing child abuse and neglect. It provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations, including Indian Tribes and Tribal organizations, for demonstration programs and projects. CAPTA also sets forth a minimum definition of child abuse and neglect. CAPTA requires state early intervention and child welfare systems to establish coordinated procedures for the referral of substantiated cases of abused, neglected, or illegal drug-exposed infants and toddlers to Part C services.

8. **How is the CAPTA screening requirement for maltreated infants and toddlers implemented in your state?** *(Select one)*

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

_____

9. **Using a scale of 1 to 5, please indicate how much of a barrier each item presents to implementing the CAPTA requirement <u>for referring maltreated infants and toddlers to Part C</u> in your state.** *(Please respond to each row in the table below)*

	1 Not at all a barrier	2 Very mild barrier	3 Somewhat of a barrier	4 Moderate barrier	5 Significant barrier
Part C staff lack familiarity with child welfare populations, policies, and/or procedures	☐	☐	☐	☐	☐
Child welfare staff lack familiarity with Part C services, policies, and/or procedures	☐	☐	☐	☐	☐
Child welfare staff lack training to identify developmental needs	☐	☐	☐	☐	☐
Foster parents, kinship caregivers, and/or adoptive parents/kinship guardians lack familiarity with Part C services, policies, and/or procedures	☐	☐	☐	☐	☐
Foster parents, kinship caregivers, and/or adoptive parents/kinship guardians lack training to identify developmental needs	☐	☐	☐	☐	☐
Court personnel lack training to identify developmental needs	☐	☐	☐	☐	☐
Court personnel lack familiarity with Part C services, policies, and/or procedures	☐	☐	☐	☐	☐
Birth parents lack training to identify developmental	☐	☐	☐	☐	☐

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needs					
Birth parents lack familiarity with Part C services, policies, and/or procedures	☐	☐	☐	☐	☐
Children lack access to primary health care and have limited contact with health care professionals (who may otherwise identify developmental needs)	☐	☐	☐	☐	☐
Children lack consistent caregivers (to identify developmental needs)	☐	☐	☐	☐	☐
Part C program has limited capacity to process referrals	☐	☐	☐	☐	☐
Referral requirement is implemented inconsistently across state or localities	☐	☐	☐	☐	☐
Federal guidance, support, and/or advice on implementing the CAPTA requirement is lacking	☐	☐	☐	☐	☐
Other *(please specify):*	☐	☐	☐	☐	☐

10. Using a scale of 1 to 5, please indicate how much of a barrier each item presents <u>to children receiving services from Part C</u> in your state. *(Please respond to each row in the table below)*

	1 Not at all a barrier	**2 Very mild barrier**	**3 Somewhat of a barrier**	**4 Moderate barrier**	**5 Significant barrier**
Challenges obtaining parental consent **for evaluations/assessments** of maltreated children	☐	☐	☐	☐	☐
Challenges obtaining parental consent **for services** for maltreated children	☐	☐	☐	☐	☐
Challenges for Part C staff with engaging children and families in the child welfare system	☐	☐	☐	☐	☐
Lack of clarity/delineation of roles between child welfare and Part C staff	☐	☐	☐	☐	☐
Children not being determined eligible for Part C	☐	☐	☐	☐	☐
Transportation or other access-related issues to supports and services	☐	☐	☐	☐	☐
Limited capacity of Part C program to serve all eligible children	☐	☐	☐	☐	☐
Delays in children receiving services through Part C	☐	☐	☐	☐	☐
Lack of appropriate services available through Part C	☐	☐	☐	☐	☐
Level of need/costs of services exceeding available funding	☐	☐	☐	☐	☐
Other *(please specify):*	☐	☐	☐	☐	☐

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

☐ Training required for child welfare staff on the Part C referral requirement

☐ Training required for child welfare staff on the supports and services available through Part C

- ☐ Training required for Part C agency staff on the needs of infants and toddlers in the child welfare system
- ☐ Formal information sharing about each system's policies/procedures (i.e., Part C and child welfare)
- ☐ Data sharing/service plan sharing between each system (i.e., Part C and child welfare)
- ☐ Leaders in child welfare and Part C engaging and collaborating to implement requirements of federal/state/local laws
- ☐ Clear delineation of roles/responsibilities of Part C and child welfare staff
- ☐ Training required for birth parents on how and when to seek services for young children under Part C
- ☐ Training required for foster parents on how and when to seek services for young children under Part C
- ☐ Training required for kinship caregivers on how and when to seek services for young children under Part C
- ☐ Training required for adoptive parents/kinship guardians on how and when to seek services for young children under Part C
- ☐ Training required for court personnel on Part C requirements and developmental delays
- ☐ Other *(please specify)*: _____

12. Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, to ensure maltreated infants and toddlers receive screenings and referrals to Part C/Early Intervention.

Questions 13-17: Supports for Parents of Maltreated Infants and Toddlers

13. The following table requests information about health, mental health, and substance abuse-related supports that may be required to be offered to parents of maltreated infants and toddlers in your state. We understand that your policies may vary based on factors such as a maltreated child's status with the child welfare agency (e.g., in foster care versus remaining at home in the birth parent's custody). Therefore, we have provided this distinction in the table for you to indicate whether policies require that certain support/services be offered in all cases or just in certain cases.

Please select the box in each row that best describes your state's policies around offering health, mental health, and substance abuse-related supports to parents of maltreated infants and toddlers.

	Policies require in all cases	**Policies require in some cases**	**Policies don't specify**	**Varies by county**
A physical exam to detect any underlying issues that may contribute to maltreatment	☐	☐	☐	☐
A psychological assessment to assess any mental health issues (including for post-partum depression, traumatic stress)	☐	☐	☐	☐
If mental health issues identified: Referral to mental health services with **demonstrated effectiveness**	☐	☐	☐	☐
A neuropsychological assessment to assess their abilities and capacities (including for fetal-alcohol exposure and resulting deficits)	☐	☐	☐	☐
Domestic violence screening	☐	☐	☐	☐

Substance abuse screening	☐	☐	☐	☐
If substance abuse identified: Referral to substance abuse treatment programs with **demonstrated effectiveness**	☐	☐	☐	☐
If substance abuse identified: Priority for substance abuse treatment services	☐	☐	☐	☐
If substance abuse identified: Participation in comprehensive family-based substance abuse treatment	☐	☐	☐	☐
Other *(please specify):*	☐	☐	☐	☐

14. Which of the following additional support services for parents of infants and toddlers in foster care are routinely provided in your state, and to whom? *(Please respond to each row in the table below. Check the box (or boxes) for each row that best reflects your policies.)*

	Service routinely provided? *(If yes, check box below)*	**If yes, to whom?** ***(Check one box)***			
		Primarily (or only) the parent from which the child was removed	Mothers	Fathers	Both mothers and fathers
Parenting education (including training on child development and the impact of trauma) using approaches developmentally appropriate for the age of the child(ren), and which have demonstrated effectiveness addressing the specific parenting issues identified for this parent	☐	☐	☐	☐	☐
Mentoring by foster parents	☐	☐	☐	☐	☐
Participation in therapeutic interventions or services provided to the child (e.g., dyadic therapy, Parent-Child Psychotherapy)	☐	☐	☐	☐	☐
Information about secondary trauma and strategies for coping with and managing their own stress or trauma histories (when applicable)	☐	☐	☐	☐	☐
Other *(please specify):*	☐	☐	☐	☐	☐

15. Using a scale of 1 to 5, please indicate how much of a barrier each item presents to parents of maltreated infants and toddlers when trying to access support services in your state. *(Please respond to each row in the table below)*

	1 Not at all a barrier	**2 Very mild barrier**	**3 Somewhat of a barrier**	**4 Moderate barrier**	**5 Significant barrier**
Lack of services in certain areas of state/unequal geographical distribution of services	☐	☐	☐	☐	☐
Low number/quantity of service providers	☐	☐	☐	☐	☐

Waiting lists for services (or, if official "waiting lists" not kept, limited capacity of service providers to serve all those seeking the service)	☐	☐	☐	☐	☐
Poor quality of services available	☐	☐	☐	☐	☐
Services not available directly through CPS/child welfare agency (e.g., referrals to outside agencies needed)	☐	☐	☐	☐	☐
Language barriers (i.e., parent does not speak English and service providers do not speak the parent's native language)	☐	☐	☐	☐	☐
Transportation to services	☐	☐	☐	☐	☐
Difficulty finding, accessing, or engaging **fathers**, specifically	☐	☐	☐	☐	☐
Lack of child care for children while parent accesses services	☐	☐	☐	☐	☐
Costs of services	☐	☐	☐	☐	☐
Parent's lack of health insurance	☐	☐	☐	☐	☐
Legal status/documentation status of parent	☐	☐	☐	☐	☐
Other *(please specify):*	☐	☐	☐	☐	☐

15a. Which of the following, if any, has your state undertaken to reduce the barriers identified above? *(Select all that apply)*

- ☐ Transportation to services provided or reimbursed
- ☐ Financial assistance for services provided
- ☐ Interpreters made available at service providers
- ☐ Alternate service provision methods (e.g., "virtual"/on-line or telephone consultations) available when providers are lacking in certain areas of the state
- ☐ Parent mentors/navigators provided to assist with accessing services
- ☐ Child care provided for children while parent receives services
- ☐ Father-specific programs
- ☐ Other *(please specify)*:

16. Please describe any initiatives in your state that are specifically focused on outreach to pregnant and parenting teens to assess and address their needs.

17. Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, to support parents of maltreated infants and toddlers.

Questions 18-19: Partnerships and Collaborations to Support Maltreated Infants and Toddlers and their Families

18. Does the child welfare agency have linkages (either formal or informal) with any of the following entities or resources to help support maltreated infants and toddlers and their families? *(Select all that apply)*

Health services (e.g., pediatricians, dentists, AAP)	☐
Adult mental health services	☐
Infant/early childhood mental health services	☐
Public assistance programs (incl. Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Children's Health Insurance Program (CHIP), and Low Income Home Energy Assistance Program (LIHEAP))	☐
Part C early intervention agency	☐
Home visiting services	☐
Early learning and development programs (e.g., Early Head Start)	☐
Substance abuse treatment programs	☐
Domestic violence services	☐
Family court (court with jurisdiction over child abuse and neglect cases)	☐
Community resources that help families build informal support systems (incl. the faith community)	☐
Immigration and customs enforcement (in cases of detained parents)	☐
Criminal justice system (in cases of incarcerated parents)	☐
Intellectual disabilities services (for parents)	☐
Law enforcement agencies	☐
Other *(please specify):*	☐

19. Please select three of the entities/resources you identified above that you consider to have the strongest linkages with the child welfare agency (with respect to maltreated infants and toddlers) and enter those in the first box next to each number. In the second box, please describe the nature of the linkage (e.g., How do the agencies partner or collaborate? What is the quality of the relationship? Frequency of contact? Do they share data? Is there an MOU in place?).

1. ☐ ☐

2. ☐ ☐

3. ☐ ☐

Questions? Please contact Kerry DeVooght at Child Trends: kdevooght@childtrends.org; 202-572-6135

II. Infants and Toddlers in Foster Care and their Families

Questions 20-23: Case Reviews, Court Hearings, and Family Group Decision Making for Infants and Toddlers

REFER TO THESE DEFINITIONS FOR QUESTIONS #20-23: "CASE REVIEWS," "PERMANENCY HEARINGS," "COURT REVIEW HEARINGS," AND "FAMILY GROUP DECISION MAKING

The questions below ask about "**case reviews,**" "**permanency hearings,**" other types of "**court review hearings,**" and "**family group decision making"** for maltreated infants and toddlers. Please review the following descriptions of these terms:

Case reviews: According to the Adoption Assistance and Child Welfare Act of 1980, "**case reviews**" are required for children in foster care at least every 6 months while the children are in out of home care. Your state's "case reviews" may entail an administrative, judicial, or citizen review model. For the purposes of this survey, you should consider the "case review" to be the process through which a comprehensive and thorough examination of a foster child's current status, plans, and case goals are discussed.

Permanency hearings: According to the Adoption and Safe Families Act of 1994, "**permanency hearings**" are to be held by the court at least once every 12 months as long as the child is in out of home care. In a permanency hearing, the court reviews whether the child should continue to be in foster care and what the child's permanent plans are, and also determines whether reasonable efforts are being made by the child welfare agency on the child's behalf to achieve this permanency plan.

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

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

According to policies in your state:

20. How soon do permanency hearings for infants and toddlers in foster care occur after initial removal?

- ◯ Within 30 days
- ◯ Within 90 days
- ◯ Within 6 months
- ◯ Within 12 months
- ◯ Other *(please specify)*: _____
- ◯ It varies by county *(Please explain/describe the variation in the text box below)*

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

	More than once a month	Monthly	Quarterly	Every 6 months	Every 12 months	Other *(please specify):*	Varies by county	Frequency not specified in policy
Case reviews (after the initial case review upon entry into care)	☐	☐	☐	☐	☐	☐	☐	☐
Permanency hearings (after the initial hearing upon entry into care)	☐	☐	☐	☐	☐	☐	☐	☐
Other court review hearings	☐	☐	☐	☐	☐	☐	☐	☐
Family group decision-making (or similar approach, per definition above)	☐	☐	☐	☐	☐	☐	☐	☐

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

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

22a. If yes, please describe how the frequency differs for infants and toddlers.

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

Questions 24-32: Promoting Stability, Attachment, and Permanency for Infants and Toddlers in Foster Care

REFER TO THIS DEFINITION FOR QUESTION #24: "DIFFERENTIAL RESPONSE"

The following question asks about "**differential response"** (also known as "alternative response") procedures for infants and toddlers suspected of being maltreated. In differential response, child protective services offer both traditional investigations and assessment alternatives to families reported for child abuse and neglect, depending on the severity of the allegation and other considerations.

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

- ◯ Yes, in all parts of the state
- ◯ Yes, but only in some parts of the state
- ◯ No

24a. If yes, can your state use differential response to respond to maltreatment referrals <u>for infants and toddlers</u>?

- ◯ Yes, in all parts of the state
- ◯ Yes, but only in some parts of the state
- ◯ No

REFER TO THESE DEFINITIONS FOR QUESTION #25: "PRE-REMOVAL CONFERENCES," "NOTIFICATION OF RELATIVES," AND "CONCURRENT PLANNING"
"**Pre-removal conferences"** may be referred to by a variety of names in your state, including "family team meetings" or "family group decision-making." "**Notification of relatives**": The Fostering Connections to Success and Increasing Adoptions Act of 2008 requires states "within 30 days after the removal of a child from the custody of the parent" to "exercise due diligence to identify and provide notice to all adult grandparents and other adult relatives of the child." **"Concurrent planning"** seeks to promote timely permanence for children in foster care, by considering reunification and other permanency options at the earliest possible point after a child's entry into foster care.

25. Do policies in your state require any of the following practices for infants and toddlers in foster care? If yes, please provide any additional information requested in the last column.

	Yes	No	Varies by county	Additional information (if requested):
Pre-removal conferences before an infant or toddler is removed from the home ***If yes,*** *in what timeframe does the pre-removal conference take place?*	◯	◯	◯	
Expedited notification of adult relatives (i.e., more quickly than the 30 days required by the Fostering Connections Act) when infants or toddlers are removed from their parent's custody ***If yes,*** *how soon after removal does notification of adult relatives of infants or toddlers take place, and how does it differ (if at all) from the timeframe for other age groups?*	◯	◯	◯	
Preference given to kin/relative placements (*when they are appropriate)* for infants and toddlers in foster care	◯	◯	◯	
Concurrent planning undertaken for infants and toddlers in foster care ***If yes,*** *what does concurrent planning for infants and toddlers entail (including when does it begin)?*	◯	◯	◯	
Expedited termination of parental rights (i.e., shorter timeframes than would typically be the case for other age groups) for infants and toddlers who will not be reunified	◯	◯	◯	

with their parents ***If yes,*** *what is the timeframe for termination of parental rights process for infants and toddlers, and how does it differ from the timeframe for other age groups?*				
More frequent caseworker visits for infants and toddlers in foster care than for other age groups	◯	◯	◯	

26. Do policies or practice guidelines in your state specifically promote keeping infants and toddlers in their first out-of-home care placement throughout their foster care tenure?

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

26a. If yes, please describe how policies or practice guidelines specifically promote this.

27. If a placement change occurs for an infant or toddler, do policies in your state require any of the following for this transition?

	Yes	No	Varies by county
Transition plans (or other similar provisions)	◯	◯	◯
Higher-level review (e.g., by management/administration) for the placement change	◯	◯	◯
Other *(please specify)*:	◯	◯	◯

REFER TO THIS DEFINITION FOR QUESTION #28: "FOSTER-ADOPT HOME PLACEMENTS" (ALSO CALLED LEGAL RISK PLACEMENTS)

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

28. Do policies or practice guidelines in your state specifically promote placing infants and toddlers with <u>foster-adopt</u> families?

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

29. With regards to congregate care placement settings (e.g., group homes, treatment facilities, intake shelters), which of the following best describes your state's policies around <u>age requirements</u>:

☐ Policies prohibit congregate care settings for children under a particular age
If selected: *Under what age is congregate care prohibited?* _____

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☐ Policies require special authorization (e.g., commissioner-level sign off) or circumstances for placing a child under a particular age in congregate care

If selected: *Please describe the authorization or circumstances required for allowing congregate care for infants or toddlers:*

☐ No age requirements in policy for congregate care

☐ Other *(please specify):*

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

30. Which of the following foster parenting models or innovations that support positive development for infants and toddlers have been implemented in your state?

☐ "Shared family care" (in which the child and parent are placed together in a foster home or kin/kith home)

☐ Foster families who mentor birth parents

☐ Foster/adoptive families who maintain contact with birth families after reunification or adoption

☐ Other *(please specify):*

31. If your state is experiencing a disparity in removal rates for infants and toddlers of different racial/ethnic groups, have any efforts been undertaken specifically to address this disparity?

○ Yes

○ No

○ Not applicable (state does not have a disparity in removal rates for infants and toddlers)

31a. If yes, please describe the efforts to undertake the disparity.

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

Questions 33-37: Parent and Sibling Visitation for Infants and Toddlers in Foster Care

33. Do policies dictate how often face-to-face visitation <u>between infants and toddlers in foster care and their parents</u> should occur?

○ Yes

○ No

○ It varies by county *(Please explain/describe the variation in the text box below)*

33a. If yes, how frequently should face-to-face contact between infants and toddlers and their parents occur?

- ◯ Daily
- ◯ At least once a week
- ◯ At least every two weeks
- ◯ At least monthly
- ◯ Other *(please specify)*: _____

33b. If yes, is parent-child visitation frequency differentiated for infants and toddlers in foster care versus other age groups?

- ◯ Yes
- ◯ No

33b1. If yes, please describe how parent-child visitation frequency for infants and toddlers in foster care differs from other age groups.

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

- ◯ Yes
- ◯ No
- ◯ It varies by county *(Please explain/describe the variation in the text box below)*

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

- ◯ Yes
- ◯ No
- ◯ It varies by county *(Please explain/describe the variation in the text box below)*

36. Are infants and toddlers in foster care routinely placed with their older siblings (who are also in foster care)?

- ◯ Yes
- ◯ No
- ◯ It varies by county *(Please explain/describe the variation in the text box below)*

37. Do policies dictate how often face-to-face visitation <u>between infants or toddlers in foster care and their siblings</u> should occur?

- ◯ Yes
- ◯ No
- ◯ It varies by county *(Please explain/describe the variation in the text box below)*

37a. If yes, how frequently should face-to-face contact between infants and toddlers and their siblings occur?

- ◯ Daily
- ◯ At least once a week
- ◯ At least every two weeks
- ◯ At least monthly
- ◯ Other *(please specify)*:

38. Please describe any policies, programs, practices, or initiatives in your state, other than those reflected in earlier questions, to promote more frequent visitation or supported visitation.

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

According to policies in your state:

39. Are post-permanency plans required to be developed before an infant or toddler's <u>reunification with birth parents, adoption, or placement with a legal guardian?</u> *(Select all that apply)*

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

39a. If yes, what must these plans entail? *(Select all that apply)*

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

☐ Other *(please specify)*:_____

40. In the table below, please indicate with a check mark all post-permanency services and supports that are routinely offered in your state <u>for parents</u> who are reunified with their infant or toddler, or who adopt or take guardianship of an infant or toddler. *(Select all boxes that apply.)*

	Offered post-reunification	Offered post-adoption	Offered post-guardianship	Varies by county
Respite care	☐	☐	☐	☐
Support groups	☐	☐	☐	☐
Linkages with community-based services	☐	☐	☐	☐
Information and referral	☐	☐	☐	☐
Educational support/advocacy	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐
Material supports (e.g., income support, job training, health care coverage, housing assistance)	☐	☐	☐	☐
Assistance with locating/paying for residential treatment	☐	☐	☐	☐
Follow-up visits/communications with child welfare staff (e.g., home visits, or mentors for some period of time)	☐	☐	☐	☐
Written agreements for open relationships between birth and foster/adoptive parents or legal guardians	☐	☐	☐	☐
Other *(please specify)*:	☐	☐	☐	☐

41. In the table below, please indicate with a check mark all post-permanency services and supports that are routinely offered in your state <u>for infants and toddlers</u> who are reunified with their birth parents, who are adopted, or who have a finalized legal guardianship. *(Select all boxes that apply.)*

	Offered post-reunification	Offered post-adoption	Offered post-guardianship	Varies by county
Health care services (e.g., pediatricians, dentist, occupational therapists)	☐	☐	☐	☐
Mental health services	☐	☐	☐	☐
Early learning and development programs (such as Early Head Start)	☐	☐	☐	☐
Part C Early Intervention services	☐	☐	☐	☐
Other *(please specify)*:	☐	☐	☐	☐

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

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

43. Do your child welfare agencies employ staff dedicated to working with (or, specifically assigned to work with) maltreated infants and toddlers?

- ◯ Yes, in all areas of the state
- ◯ Yes, but only in some areas of the state
- ◯ No

44. In the table below we hope to learn more about your state's policies related to professional training on developmentally-appropriate practices for maltreated infants and toddlers. Please indicate whether training on developmentally-appropriate practices for maltreated infants and toddlers is "offered" or "required" for the each of the various groups listed in the rows.

	Training offered	Training required	Training is neither offered nor required for these individuals
Front-line child welfare staff (e.g., caseworkers) – only for those assigned to infant/toddler cases	◯	◯	◯
Front-line child welfare staff (e.g., caseworkers) – regardless of the age of children on their caseload	◯	◯	◯
Child welfare supervisors	◯	◯	◯
Child welfare administrators	◯	◯	◯
Other child welfare agency staff	◯	◯	◯
Foster parents	◯	◯	◯
Kinship care providers	◯	◯	◯
Adoptive parents/kinship guardians	◯	◯	◯
Attorneys, judges, and other court staff	◯	◯	◯
Early care and education providers	◯	◯	◯
Part C (Early Intervention Program) providers	◯	◯	◯
Home visiting providers	◯	◯	◯
Health care providers (including pediatricians, occupational therapists, etc)	◯	◯	◯
Mental health providers	◯	◯	◯
Other *(please specify):*	◯	◯	◯

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45. **What does your state's training for child welfare staff, supervisors, and related personnel around maltreated infants and toddlers comprise (e.g., infant/toddler development, recognizing developmental delays, cultural competence, supporting families, trauma-informed)?** *(Please briefly describe)*

V. Data Collection and Analyses

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

	Data currently collected state-wide	Data currently collected only in certain areas of the state	Data <u>not</u> currently collected
Characteristics of infants and toddlers who have experienced abuse and/or neglect, such as age, sex, race/ ethnicity, maltreatment type experienced	◯	◯	◯
Characteristics of infants and toddlers entering foster care, such as time in care, episodes in care, placement settings, siblings in care, reason for entering care	◯	◯	◯
Frequency of contact between infants and toddlers in foster care and **<u>their parents</u>** (including face-to-face visits, phone calls, overnight or weekend visits)	◯	◯	◯
Frequency of contact between infants and toddlers in foster care and **<u>their siblings</u>** (including face-to-face visits, phone calls, overnight or weekend visits)	◯	◯	◯
Frequency of **<u>case reviews/ administrative reviews</u>** for infants and toddlers in foster care	◯	◯	◯
Frequency of **<u>permanency hearings</u>** for infants and toddlers in foster care	◯	◯	◯
<u>Services referred</u> for infants and toddlers who have experienced abuse and/or neglect	◯	◯	◯
<u>Services received</u> by infants and toddlers who have experienced abuse and/or neglect	◯	◯	◯
Infants and toddlers referred to Part C, including how many are eligible and how many receive services	◯	◯	◯
Training (type, frequency) for professionals and caregivers involved with maltreated infants and toddlers	◯	◯	◯
Permanent placements of infants and toddlers from foster care by race, sex, and age (including reunifications with parents, relative guardianships, adoption)	◯	◯	◯
Infants and toddlers who have a chronic, on-going illness (e.g., asthma, diabetes, sickle cell anemia)	◯	◯	◯

Infants and toddlers who have a developmental disability (e.g., autism, cerebral palsy)	◯	◯	◯
Infants and toddlers who have a physical disability	◯	◯	◯
Other data specific to maltreated infants and toddlers (*please specify*):	◯	◯	◯

46a. Does your state analyze disaggregated data within the maltreated infant and toddler population for any of the items you selected above (e.g., isolating 0-1 yr olds, certain racial/ethnic groups within the population, or certain jurisdictions in the state)?

◯ Yes, for all of the items selected above

◯ Yes, but only for some of the items selected above *(please indicate which items in the box below)*

◯ No

46a1. If yes, can you provide an example of the disaggregated data your state has analyzed?

VI. Additional Initiatives Targeting Maltreated Infants and Toddlers and their Families

47. Are there any other policies, programs, practices, or initiatives in your state <u>specifically addressing the needs of maltreated infants and toddlers and their families,</u> other than those reflected in the questions above, that you would like to share? If so, please briefly describe them in the box below.

Please also use this space to share any descriptions of policies, programs, practices, or initiatives targeting either specific age groups within the larger 0-3 group (e.g., a program specifically for 0-1 year olds), or a broader early childhood age group (e.g., a program for children 0-4, or specifically for 3-4 year olds).

THANK YOU FOR COMPLETING THE SURVEY!
Please email the completed survey to kdevooght@childtrends.org

----------END OF SURVEY----------

Appendix C: Summary of federal laws

The following federal laws are referenced throughout the survey:

- The Adoption Assistance and Child Welfare Act: requires case reviews for children in foster care at least every 6 months while the children are in out-of-home care.
- The Adoption and Safe Families Act: requires permanency hearings be held by the court at least once every 12 months as long as the child is in out-of-home care. In a permanency hearing, the court reviews whether the child should continue to be in foster care and what the child's permanent plans are, and also determines whether reasonable efforts are being made by the child welfare agency on the child's behalf to achieve this permanency plan.
- The Child Abuse Prevention and Treatment Act (CAPTA): requires states to define abuse and neglect. It also provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations, including Indian Tribes and Tribal organizations. Further, CAPTA requires that all children under age three with a substantiated case of abuse, neglect, or illegal drug exposure be screened for developmental delays and referred to the Part C early intervention agency. CAPTA calls on state early intervention and child welfare systems to establish coordinated procedures for the referral of substantiated cases of abused, neglected, or illegal drug-exposed infants and toddlers to Part C services.
- The Child and Family Services Improvement and Innovation Act: requires states describe in their state child welfare plans how they promote permanency for and address the developmental needs of young children in their care.
- The Fostering Connections to Success and Increasing Adoptions Act: requires states "within 30 days after the removal of a child from the custody of the parent" to "exercise due diligence to identify and provide notice to all adult grandparents and other adult relatives of the child."

Appendix D: Structure of state child welfare systems

Alabama	County administered, state supervised
Alaska	State administered
Arizona	State administered
Arkansas	State administered
California	County administered, state supervised
Colorado	County administered, state supervised
Delaware	State administered
District of Columbia	Other: City administered
Florida	State administered
Georgia	County administered, state supervised
Hawaii	State administered
Idaho	State administered
Illinois	State administered
Indiana	State administered
Iowa	State administered
Kansas	State administered
Kentucky	County administered, state supervised
Louisiana	State administered
Maryland	State administered
Massachusetts	State administered
Michigan	State administered
Minnesota	County administered, state supervised
Missouri	State administered
Nebraska	State administered
Nevada	While the Division oversees all child welfare services in Nevada, it performs direct services in 15 of the Rural counties in Nevada. The two urban counties of Washoe and Clark County perform their own child welfare services.
New Hampshire	State administered
New Jersey	State administered
New Mexico	State administered
New York	County administered, state supervised
North Carolina	County administered, state supervised
North Dakota	County administered, state supervised
Ohio	County administered, state supervised
Oklahoma	State administered
Oregon	State administered
Pennsylvania	County administered, state supervised
Rhode Island	State administered
South Carolina	State administered
South Dakota	State administered
Tennessee	State administered

Texas	State administered
Vermont	State administered
Virginia	County administered, state supervised
Washington	State administered
West Virginia	State administered
Wisconsin	County administered, state supervised
Wyoming	County administered, state supervised

Appendix E: Number of states offering post-permanency supports for infants and toddlers

	Post-reunification	Post-adoption	Post-guardianship	Varies by county
Health care services (e.g., pediatricians, dentist, occupational therapists)	**29**	**34**	**29**	**8**
Mental health services	**30**	**39**	**32**	**10**
Early learning and development programs (such as Early Head Start)	**33**	**35**	**34**	**9**
Part C early intervention services	**34**	**37**	**33**	**10**
Other	**1**	**3**	**3**	**1**