Improving Permanency Outcomes for Children and Families Impacted by Trauma and Serious Adversity: Lessons Learned from Infant-Toddler Court Teams
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Infant-Toddler Court Teams: Meeting the Needs of Young Children & Meeting Parents ‘Where They Are’

Tiffany Kell, JD
Maltreatment Rates by Age Group

INFANTS AND TODDLERS ARE THE LARGEST AGE GROUP OF MALTREATED CHILDREN

- < 3 years: 28.5%
- 3-5 years: 18.0%
- 6-8 years: 16.6%
- 9-11 years: 14.1%
- 12-14 years: 12.4%
- 15-17 years: 9.8%

Children Entering Foster Care, by Age

- < 3 years: 32.8%
- 3-5 years: 16.4%
- 6-8 years: 13.6%
- 9-11 years: 11.5%
- 12-14 years: 11.9%
- 15-17 years: 13.3%

INFANTS AND TODDLERS ARE THE LARGEST GROUP OF CHILDREN ENTERING FOSTER CARE.

Permanency within 12 months of Entry, by Age

- Babies under 1: 35%
- Ages 1-5: 42%
- Ages 6-12: 44%
- Ages 13-17: 53%

Infant-Toddler Court Teams

• Infant-toddler court teams provide developmentally and trauma-informed intensive support to adjudicated infants and toddlers (in foster care or at imminent risk of foster care) and their families.
• The goal is to ensure very young children and their families receive the support and services they need to ensure the child’s healthy development, strengthen the family, and achieve lasting permanency.
Infant-Toddler Court Teams across the US

*Sites actively supported by the ZERO TO THREE National Infant-Toddler Court Program Training & Technical Assistance Center
The Safe Babies Court Team™ Approach: Core Components

Judicial Leadership

Local Community Coordinator

Active Court Team focused on the Big Picture

Valuing Birth Parents

Placement and Concurrent Planning

The Foster Parent Intervention, Mentors and Extended Family

Post-Removal Conferences & Family Team Meetings

Frequent/Quality Family Time (Parent-Child, Sibling Visitation)

Continuum of Mental Health Services

Data-Driven Decision Making
Fostering an atmosphere of mutual respect

Leading with parent strengths – empowering and engaging parents

Building rapport and trust in a trauma-informed way

Collaboration, problem-solving, and out-of-court advocacy

Compassionate transparency
The Critical Attorney Role

Jami Hagemeier, JD
Supporting Parents Affected by SUDs

Jenifer Goldman Fraser, PhD, MPH
**Legislative Context: CARA/Plan of Safe Care**

- **CAPTA (2003, 2010):** A plan of safe care refers to policies and procedures relating to “infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder.”

- Comprehensive Addiction and Recovery Act of 2016 (went into effect July 22, 2016). Changes to Title V, Section 503 - “Infant Plan of Safe Care”:
  - **Removes** the term “illegal” in regard to substance abuse
  - **Requires** that the Plan of Safe Care address the needs of both the infant and the affected family or caregiver
  - **Specifies data to be reported by States:**
    - # of infants affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder
    - # infants for whom a plan of safe care was developed
    - # of infants for whom referrals were made for appropriate services – including services for the affected family or caregiver
A Plan of Safe Care is a guide developed by service providers and their clients to ensure mothers and other caregivers have the skills and resources necessary to care for infants who were substance exposed during their mother’s pregnancy. Each woman and infant’s needs vary. The service needs addressed in this Plan of Safe Care parallel the requirements set forth in the Substance Abuse Prevention and Treatment Block Grant (SAPT) for treating pregnant and parenting women who use substances.

To promote the best outcomes, a Plan of Safe Care (POSC) should include input from all service providers involved in the mother and infant’s care such as OB/GYNs, Doctors, Nurse Practitioners, Midwives, Opioid Treatment Programs, Behavioral Health Providers, Child Welfare Providers, Home Visitors, and Part C Early Intervention. The POSC should be shared with each provider and, together, they should determine which provider will assume responsibility for managing and monitoring the plan with the client. Depending upon the mother and infant’s needs and wishes, this could be the medical provider, behavioral health clinician, home visitor or the child welfare provider. Please be sure to indicate any services that were recommended but declined by the family.

MOTHER’S HEALTH CARE

<table>
<thead>
<tr>
<th>Mother’s Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Postpartum and Other Medical Care</td>
</tr>
<tr>
<td>Coverage for Mother’s Medical Care (e.g. FAMIS, Medicaid, private insurance, etc.)</td>
</tr>
<tr>
<td>Does Mother have a Delivery Plan that addresses location, transportation,</td>
</tr>
</tbody>
</table>

STATE OF DELAWARE
PLAN OF SAFE CARE
For Infants with Prenatal Substance Exposure and their Families

INTRODUCTION: This Plan of Safe Care (POSC) is being developed to ensure that necessary services and supports are in place for the mother, infant and family upon discharge from the birthing hospital. The POSC is developed by gathering information from the mother and her family, from the birthing hospital medical record and social worker notes, as well as input from community partners involved in supporting the mother and infant. The Family Assessment Form may be used as an information gathering tool to assist with the preparation of the POSC. A copy of this POSC will be shared with the identified “Plan Participants” in Section C of this document with the consent of the family within 48 hours after infant is discharged from the hospital.

A. FAMILY INFORMATION

INFANT

<table>
<thead>
<tr>
<th>Infants Name (as it appears on birth certificate)</th>
<th>DOB</th>
<th>Gender</th>
</tr>
</thead>
</table>

Birth Hospital:

PARENTS

<table>
<thead>
<tr>
<th>Parent</th>
<th>DOB</th>
</tr>
</thead>
</table>

Street Address: City: State: Zip:

Contact/Cell Number:

Mother’s Employer | Employee Contact Number |
|-----------------|------------------------|

Father’s Full Name | DOB |
|------------------|-----|

Street Address: City: State: Zip:

Contact/Cell Number:

Father’s Employer | Employee Contact Number |
For cases involving prenatally exposed infants, ask the child welfare caseworker:

- If there is a plan of safe care (POSC) for the child and mother, if not in the child welfare record
- If there is a POSC, who is managing and monitoring the plan with the client

If there is a POSC, review and consult with the provider responsible for managing and monitoring the plan to understand how the service array will meet the needs of the infant/mother, identify gaps, and advocate accordingly.

Parent attorneys should review the POSC with their client, to ensure that the service needs addressed in the plan are sufficient and appropriate.

Seek training to be current on effective approaches and treatment, particularly Medication-Assisted Treatment (MAT), for pregnant women and women with OUDs.

Share information about CARA and Plans of Safe Care with your colleagues to raise awareness and capacity to advocate effectively for infants prenatally exposed to substances and their family/caregivers.
Infant-Toddler Court Teams: Permanency Outcomes by ACEs/Risk

Jenifer Goldman Fraser, PhD, MPH
Adverse Childhood Experiences (ACEs)

**ABUSE**
- Physical
- Emotional
- Sexual

**NEGLECT**
- Physical
- Emotional

**HOUSEHOLD DYSFUNCTION**
- Mental Illness
- Incarcerated Relative
- Mother treated violently
- Substance Abuse
- Divorce

*Source: Centers for Disease Control and Prevention*
*Credit: Robert Wood Johnson Foundation*
ACEs Scores: General Population vs Parents of Young Children in CWS

ITCT Sites: Quality Improvement Center for Research-Based Infant-Toddler Court Teams 10 demonstration sites, funded by the Administration for Children and Families, Children’s Bureau (2014-2018)
Type of Permanency within 12 Months of Entry, by Parent ACE Score

Parental Rights Outcomes, by Parent ACE Score

Parent Risk Factors

Parental Rights Outcomes, by Parent Risk Factors

Risk score 0-3 | Risk score 4-5 | Risk score 6-8

PARENT RELINQUISHED RIGHTS
- 14.3
- 9.2
- 27.8

PARENTAL RIGHTS TERMINATED
- 3.6
- 35.6
- 18.1

PARENT RETAINED RIGHTS
- 82.1
- 55.2
- 54.2

Through the Eyes of a Parent: Case Illustration

Darneshia Bell, ITCT Senior TA Specialist
Discussion Activity
OBJECTIVE:

• To support parents by meeting them ‘where they are’ at the beginning of the case

THE INVITATION:

• **STEP 1:** Make a list of all you can do to make sure that you achieve the worst result imaginable with respect to your objective.

• **STEP 2:** Go down the list, item by item, and ask yourselves, “Is there anything that I am currently doing, that we are currently doing, in any way, shape, or form that resembles this activity or behavior/
  • BE BRUTALLY HONEST
  • MARK ALL THAT APPLY

Now go through all the items and **decide on a first step for each** that will help you stop what you know creates undesirable results.
Wrap-Up/Questions
EXECUTIVE SUMMARY

Each year, over 45 million children in the United States are affected by violence, crime, abuse, or psychological trauma. Trauma exposure can significantly interfere with the way children’s brains assess threat, which in turn can affect how they respond to stress. The negative impact of trauma exposure is particularly relevant for children and families in the child welfare system, as the majority of child welfare-involved clients have experienced multiple traumas, including abuse, neglect, and exposure to domestic violence. By understanding the impact of trauma on youth and families, and incorporating trauma-informed skills into legal advocacy, attorneys representing children or parents in child welfare cases can improve outcomes for their clients.

This document is intended to provide you with knowledge about the impact of trauma, practice tips for incorporating trauma-informed practices into legal representation, and resources to assist in the representation of clients with histories of trauma. Its intent is to guide you in your representation of clients, with the understanding that not all suggestions will be applicable or appropriate in all cases.

Trauma-informed legal practice can strengthen legal advocacy, improve attorney-client relationships, and ensure appropriate screening, in-depth assessment, and evidence-based treatment. In addition, awareness of secondary traumatic stress can improve prevention, identification, and self-care among legal professionals.

Below is a summary of tips that may assist you in incorporating trauma-informed skills and principles into your everyday practice. More detailed information about each of these tips can be found in the document that follows.
General Tips for Representing Clients in Child Welfare Cases

- Identify known or suspected trauma the client may have experienced.
- Consider the role trauma exposure may play in a client’s behaviors, including refusal to engage in treatment, missing court appearances or appointments, as well as exhibiting hostility, apathy, or defiance during court proceedings. These behaviors could be misinterpreted signs of an alarm reaction or trauma response.
- Provide structure, predictability, and opportunities for the client to exert control over decisions as appropriate.
- Provide adequate explanation to the client about his case, including your role as the attorney, a reasonable understanding of the purpose of court proceedings, and a realistic expectation of the potential outcome of court proceedings.
- Advocate for placement stability for children. When placement change is necessary, advocate for a planned transition that occurs gradually rather than abruptly.
- Advocate for visitation to begin immediately between child and parent, unless this poses a threat to the child’s physical or psychological safety or the child does not want visitation.
- Support visitation that is intentional, well-planned, and held in a neutral location away from where the trauma occurred. Make every effort to prepare the child for visitation.
- Encourage continuity of treatment after transitions and collaboration among professionals providing services for the client.
- Promote client resilience by leveraging existing social supports, advocating for client involvement in services and activities that increase a sense of mastery and competence, and making referrals for trauma-informed mental health treatment when appropriate.

Trauma Screening, Assessment, and Treatment

- Advocate for universal screening of trauma exposure and related symptoms.
- Provide universal in-depth assessment for those children and parents for whom a screening identifies a history of trauma.
- Make referrals or advocate for appropriate trauma treatment for clients affected by trauma exposure. Not all mental health providers are trained to provide evidence-based trauma treatment, so it is important to identify the type of treatment offered.
- Coordinate with a client’s existing therapist to ascertain information about trauma triggers, suggested steps for ameliorating trauma triggers, the treatment being provided, and any other relevant information, such as risk for self-harm.
**Attorney-Client Relationship**

- Consider issues of physical and psychological safety when advocating for clients and resist practices that may re-traumatize children and parents.

- Meet in a quiet space with minimal distractions and outside the presence of other parties who may contribute to the client feeling threatened.

- Provide adequate information about the attorney-client meeting, including the purpose of the meeting, expectations for the meeting, and length of the meeting.

- Provide a thorough explanation about the court process, including the purpose of each court hearing, the information that you will present in court, and potential questions that the judge or attorneys may ask of the client. Allow the client time to practice and role-play responses.

- Be alert for signs of a trauma reaction, which typically present as some variation of the fight, flight, or freeze response. These signs may include lashing out, shutting down or withdrawing, or regressive, defiant, or disrespectful behaviors.

- Try to avoid startling the client with loud noises, sudden movements, or unexpected news without adequate explanation or preparation.

- Minimize touching the client, which can trigger a reaction in individuals with histories of physical or sexual abuse.

- Avoid overpromising or telling the client that “everything will be fine.” Clients may be triggered by feeling let down or misled by their attorney.

**Secondary Traumatic Stress**

- Maintain work environments for staff that increase resilience and acknowledge, reduce, and treat vicarious or secondary traumatic stress.

- Identify and engage in self-care on an individual and organizational basis.
TRAUMA: What Child Welfare Attorneys Should Know

Defining Trauma-Informed Legal Advocacy

In 2014, more than 700,000 children in the United States were exposed to child maltreatment and more than 400,000 children were residing in foster care.1 Children in foster care are likely to have been exposed to multiple forms of trauma, such as physical or sexual abuse, neglect, family and/or community violence, trafficking or commercial sexual exploitation, bullying, or loss of loved ones.2 In addition to situations of abuse or neglect that lead to their removal from their homes, children in care may experience further stresses after entering the system. Separation from family, friends, and community is often referred to as system-induced trauma.

The majority of parents or caregivers involved in the child welfare system have also experienced trauma and many were maltreated or placed in foster care as children. Addressing trauma among families involved in child welfare is essential to stopping this cycle of maltreatment. Without proper intervention, the negative effects of childhood trauma may persist into adulthood, and can result in higher rates of psychiatric or medical illness, substance use, criminal offending, and early death.3

The Attorney General’s National Task Force on Children Exposed to Violence1 recommends that all professionals serving children exposed to violence and psychological trauma learn about and provide for trauma-informed care and trauma-focused services. Similarly, the American Bar Association has called for integrating trauma knowledge into daily legal practice and integrating and sustaining trauma awareness and skills in practice and policies.4

Trauma-informed systems are structured with an understanding of the causes and effects of traumatic experiences, and incorporate practices that support recovery.5 A system-wide approach requires involvement by all stakeholders working with children and their families, including caseworkers, attorneys for all parties, judges, service providers, birth parents, and caregivers such as foster parents and kinship caregivers.

By enhancing the ability to recognize the impact of trauma, respond appropriately, and avoid legal practices that may re-traumatize children or parents, trauma-informed legal representation can support recovery and enhance resilience, thus improving outcomes for children and families. Incorporating trauma-informed skills into legal practice can also improve attorney-client relationships, increase opportunities to advocate for appropriate services, and enhance prevention, recognition, and mitigation of secondary traumatic stress (STS; see Section Eight).

Trauma-informed legal representation may include:

1. Identifying all known and suspected trauma the client may have experienced
2. Understanding parent and caregiver trauma and its impact on the family
3. Considering the legal implications of routine screening for trauma exposure and related symptoms, particularly for parents and dual-system involved youth (see Glossary)
4. Making appropriate referrals for culturally sensitive, evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
5. Advocating for provision of resources (e.g., psychoeducational books, victim assistance information) about trauma exposure, its impact, and treatment for children, families, and stakeholders
6. Understanding and promoting resilience and protective factors for children and their families
7. Encouraging continuity of care and collaboration across child-serving systems
8. Maintaining work environments for staff that increase staff resilience and address, reduce, and treat vicarious or secondary traumatic stress
9. Considering issues of physical and psychological safety when advocating for clients and resisting practices that may re-traumatize children and parents
10. Maintaining awareness of one’s own behaviors, tone of voice, body language, and approach when engaging and questioning clients who may have a history of trauma
11. Taking steps to make clients more comfortable and to recognize when clients are having a trauma reaction
12. Engaging in continuing education about trauma to learn new and developing information that can benefit clients
These suggestions identify actions you can take to promote a trauma-informed response to your clients, with the understanding that the confines of professional conduct, including confidentiality and ethical considerations as well as strategic case planning, may affect one’s ability to act on these recommendations in individual cases. In addition, advocates should always clearly explain their role to child clients, whether they are representing the client’s expressed wishes as an attorney, best interest as guardian ad litem, or taking a hybrid approach.

By keeping these principles in mind, you can build more effective relationships with your clients to serve their legal interests, work to ensure necessary service needs are met, and support clients’ current and future well-being.

2 The Impact of Trauma Exposure on Child Development

Approximately 80 to 90 percent of youth involved in the child welfare system have experienced at least one traumatic event. Trauma may result from either direct experiences, such as being neglected or abused, or witnessed experiences including domestic violence between caregivers. Children may also be traumatized by hearing about something that happened to their parent or caregiver (e.g., serious injury, incarceration).

Traumatic experiences early in life may alter how the brain assesses threat and how clients respond to stress. A fight or flight response may be “triggered” by anything that reminds a client of past traumatic events, causing a perception of immediate danger. A triggered youth or adult may engage in aggressive or avoidant behaviors in an effort to feel safe; behave defiantly or aggressively to keep others at a distance; or attempt to escape the situation. Common responses include running away from home or school; avoiding attorneys or court hearings perceived as threatening; shutting down; or “spacing out.”

There are a range of potential reactions to traumatic events. Most trauma survivors, including youth in the juvenile justice system or parents accused of maltreatment, will recover from their experiences and thus should not be viewed as “damaged” or beyond help. Trauma’s impact on the brain and normal child development can be reversed with appropriate treatment and other supports (see Section Six). Recovery is related to resilience; and attorneys can promote clients’ resilience in a number of ways, listed below.

PRACTICE TIPS: PROMOTING CLIENT RESILIENCE

Leverage existing social supports – immediate and extended family, fictive kin (see Glossary Terms, page X), community and religious leaders, school staff, coaches, etc.

Advocate for clients’ involvement in services or activities that increase their sense of mastery or competence, such as parenting classes/training for caregivers, or afterschool activities for children and youth.

Support clients in developing effective coping skills by referring them to trauma-informed treatment as indicated, and helping them cope with potentially distressing court proceedings or transitions by adequately explaining them in advance.

While many youth and adults who experience trauma are able to work through subsequent challenges without professional intervention, some will develop symptoms of Posttraumatic Stress Disorder, or PTSD (see Glossary Terms, page 6, for definition). PTSD increases the risk for negative outcomes across the lifespan, including academic challenges and peer problems in childhood and criminal justice involvement in adolescence and adulthood. (See Appendix, Section Two, for additional resources on how trauma may affect clients in different age groups.) Some clients may experience partial symptoms of PTSD or develop other disorders such as substance use, depression, or anxiety.

Many trauma survivors will not meet criteria for a PTSD diagnosis but will experience significant trauma-related impairment in daily living. Youth or adults with more chronic or pervasive exposure to traumatic events, termed complex trauma, may suffer additional challenges that are not captured by the PTSD diagnosis (see Glossary Terms). Whenever possible, clients should be screened. If a trauma screen reveals trauma exposure, a further in-depth assessment for trauma exposure and related symptoms to determine the impact of their traumatic experiences and need for appropriate treatment is warranted (see Section Five).
Approximately 90 percent of parents or caregivers involved in the child welfare system have histories of trauma exposure, including high rates of childhood abuse and neglect, and a significant number were involved in the system as children. Additionally, families may be affected by historical trauma resulting from societal racism and oppression towards ethnic minorities, particularly African-American, Native American, and immigrant communities. The impact of these traumatic experiences on both caregivers and their children can be inadvertently intensified by institutional practices within systems such as child welfare or juvenile justice.

Exposure to trauma does not always determine adverse outcomes for parents and their children. However, for some parents, prior trauma exposure may negatively impact the manner in which they interact with their children, thereby placing children at higher risk for traumatic stress. This is also known as intergenerational trauma. For example, parents with histories of repeated exposure to violence may have greater difficulty recognizing the adverse effects of violence exposure for children. Untreated PTSD can also interfere with a parent’s ability to use safe and effective parenting strategies and protect their children from abuse by others. In turn, without effective intervention, children exposed to neglect or abuse are significantly more likely to perpetrate violence against dating partners, enter into abusive relationships in adolescence and adulthood, and perpetrate abuse of their own children when they become parents. Consequently, addressing traumatic stress within families in the child welfare system is essential for reducing rates of child maltreatment and interrupting the intergenerational transmission of trauma. Further, recognition of these risks can position attorneys to recommend resources to clients that lessen the impact of risks and bolster clients’ resiliency.

**Trauma can affect a parent’s approach to discipline and child-rearing.**

Parents with trauma histories who abuse or neglect their children may view their parenting behavior as normal, and may not understand that there are alternative ways of interacting with their children. Additionally, a traumatized parent may be hypervigilant or overly focused on identifying potential threats to his or her child. Hypervigilant parents may react harshly to child misbehavior because they fear consequences or reactions from others if their children continue to misbehave. Parents with trauma histories may also place extreme restrictions on their children, such as requiring them to spend all free time at home to avoid potential danger. Trauma can also deplete a parent’s psychological and physical energy as well as the financial and social resources necessary to accomplish parenting tasks.

After a client-centered decision-making process that includes legal counseling of the client, parent attorneys can advocate for participation in trauma-informed parenting workshops and treatment (see Section Six). Since reunifi-
ocation is the ultimate goal in most child welfare cases, and most children in the child welfare system reunify with their biological families\(^\text{17}\), it is essential that parents and caregivers receive needed trauma-informed services in order to begin the healing process and improve their capacity to provide safe and stable home environments.

**Trauma can affect parental reactions to court proceedings and an attorney’s working relationship with the parent.**

For parents or caregivers with histories of trauma, child welfare proceedings may present particular challenges that can significantly interfere with their ability to effectively manage court proceedings and relationships with court and child welfare professionals. Parents who have experienced trauma may exhibit difficult behaviors such as angry outbursts, lateness, refusal to return phone calls, and missed appointments or court appearances. One study of child welfare-involved mothers also found that those who had previous involvement with the system as children were significantly less engaged with services provided through child welfare agencies.\(^\text{18}\) These behaviors may be interpreted as hostility or apathy, but may in fact be symptoms of traumatic stress. Traumatic stress pushes the brain into a hypervigilant mode that may cause individuals to be highly sensitive to power differentials, perceived attacks, and a perceived loss of control. This may result in a parent’s distrust of, and irritability toward, those who appear more powerful and in control, such as attorneys, judges, and child welfare caseworkers.\(^\text{a}\) In such cases, parents may need additional support to help them understand those reactions, and the impact of those reactions on the overall case. Lifelong traumas may also teach ineffective ways to assert power in the world. It is understandable for parents to exhibit distrust of a system that may have been unhelpful, even harmful, in the past, especially if they have lived in poverty and have dealt with structural racism in the very systems designed to help them. Understanding these reactions can help you develop a more effective attorney-client relationship.

\(^{a}\)Traumatic stress may decrease a parent’s ability to perceive the world accurately, process information, remain organized due to executive function deficits, and increase risk of substance use. In turn, this may contribute to an increased risk of maltreating their children.
The Impact of Trauma on the Attorney-Client Relationship

Trauma can interfere with the formation of strong client-attorney relationships by impairing the client’s capacity to trust others, process information, communicate, and respond to stressful situations. Understanding trauma’s impact on behavior can help you modify your approach with traumatized clients, prepare clients for court proceedings in a way that reduces their likelihood of a traumatic response, and advocate for clients in a way that empowers them and helps build a sense of safety and resiliency. With adequate preparation, clients may feel empowered by the opportunity to tell their stories and receive empathy and effective support from the professionals involved.

To establish an effective working relationship with traumatized clients, you should focus on physical and psychological safety, communication, and client support.

**Physical and psychological safety:**

When a client is reminded, either consciously or unconsciously, of a past trauma, that trigger may cause the client to feel as if she is in imminent danger. When traumatized clients feel physically or psychologically unsafe, they may become focused on protecting themselves and avoiding the perceived danger. As a result, they may not listen to or process information accurately, may refuse to talk, or simply agree to anything in order to leave. You can assist your client and establish a safe environment by providing structure and predictability, allowing the client to make informed decisions about his or her case whenever possible.

Court hearings and other procedures in the child welfare system may inadvertently trigger or re-traumatize clients with trauma histories. For example, clients are frequently triggered by a perceived loss of control or power, such as court decisions made about placement or visitation. Therefore, you should give clients a clear voice in decisions related to their representation, elicit their views, and seek active, age-appropriate involvement.

When triggered, clients may react in ways that are misinterpreted by the court. For example, a child may withdraw emotionally or physically *(often described as freezing or shutting down)* in response to questions about desire for contact with a parent. Or, a parent with a trauma history may shut down or react defiantly during cross-examination. A child placed in foster care, particularly an adolescent, may run away or act out in response to conflict with a foster parent or group home staff member. Judges, attorneys, and other professionals may view such a client as uncooperative or disinterested rather than as someone who is having a trauma response. You can advocate for clients by explaining to the court and the other parties that the client’s behavior is a reflection of underlying trauma. Decisions regarding such disclosures should be case-specific and within the bounds of attorney-client privilege and your specific attorney role.

Some suggestions for increasing physical and psychological safety include:

- Meet in a quiet space where there are minimal distractions, away from other parties who may make your client feel threatened.
- Inform the client of the purpose of that day’s meeting, what to expect during the meeting, and how long the meeting will last. Several shorter meetings can build familiarity and be more productive than a single, longer meeting. Make sure to ask what questions the client may have.
- Explain the court process. Let the client know what you are going to say in court, questions you may ask the client, and questions the judge or opposing attorney may ask (particularly when you anticipate an adversarial cross-examination). Knowing what to expect can help your client feel less anxious during a hearing. Allowing the client time to practice responding and role-playing can increase a sense of control and safety.

As part of explaining the court process to child clients, it is also important to provide a realistic understanding of the potential outcomes of a court hearing. It can be empowering for child clients to know that their attorney is listening to them and will express their wishes in court, but it is also important for them to be prepared for the possibility that those wishes may or may not be granted or taken into consideration.
Additionally, when child clients are not present for court hearings, it can be triggering for them to know there was a court date but not be informed about what happened at that hearing. Children and youth should attend their own hearings whenever possible. When their presence is not possible, it is important to provide information about what happened or some type of update in an age-appropriate manner.

**Communication:**
Clients who have experienced trauma may experience greater difficulty forming trusting relationships with their attorneys. Many youth in the child welfare system have been hurt by a caretaker or authority figure they trusted, and many parents distrust “the system.” Such clients may not believe that you will actually advocate for them. Clients also may be slow to share emotionally-charged information, or may not feel safe expressing preferences regarding their desired outcomes, such as visitation or placement. Developing an effective attorney-client relationship takes time and patience.

You can learn to recognize signs that a client may be experiencing a trauma reaction so that you do not misinterpret or exacerbate the client’s response. Trauma reactions typically represent some version of fight, flight, or freeze. A client who suddenly becomes loud or combative may be going into “fight mode” in order to keep herself safe by pushing others away. Clients may go into “flight mode” and try to avoid a triggering situation by refusing to answer sensitive questions or attempting to leave a meeting or court hearing. Clients may also “freeze” by shutting down or dissociating *(a common response to trauma when a person mentally shuts down or “goes elsewhere”)*. She may sit quietly but will no longer be paying attention. Do not assume that silence means the client understands or consents. *(Appendix Section Four includes information about identifying signs of trauma reactions in clients.)*

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**PRACTICE TIPS TO AVOID TRIGGERING CLIENTS WITH PRIOR TRAUMA**

*Look for signs of trauma reactions.* As discussed in this section, clients may exhibit variations of the fight, flight, or freeze response.

*Try not to startle the client.* Loud noises *(including yelling)*, sudden movements *(jumping up from a chair)*, or unexpected news can all trigger trauma responses.

*Prepare the client for what is ahead.* Predictability is important to establishing a trusting relationship. Preparation can help minimize your client’s hypervigilance to threats from unfamiliar or unexpected sources.

*Minimize touching the client.* You may intend to be supportive when you put your arm around a child or touch a parent’s shoulder, but that can trigger a reaction in people who have been physically or sexually abused. By respecting your client’s personal space, you can help build the client’s sense of control and safety.

*Do not overpromise or tell the client “everything will be fine.”* This includes promising clients you will always be there for them. Attorneys frequently change. Be honest in your communications because clients may be triggered by feeling let down or misled by their attorney. Remember that clients’ behaviors may also be influenced by the expectation that you will inevitably disappoint them, so be honest and forthright from the start.

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*A Child participation in the court process is considered a best practice by national organizations such as the American Bar Association, National Council of Juvenile and Family Court Judges, and National Association of Counsel for Children. A study in Nebraska found that children’s anxiety levels related to court participation were low overall and even lower for children who had attended court. The children who attended court also viewed the judgments as more fair. A recent New Jersey study showed that court participation is not upsetting for youth, but can provide an opportunity for them to be heard. It also provides better information to both the youth and the court.*

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9
**Client support:**
Parents and children who are involved in the child welfare system may still have strong attachments to and pleasant memories of family members. In fact, a child can remain emotionally attached to a dysfunctional family and may be further traumatized by complete loss of contact with relatives. Family members can offer the best source of long-term support for a traumatized child. It is essential that a child stay connected with siblings, relatives and extended family (as defined by the client), and friends. In cases in which ongoing family contact is not feasible or is contraindicated for safety reasons, you can look for ways to involve other people trusted by your client, such as a family friend, coach, teacher, or pastor.

Finally, you should be aware that some clients may find the experience of court involvement traumatizing, whether from memories of past involvement, interactions with or observations of others in the courthouse, and especially the intensity of the courtroom environment itself. Trauma triggers might include an attorney’s behaviors, tone of voice, body language or approach to questioning. You can take steps to make your clients more comfortable and to recognize when clients are having a trauma reaction.

### POSSIBLE SIGNS THAT YOUR CLIENT HAS BEEN “TRIGGERED”

- Lashes out verbally or physically
- Becomes defiant, disrespectful *(fight response meant to keep potential threats at a distance)*
- Has difficulty tracking the attorney’s questions
- Shuts down, stops talking
- Becomes jumpy, fidgety, starts pacing
- Has sudden, dramatic shifts in mood
- Looks spaced out, gets lost in conversation, or appears to have “gone somewhere else”
- Speech grows louder, faster
- Suddenly tries to leave situation *(flight response)*
- Adopts regressive behaviors *(thumb sucking, rocking)*

**Client Resiliency:**
It should be noted that despite trauma histories and traumatic stress reactions, clients are often resilient. Your actions during the course of legal proceedings can further bolster resiliency. Whether through advocacy for treatment *(Section Six: Effective Treatments for Traumatic Stress)* or facilitating a client-attorney relationship that conveys awareness of traumatic stress reactions, promoting a psychologically safe environment using the above strategies can support your clients’ improved management of traumatic stress reactions.
Clients involved in child welfare proceedings should be routinely screened for exposure to trauma and related mental health conditions in order to determine their need for therapy and other services. In this section we distinguish between screening, assessment, and neuropsychological evaluations.

**Screening** refers to a brief set of questions administered to children, parents or caregivers to identify clients who likely suffer from trauma-related impairment. Screening can be conducted by attorneys using validated assessment instruments. Any client who screens positive for likely trauma exposure or symptoms can be referred to a qualified mental health professional for a full assessment. Various trauma-informed screening instruments and questionnaires are available for use (see NCTSN Measures Review Database).

A **trauma-informed mental health assessment** refers to a comprehensive evaluation conducted by a trained mental health provider such as a social worker, psychologist, or psychiatrist. The goal is to determine if the client is suffering from traumatic stress or other mental health problems and to generate recommendations for treatment or other social services. The provider conducting the assessment gathers information on trauma experiences or symptoms along with other mental health symptoms, medical issues, academic and employment history, and family dynamics, as well as strengths exhibited by the child, parent, family, and community. A thorough assessment should include information from several sources, including clinical interviews with the child, caregivers, and collateral informants; review of client records (school, medical, and mental health treatment); and behavioral observations.

**Neuropsychological evaluation** (also referred to as cognitive evaluation) is used to assess a child’s current level of intellectual and academic functioning. Such evaluations may be warranted for clients who are experiencing significant academic or vocational problems or are suspected of having undiagnosed learning disorders or developmental delays. The latter are quite common among children with prior trauma exposure. You may need to make the case that such an assessment is required by reasonable efforts and request that the court order the assessment and approve payment by the child welfare agency.

Integrating trauma screening and assessment findings into court reports is a key element of a trauma-informed child welfare court system. Including these findings will assist the court to understand the impact of trauma on the child and parent, develop plans that support their resilience, and avoid decisions that may re-traumatize the child and parent. Screenings, assessments, and evaluations may need to be court-ordered. Depending on local law, the results are generally made available to all parties or may be obtained by one party or the other for use as an advocacy tool.
PRACTICE TIPS: CONSIDERATIONS FOR TRAUMA SCREENING AND ASSESSMENT

A trauma assessment is very different from a mental health assessment conducted as part of a custody evaluation. The former is not designed to provide recommendations regarding placement and visitation within the child welfare context.

Although it is recommended that you advocate for trauma-informed assessments of clients who screen positive for trauma exposure or symptoms, this may not always be possible within the confines of your particular role. Parents’ attorneys in particular may resist trauma assessments if the parent client is not amenable to an assessment or if the attorney has concern that the parent may be viewed by courts as too “damaged” to be rehabilitated. In this case, one option is to consider whether this concern is outweighed by the potential benefits. Trauma screening and assessment will help ensure that parents with traumatic stress receive appropriate services to help facilitate their healing and address mental health issues that potentially impact their legal cases. While it is ultimately the client’s decision, parents’ attorneys can also engage in client-centered counseling to present both the potential benefits and potential risks of a trauma-informed assessment.

You should be aware of potential legal consequences related to information shared during court-ordered assessments. For example, an accused parent may report information on trauma history that could be used against him in court proceedings. Likewise, acknowledgment of living with an abusive spouse could be used as evidence that the parent is providing an unfit home environment for the child.

Whenever possible, each child and parent involved in child welfare proceedings should be screened for traumatic events and related symptoms as long as the jurisdiction has sufficient legal protections to ensure the information will not be used in ways that will further harm the youth or family.

Not all mental health agencies routinely ask about trauma exposure or symptoms during their assessments. You should make efforts to ensure that the child welfare agency arranges for trauma-informed assessments.

Effective Treatments for Traumatic Stress

Even severely traumatized youth and adults can recover from trauma with the right supports, including effective mental health treatment. The terms trauma-informed or trauma-focused treatment refer to mental health interventions designed to help people recover from traumatic stress. There are evidence-based trauma-informed or -focused interventions for every age group, ranging from infants to adults (see NCTSN Empirically Supported Treatments and Promising Practices).21

There are individual treatments for a traumatized child or parent as well as treatments designed for the parent and child to work together. Trauma-focused treatments can support client resilience by helping the client develop effective coping and problem-solving skills, build on strengths, reduce trauma-related symptoms, and improve social, academic, and developmental functioning. Trauma-informed treatment has been shown to improve mental health and behavioral outcomes among children and parents and to reduce the likelihood of future abuse or neglect.22, 23

Whenever a client undergoes a comprehensive assessment (see Section Five) and is found to suffer from trauma-related impairment, you should advocate for trauma-informed treatment. A core principle of trauma-informed practice is to provide clients with a sense of control over the process. Thus, you should ask about and advocate for client preferences about treatment modality (e.g., individual, family, or group treatment) and therapist gender. Regarding the latter, some youth have an aversion to or may be triggered by a clinician of the same gender as their abuser.
Not all treatments are trauma-informed, including many of the treatments commonly recommended in family courts, such as parenting groups, substance abuse treatment, or anger management. Clients with traumatic stress are less likely to benefit from such interventions and more likely to end treatment prematurely. A negative treatment outcome may be used against the client (particularly a parent) as evidence he is unwilling or too damaged to change behaviors. Therefore, you should advocate that your clients are referred to trauma-informed treatment when indicated.

Many mental health providers have not been trained in trauma-informed treatment. In order to identify trained providers, you can search through relevant online directories. You can also interview prospective treatment providers to determine whether they offer trauma-informed treatment (see Appendix Section Six).

## CORE ELEMENTS OF TRAUMA-INFORMED/FOCUSED TREATMENT

- Educating clients regarding trauma and its impact
- Increasing client sense of physical & psychological safety
- Identifying triggers for trauma reactions
- Developing emotional regulation skills (i.e., skills to help control and express strong feelings)
- Developing trauma-informed parenting skills
- Addressing grief and loss (when appropriate)
- Processing traumatic memories

### Placement Decisions, Transitions, and Visitation

The child welfare court system has historically focused on physical safety. More recently, however, there has been increased attention on ensuring psychological safety for children and families. Psychological safety is the ability to feel safe within one’s self as well as safe from external harm. The inability to feel safe can impact an individual’s interactions with others, can lead to a variety of maladaptive coping strategies, and can result in anxiety.

Removing a child from a home where there is neglect or abuse may improve his or her physical safety, but at the same time may impair the sense of psychological safety for both the child and the parents. Research shows that frequent placement changes are associated with poor outcomes for children involved in the child welfare system. You may not have the power to alleviate your clients’ distress, but you can minimize trauma caused to families involved in the child welfare system and improve their sense of safety by becoming an advocate for them during the following critical junctures:

**Placement Decisions:**
In jurisdictions with client-directed representation, you should advocate for a child client’s stated interests. Giving a child a voice in the proceedings will help the child feel that she has some control in a process that can otherwise be overwhelming and even traumatic. Attorneys advocating for the child’s best interest should also consider the child’s wishes in making the best-interest determination. You should first consider whether the child can safely remain in the home with any needed supports to minimize disruptions. When children must be removed from their homes, you should advocate that they be placed with a relative who is willing and able to provide a physically and psychologically safe home environment.
You should seek the input of your client, whether this is a child or parent, regarding relatives who may be able to provide a safe home for the child. You should also advocate for siblings to be placed together except in cases of suspected sibling abuse or other safety concerns. Research shows that youth who are initially placed in kinship foster care and with all their siblings are significantly more likely to achieve stable placement and exit the system.26

In cases when an out-of-home placement is unavoidable, you should consider advocating for a placement close to the child’s home community. This will allow the child to maintain connections with his or her support systems including extended family, church, school, teachers, mentors, and coaches. When a child is placed outside his community, you should advocate that he remain in the same school, unless it is in his best interest to move to a new school. This can also provide the stability, continuity, and connections with adults that are needed. One positive relationship with an adult can make all the difference for a child! Having a stable, nurturing relationship with an adult can facilitate tremendous healing and develop resilience for a child who has experienced trauma.

Transitions:
You can help with transitions through thoughtful and planned decisions regarding placements, visitation, and reunification.
You can:

- Advocate for a minimal number of moves and placement changes
- Assess the appropriateness of any placement based on the child’s emotional, social, developmental, and medical needs
- Advocate for allowing both the child and caregiver time to prepare for visits with a parent
- Request time to say goodbye to a foster family by planning for reunification or a placement change in advance.

Visitation:
Children involved in the child welfare system often strongly voice a desire for contact with their parent(s), even in cases when the parent was abusive or neglectful. Thus, attorneys representing children or parents should advocate for visitation to begin as soon as possible except when it threatens the physical or psychological safety of the child or the child expressly does not want visitation with a parent.

Visitation should be intentional and well planned. It should be held in a neutral location away from any environment where a child may have experienced trauma. When appropriate, encourage and facilitate positive relationships and communication between birth parents and caregivers about the child’s routines, habits, triggers, and coping skills. (See Appendix Section Seven: “Working with Parents Involved in the Child Welfare System – Visitation.”)

Visits may trigger trauma reactions, so you can prepare your client (child or parent) in advance. It may be beneficial to communicate with the client’s therapist to understand potential reactions to visits or when considering advocating for a change in visitation. Ask child clients how they feel about visits and try to determine what might trigger them (sights, sounds, smells, places, voices, etc.). You should communicate with the therapist regarding a client’s reactions to visits before requesting changes in visitation. You can also encourage parent clients to use visits as an opportunity to practice certain skills and demonstrate their ability to parent safely.
Secondary Traumatic Stress and Attorneys

The terms vicarious trauma or secondary traumatic stress (STS) describe the negative physical and psychological health consequences resulting from repeated exposure to the stories and experiences of traumatized clients. Attorneys handling child welfare cases are at high risk for developing secondary traumatic stress reactions due to frequent exposure to trauma survivors and their stories of maltreatment. Furthermore, research suggests that a substantial number of attorneys, particularly attorneys practicing specialties such as criminal law and family law, will be threatened with violence at least once in their careers. One study of public defenders found that 34 percent of attorneys reported symptoms of STS while 11 percent met criteria for a diagnosis of PTSD.

STS reactions range from decreased empathy towards clients and changes in a sense of personal safety to the onset of PTSD symptoms (see Section Two). STS can lead to impairment in your mental or physical health, job performance, and personal relationships. Those affected by STS may engage in risky or unhealthy behaviors to cope with STS. These behaviors may include increased substance use, experiencing feelings of estrangement from loved ones, or being overly focused on protecting one’s own children from danger.

Risk Factors for Secondary Traumatic Stress:
Both individual and job-related or organizational factors may increase your risk for developing STS. Individual factors include a prior history of trauma exposure, such as attorneys who were themselves abused as children, and unhealthy strategies for coping with distress. Job and organizational factors that influence risk for STS include the number of trauma survivors in your caseload, level of coworker and supervisor support, and education and training about STS. In a study on the incidence of STS among attorneys, participants attributed their traumatic stress reactions to a lack of education about understanding clients with trauma histories and the absence of a regular forum for discussing the stress of working with such clients.

Preventing Secondary Traumatic Stress:
There are several strategies that individual attorneys and agencies can adopt to help prevent STS. Training on working with trauma survivors has been shown to increase empathy and confidence in working with this population among mental health providers. Recommended areas of focus for training with attorneys include:

- Understanding the impact of trauma on children and adults
- Acquiring skills for working with trauma survivors
- Recognizing the signs and risks for secondary trauma and
- Practicing stress reduction and management skills such as mindfulness techniques

Formal supervision and peer support groups can also help prevent STS by providing support and a forum for discussing the challenges of working with trauma survivors. Agencies should also offer employee assistance programs or referrals to outside mental health providers for attorneys who develop symptoms of STS.
**STRATEGIES FOR SELF-CARE**

- Exercise regularly and maintain a consistent sleep schedule
- Eat healthy food and reward yourself with your favorite food occasionally
- Build breaks into your schedule—even if just a few minutes
- Connect daily with others who recharge your emotional state
- Practice mindful activities that can include meditation, yoga, or spiritual practices
- Set and maintain boundaries with clients: clarify that your role as attorney differs from those of social workers, case managers, or other service providers
- Reduce your caseload or diversify your practice, if possible
- Monitor your risk for STS by periodically completing a STS self-assessment tool such as the ProQOL or the Secondary Traumatic Stress Scale (see Appendix Section Eight for links)
- Connect clients with appropriate service providers—use a team approach for clients who have experienced trauma and need a high level of support
- Create a go-to list of local resources for clients
- Access state bar legal assistance programs or confidential support services when available or seek counseling services as needed

**SIGNS OF VICARIOUS OR SECONDARY TRAUMATIC STRESS**

- Disruption in perceptions of safety, trust, and independence
- Sleeping difficulties or nightmares
- Exhaustion
- Alcohol or drug use to self-medicate
- Anger or cynicism towards “the system”
- Difficulty controlling emotions
- Hyper-sensitivity to danger
- Increased fear and anxiety
- Intrusive thoughts or images of client trauma stories
- Social withdrawal
- Minimizing the impact of trauma
- Illness, increase in sick days at work
- Diminished self-care and depletion of personal resources
- Reduced sense of self-efficacy
POTENTIAL IMPACT OF SECONDARY TRAUMATIC STRESS ON JOB PERFORMANCE

- Reduced empathy towards clients
- Inability to listen to, or active avoidance of, clients
- Over-identification with clients, or conversely, shutting down emotionally (both responses interfere with effective legal representation)
- Distancing oneself from exposure to key aspects of a client’s history and ongoing trauma, thereby potentially missing events with high probative value in litigation
- Overreaction by displaying hypervigilance through angry outbursts in court, or unduly questioning the credibility of witnesses when emotional legal issues become triggers
- Excessive anger or irritability, as a result of STS, may be masked as zealous advocacy in a trial setting, but may in fact be damaging to the attorney and client.
- Compromised quality of legal service due to emotional depletion or cognitive effects of STS. Some traumatized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies indicate that the development of secondary traumatic stress often predicts that a helping professional will eventually leave the field for another type of work.

The Importance of Collaboration

Collaboration and coordination among service providers and systems comprise a key principle of trauma-informed practice. Therefore, it is important for attorneys and other providers working on a case to both collect and share information to support their clients as appropriate within legal and ethical confines. Benefits of information-sharing include:

- Preventing clients from having to repeat their trauma histories to multiple agencies or providers
- Ensuring that all involved parties understand trauma’s impact on the client and tailor their services accordingly
- Increased ability to make sense of the client’s behaviors or difficulties

The following section lists the roles played by professionals most often involved in child welfare cases, their scope of practice, and recommendations regarding how to work with each.

Children’s Attorneys and Guardians ad Litem:
Many children do not immediately disclose traumatic events, like sexual abuse. Such children are frequently misdiagnosed, based on their behavior, with emotional disturbance, oppositional defiance, bipolar disorder, attention deficit hyperactivity disorder (ADHD) or other physical or developmental disabilities. Children may not understand why they engage in these behaviors, and may be afraid to tell the truth because it would require disclosure of the trauma. Collaboration with other parties is key to determining whether another assessment might be warranted. Foster parents and other caregivers often have a wealth of information that can be helpful. Has the child experienced known or suspected abuse or other trauma? If the child is engaging in conduct at home, could that conduct be caused by neurological responses to trauma? Unprovoked anger may be a manifestation of the fight response; running out of school or from home, the flight response; and tuning out, the freeze response. Sleep disturbances (losing sleep at night, and sleeping during the day), inability to focus, and depression may all be caused by trauma. Are there situations that trigger these behaviors? Does the child engage in self-harm, or appear depressed? What helps the child calm down? Conducting a thorough and independent investigation by collecting information from others can help you better understand the child’s situation.
Sharing information (as allowed under ethics rules and privacy statutes) with parent attorneys, the treating therapist, school personnel, and court staff may benefit the child as well.

**Parent Attorneys:**
Parents may also have information that can help. However, there are important considerations related to confidentiality and other barriers that a parent attorney must consider. When it can benefit the parent and facilitate help for the child, a parent’s attorney can encourage the parent to consider sharing this information. Parent attorneys can also ask their clients about how trauma may affect their parenting ability and discuss with their client the benefits and drawbacks of sharing this information.

**Child Welfare Agency Case Worker:**
Child services workers are required to regularly check on the child. They see children interact with their parents, foster parents, or kinship caregivers, often in the home. Much of the information case workers discover is incorporated into case planning and reports to the court. They often have additional information that may shed light on the child’s experiences.

**School Personnel:**
Knowledge and incorporation of trauma-informed practices varies widely among different school systems. It is important that providers involved with the child’s case, after obtaining the appropriate releases, inform the school about the child’s special trauma needs. A child’s case file will often contain information about the child’s history, experiences, and family background that the school does not need in order to provide services. However, not all schools have comprehensive policies to protect children’s privacy. You should ensure that only the information needed to serve the child is provided to the school, and that such information is provided only to individuals who have been trained to ensure and protect the child’s confidentiality.

Many children who are experiencing neurological responses to trauma require accommodations in school to access their education. Common accommodations often provided in an Individual Education Plan (IEP) or 504 plan, include:

- Permitting the child to leave class early (to avoid the hustle and bustle of busy pass times in the hall)
- Permitting the child to leave class at any time to speak to a counselor
- Providing trigger warnings of materials in the curriculum that might trigger the student, and furnishing alternative assignments (for example, doing an independent study in English when the class is studying a book that will likely trigger the student)
- Adjusting the child’s class schedule so the child can sleep later in the morning

The school may also have information that will help with understanding the child’s needs. For this reason, ongoing dialogue with the school is essential.

**Court staff:**
Children’s attorneys should take the lead to make sure that the child’s needs are met in court and that court staff are aware of potential concerns. Important questions to consider include: Will the child or caregiver need accommodations in court? Will the client be triggered if the abuser (i.e., abusive parent or partner) will be in the courtroom? Do special arrangements need to be made?

**Treating therapist:**
With regular collaboration, the treating therapist can play a key role in making sure that a client’s needs are met at school, at home, and in court. Attorneys and therapists alike must be mindful of their respective ethical duties to their clients. Treating therapists can generally opine about a client’s needs and what would be helpful without violating client confidentiality. You should advise the therapist of upcoming court hearings so the therapist can help the client process the information, address potential triggers, and prepare for court. It is also helpful to obtain information from the treating therapist about a client’s potential trauma triggers and strategies for preventing, addressing, or mitigating those triggers. Likewise, if a client is at risk for self-harm, you should speak to the therapist and inquire about steps or strategies that have been discussed with the client or put into place to reduce this risk.
The current guide was developed with two goals. The first goal is to increase the knowledge and skills of individual attorneys who work with clients who have survived trauma. The second, broader goal is to create trauma-informed child welfare and family court systems, in which all professionals, consumers, and stakeholders are educated about the impact of trauma and trauma-informed practices and policies. Creating trauma-informed service systems is a time- and resource-intensive effort that will require the involvement of a variety of stakeholders in child welfare and other service systems. In the list below, we have included specific resources that may assist attorneys and other system stakeholders in beginning to implement trauma-informed care in their local child welfare and family court systems. The Appendix to this document also includes additional resources to assist attorneys in both individual and systems-wide advocacy and practice.

**Resources for educating other stakeholders on trauma-informed care**


APPENDIX

Section One: Defining Trauma-Informed Legal Advocacy


National Council of Juvenile & Family Court Judges (NCJFCJ) site on Trauma-Informed Systems of Care http://www.ncjfcj.org/our-work/trauma-informed-system-care

Section Two: The Impact of Trauma Exposure on Child Development


Section Three: The Impact of Trauma Exposure on Parents

NCTSN Fact Sheet: *Birth Parents with Trauma Histories and the Child Welfare System*

This factsheet series from the Birth Parent Subcommittee of the Child Welfare Committee highlights the importance of understanding the serious consequences that trauma histories can have for birth parents and the subsequent potential impact on their parenting.

- For Parents (2012)
- For Child Welfare Staff (2011)
- For Judges and Attorneys (2011)
- For Mental Health Professionals (2012)
- For Resource Parents (2011)
- For Court-Based Child Advocates and Guardians ad Litem (2013)

Section Four: The Impact of Trauma on the Attorney-Client Relationship


Section Five: Screening and Assessment


Section Six: Effective Treatments for Traumatic Stress

*Finding Effective Trauma-Informed Treatment for Children, Teens, & Families*
http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices

The National Child Traumatic Stress Network’s website includes a comprehensive list of the most effective and widely used trauma-informed treatments for children, adolescents, and families. This site includes a description of the core components of trauma-informed treatments and a list of trauma-informed interventions for children, adolescents, and families, with fact sheets summarizing the key components of each treatment and the research evidence that shows its effectiveness.

*Finding a Trauma-Informed Therapist or Expert in Your Area*
http://www.nctsn.org/about-us/network-members

The National Child Traumatic Stress Network is comprised of more than 100 federally-funded and affiliated academic and treatment centers around the US that provide trauma-informed mental health services and training/consultation on child traumatic stress. To find a trauma expert in your area, search the NCTSN’s list of network members by state
The International Society for Traumatic Stress Studies offers a searchable online database of mental health professionals that offer trauma-informed treatment across the globe.

The NCTSN's Get Help Now site offers information on finding help for children who have experienced abuse or neglect.

NCTSN Fact Sheet: List of Questions to Ask Mental Health Professionals
1. Does the individual/agency that provides therapy conduct a comprehensive trauma assessment? If so: What specific standardized measures are given? What did your assessment show? What were some of the major strengths and/or areas of concern?
2. Is the clinician/agency familiar with evidenced-based treatment models?
3. Have clinicians had specific training in an evidenced-based model (when, where, by whom, how much)?
4. Does the individual/agency provide ongoing clinical supervision and consultation to its staff, including how model fidelity is monitored?
5. Which approach(es) does the clinician/agency use with children and families?
6. How are parent support, conjoint therapy, parent training, and/or psychoeducation offered?
7. Which techniques are used for assisting with the following: Building a strong therapeutic relationship; affect expression and regulation skills; anxiety management; relaxation skills; cognitive processing/reframing; construction of a coherent trauma narrative; strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child’s experience; personal safety/empowerment activities; resiliency and closure
8. How are cultural competency and special needs issues addressed?
9. Is the clinician or agency willing to participate in the multidisciplinary team (MDT) meetings and in the court process, as appropriate?

Section Seven: Placement Decisions, Transitions, and Visitation

ReMoved – video about the experience of children in foster care system http://vimeo.com/73172036


Section Eight: Secondary Traumatic Stress and Attorneys


The Professional Quality of Life Scale (ProQOL) is a 30 question assessment of secondary traumatic stress, burn-out, and compassion satisfaction that is intended for use by a wide range of helping professionals. To download a free copy of the ProQOL, including instructions on how to complete and score the questionnaire, visit http://www.proqol.org/ProQol_Test.html. Mental health counseling or other supports can be helpful for addressing high scores on the secondary trauma or burnout scales of the ProQOL. Refer to Section 6 of this Appendix for additional information on locating a trauma-informed therapist in your area.

**Section Nine: The Importance of Collaboration**


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**Suggested Citation:**

Child Abuse and Prevention Treatment Act (CAPTA)
Substance Exposed Infants Statutory Summary

The Keeping Children and Families Safe Act of 2003 created new conditions for States to receive their grant allocations under CAPTA. The grant conditions were intended to provide needed services and supports for infants, their mothers, and their families and to ensure a comprehensive response to the effects of prenatal drug exposure.

The committee report on H.R. 14 (2003), the House version of the Keeping Children and Families Safe Act, stated that the requirement was intended to “identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child.”

The authors of this bill called for…

“the development of a safe plan of care for the infant under which consideration may be given to providing the mother with health services (including mental health services), social services, parenting services, and substance abuse prevention and treatment counseling, and to providing the infant with referral to the statewide early intervention program funded under part C of the Individuals with Disabilities Education Act for an evaluation for the need for services provided under part C of such Act.”

The legislation required that Governors of States receiving a CAPTA grant assure the Federal government that they have Policies and Procedures for:

- Appropriate referrals to child protection service systems and for other appropriate services, to address the needs of infants born with and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure
- A requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition except that such notification shall not be construed to establish a definition under Federal law of what constitutes child abuse or require prosecution for any illegal action
- A plan of safe care for the infant born with and identified as being affected by illegal substance abuse or withdrawal symptoms
- The immediate screening, risk and safety assessment, and prompt investigation of such reports.

As Amended by P.L. 111-320, The CAPTA Reauthorization Act of 2010 made further changes to the prenatal exposure issues to include identification of infants affected by a Fetal Alcohol Spectrum Disorder (FASD) and added to the requirement of the development of the plan of safe care infants affected by FASD. It also added the following reporting requirements to the Annual State Data Reports:

- The number of children referred to a child protective services system born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.
- The number of children involved in a substantiated case of abuse or neglect determined to be eligible for referral, and the number of children referred to agencies providing early intervention services under Part C of the Individuals with Disabilities Education Act.
On July 22, 2016, P.L. 114-198, “Comprehensive Addiction and Recovery Act of 2016” (CARA) went into effect including Title V, Section 503, “Infant Plan of Safe Care.” The legislation makes several changes to CAPTA. The law:

- Removes the term, “illegal” in regard to substance abuse
- Requires that the Plan of Safe Care address the needs of both the infant and the affected family or caregiver
- Specifies data to be reported by States, to the maximum extent practicable on the affected infants and the plans of safe care:
  - The number of infants identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or Fetal Alcohol Spectrum Disorder
  - The number of infants for whom a plan of safe care was developed
  - The number of infants for whom referrals were made for appropriate services— including services for the affected family or caregiver
- Requires that States develop and implement monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

The 2016 changes were made in the context of attention generated by the nation’s prescription drug and opioid epidemic, which has focused State agencies on the requirement that a Plan of Safe Care be implemented for these infants.

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2 In 2010, the law was amended to include the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.
**PROGRAM INSTRUCTION**

**TO:** The State Office, Agency or Organization Designated by the Governor to Apply for a Child Abuse and Neglect State Grant

**SUBJECT:** Guidance on amendments made to the Child Abuse Prevention and Treatment Act (CAPTA) by Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016

**LEGAL AND RELATED:** Title I of CAPTA; Public Law 114-198, the Comprehensive Addiction and Recovery Act of 2016 (CARA).

**PURPOSE:** To provide guidance to states on implementing provisions in CAPTA, as amended by CARA, relating to infants affected by substance abuse.

**BACKGROUND:** Since 2003, CAPTA has included a state plan requirement that the Governor of each state provide an assurance that the state has policies and procedures to address the needs of substance-exposed infants, including requirements to make appropriate referrals to child protective services (CPS) and other appropriate services, and a requirement to develop a plan of safe care for the affected infants. As originally incorporated in sections 106(b)(2)(B)(ii) and (iii) of CAPTA\(^1\), the provisions required states to have policies and procedures relating to “infants born and identified as being affected by illegal [emphasis added] substance abuse or withdrawal symptoms resulting from prenatal drug exposure.” In 2010, the provision was amended by Congress to also include infants affected by Fetal Alcohol Spectrum Disorder.

Most recently, on July 22, 2016, the President signed into law CARA which, among other provisions, amended sections 106(b)(2)(B)(ii) and (iii) of CAPTA to remove the term “illegal” as applied to substance abuse affecting infants and to specifically require that plans of safe care address the needs of infants affected by substance abuse.

\(^1\) As originally incorporated into the statute in 2003, these provisions appeared in sections 106(b)(2)(A)(ii) and (iii).
both infants and their families or caretakers. CARA also added requirements relating to data collection and monitoring.

The text of sections 106(b)(2)(B)(ii) and (iii) of CAPTA, as amended by CARA, appears below. * Deleted text is shown in strike out **Added text is shown in bold.

The state must “submit an assurance in the form of a certification by the Governor of the State that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes…..

(ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by *illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to –

(I) establish a definition under Federal law of what constitutes child abuse or neglect; or
(II) require prosecution for any illegal action;

(iii) the development of a plan of safe care for the infant born and identified as being affected by *illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder **to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through –

(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and
(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

CARA also amended the annual data report requirements in section 106(d) of CAPTA. States will now need to report, to the maximum extent practicable:

- the number of infants identified under subsection 106(b)(2)(B)(ii);
- the number of such infants for whom a plan of safe care was developed; and
- the number of such infants for whom a referral was made for appropriate services, including services for the affected family or caregiver.

The Children’s Bureau (CB) intends to collect this information through the National Child Abuse and Neglect Data System (NCANDS) beginning with the submission of fiscal year (FY) 2018 data. Information on reporting these data to NCANDS will be provided separately. As states consider any changes that may need to be made to their child welfare information systems to comply with updated data reporting requirements, they should be aware that system enhancements associated with NCANDS reporting may be eligible for Federal Financial Participation under the title IV-E foster care
program. To qualify for reimbursement, agencies must address these changes in their appropriate Advance Planning Document.

More information on the changes made to CAPTA by CARA, as well as information on best practices, can be found in Information Memorandum ACYF-CB-IM-16-05, issued August 26, 2016.

**INSTRUCTION:**

The changes to CAPTA made by CARA were effective upon enactment (July 22, 2016). Consistent with sections 106(b)(1)(C) and 108(e) of CAPTA, states will be required to submit an updated Governor’s assurance (see Attachment A) and information on the actions the state has taken to comply with the CARA amendments as part of the Annual CAPTA Report submitted in conjunction with the FY 2018 Annual Progress and Services Report (APSR) (due June 30, 2017).

Because the changes made by CARA are already in effect, we expect states to be actively working to ensure they comply with these requirements prior to the FY 2018 APSR submission. We note that states provided updated information on the implementation of the CAPTA provisions relating to substance-exposed newborns as part of the Annual CAPTA Report submitted with the FY 2017 APSR. We encourage states to work with their CB regional offices to review that submission and determine the actions the state may need to take and the technical assistance the state may need to fully implement the changes.

To assist states in reviewing and adjusting their policies, as necessary, to comply with the provisions as amended, CB is taking this opportunity to reiterate and provide references to relevant guidance previously issued through the CB Child Welfare Policy Manual (CWPM) and provide information clarifying the scope of these changes.

**What population of infants and families is covered by the CAPTA assurance in section 106(b)(2)(ii)?**

CAPTA now requires states to have “policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder….” CAPTA does not define “substance abuse” or “withdrawal symptoms resulting from prenatal drug exposure.” We recognize that by deleting the term “illegal” as applied to substance abuse affecting infants, the amendment potentially expands the population of infants and families subject to the provision. States have flexibility to define the phrase, “infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure,” so long as the state’s policies and procedures address the needs of infants born affected by both legal (e.g., prescribed drugs) and illegal substance abuse.

We encourage states to consult with the State Substance Abuse Treatment Authority, pediatricians and other health care professionals as they review their state policies and update definitions, consistent with the amendments to CAPTA.
**Must states have a law, policy and/or procedure requiring Health Care Providers to refer substance-exposed infants to child protective services (CPS)?**

Yes. Consistent with the definitions adopted by the state, the state must have statewide laws, policies and/or procedures requiring health care providers involved in the delivery or care of infants born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder to notify CPS of the occurrence of such conditions of infants.

**Does a notification to or referral of a case to CPS involving a substance-exposed newborn constitute a report of abuse or neglect?**

Not necessarily. The CAPTA provision as originally enacted and amended requires the referral of certain substance-exposed infants to CPS and makes clear that the requirement to refer infants affected by substance abuse does not establish a federal definition of child abuse and neglect. Rather, the focus of the provision is on identifying infants at risk due to prenatal substance exposure and on developing a plan to keep the infant safe and address the needs of the child and caretakers. (See CWPM, Section 2.1F, Questions 1 and 2.) Further, the development of a plan of safe care is required whether or not the circumstances constitute child maltreatment under state law.

**What is a plan of safe care?**

While CAPTA does not specifically define a “plan of safe care,” CARA amended the CAPTA state plan requirement at 106(b)(2)(B)(iii)(1) to require that a plan of safe care address the health and substance use disorder treatment needs of the infant and affected family or caregiver. We want to highlight that this change means that a plan of safe care must now address not only the immediate safety needs of the affected infant, but also the health and substance use disorder treatment needs of the affected family or caregiver. Consistent with good casework practice, the plan should be developed with input from the parents or other caregivers, as well as any collaborating professional partners and agencies involved in caring for the infant and family.

**Who is responsible for developing and monitoring plans of safe care?**

CAPTA does not specify which agency or entity must develop the plan of safe care; therefore the state may determine which agency will develop the plans. We understand that in most instances the state already has identified the responsible agency in its procedures. When the state reviews and modifies its policies and procedures to incorporate the new safe care plan requirements in CARA, the state may wish to revisit its procedures regarding which agency develops the plan of safe care, including any role for agencies collaborating with CPS in caring for the infant and family.

In addition to the requirements for developing plans of safe care, CARA also added a CAPTA state plan requirement for state monitoring of plans of safe care to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver (section 106(b)(2)(B)(iii)(2) of CAPTA). State monitoring may be carried out by the state child welfare agency or by another state-level entity. (See CWPM Question 2.1F.1, Question 1.)
As discussed in ACYF-CB-IM-16-05, development of a multi-agency collaborative to jointly assess, treat and monitor the progress of substance-exposed infants and their families is a best practice we encourage states to consider in implementing these new CAPTA provisions.

**How will CB monitor states’ compliance with these provisions?**

Section 114 of CAPTA, as amended by CARA, requires the Secretary of Health and Human Services to monitor states to ensure compliance with the requirements in section 106(b) and specifically the policies and procedures of sections 106(b)(2)(B)(ii) - (iii). Consistent with this provision, CB will require states to provide an update on the steps the state has taken to implement provisions in 106(b)(2)(B)(ii) - (iii), as amended, as part of their annual CAPTA report submitted with the FY 2018 APSR due June 30, 2017. CB will also require states to submit the Governor’s Assurance (Attachment A) at that time. States unable to provide the required assurance and document compliance by June 30, 2017 will be required to develop a Program Improvement Plan to address needed actions to come into full compliance. Additional information on submission requirements will be provided in the annual APSR Program Instruction to be issued in the spring of 2017.

**CONCLUSION:**

We encourage states to work with CB regional offices now to ensure that the state is meeting these new CAPTA requirements and to discuss any technical assistance needs. We also strongly encourage states to take a multi-disciplinary approach to implementation of these CAPTA requirements by including not only the state child welfare agency, but also partner agencies and professionals, such as the State Substance Abuse Treatment Authority, hospitals, health care professionals, home visiting programs, and Public Health or Maternal and Child Health Programs in the assessment and strengthening of state policies and procedures, as necessary.

**INQUIRIES TO:**  Children’s Bureau Regional Program Managers

/s/

Rafael López, Commissioner
Administration on Children, Youth and Families

Attachments:

A – Updated CAPTA Governor’s Assurance
B – CB Regional Office Program Managers
HOW TRAUMA CAN AFFECT PARENTS’ THINKING AND BEHAVIOR

1. **Difficulty with Decision-Making and Judgment**
   Trauma negatively affects the parts of the brain involved with planning, evaluating situations, thoughtful decision-making, and problem solving. This leads to difficulty making appropriate safety judgments, resulting in either overprotection or an inability to recognize dangerous situations. Difficulty with planning and thinking ahead leads to missed visits, court dates, and appointments which can interfere in completing their case plans.

2. **Re-Experiencing Trauma: Avoidance**
   People with trauma histories may re-experience past trauma when “triggered” by reminders. For this reason, they may avoid places or people that remind them of past traumas and that make them feel unsafe. Re-experiencing includes intrusive memories, nightmares, and reacting to reminders as if the traumatic event was happening again. Parents may avoid core activities of their case plan such as visits with the child, case conferences, and coming to court because these experiences are so connected with the trauma of losing their child. For many parents, these experiences may be reminders of their own distressing childhood memories of being in foster care or court.

3. **Re-Experiencing Trauma: Disconnecting and Disengaging**
   Trauma can cause people to disconnect from strong negative emotions and to disengage from triggering experiences. Trauma can also create distressing bodily sensations such as nausea, heart palpitations, shakiness, and other stress responses that we all feel when we’re frightened or devastated. These sensations can make us feel like we are out of control, anxious, or depressed. Many trauma survivors cope by using substances to dampen intolerable sensations. Parents may appear uncooperative or look like they don’t care or aren’t interested in reunification efforts during high stake events because they are “checking out” from their painful experience. Relapse may also be a traumatic stress reaction, as the parent seeks relief from their overwhelming emotional distress.

4. **Hyperarousal**
   Trauma can impair the body’s stress system—the “fight or flight” response—so that it is constantly on high alert. This situation causes people to overreact to even ordinary stress. It also causes people to be overly focused on threats in the present. This can lead to intense emotional and behavioral agitation and difficulty sorting through real and perceived threats. Thus, parents may be “triggered” by things that feel dangerous to them but that are not truly dangerous; from the outside perspective, this can look like a complete over-reaction. This trauma-driven reaction can cause parents to respond impulsively, react angrily to their child’s behavior, and have extreme outbursts and confrontations with professionals. They may appear on guard, on edge, and highly agitated.
5. **Negative Self-Concept and Difficulty with Trust**

People who experienced abuse and neglect in childhood commonly internalize the way they have been treated by others, experiencing strong feels of shame and viewing themselves as “damaged goods.” Because their childhood relationships were fraught with hurt and danger, they can feel undeserving of others’ caring and support and be reluctant to open-up about their distress and pain out of fear that they will be rejected. This leads to **difficulty trusting others and forming healthy relationships**, which causes difficulties in the relationship between a parent and foster caregiver and pushing away service providers who are offering help. Parents affected by complex trauma may particularly have difficulty feeling trust towards people in positions of authority or power, such as a judge and attorney, as these figures can trigger trauma reactions associated with their childhood experiences of abuse or neglect.

6. **Feelings of Powerlessness**

Childhood abuse and adult experiences of victimization cause **profound feelings of loss of control and a sense of helplessness and hopelessness.** When parents are interacting with the court system and the child welfare system, it can feel like everyone but them has power and control. The court setting, hearings, legal process, interacting with authority figures like a judge, case conferences – these can trigger feelings of helplessness and loss of control. Parents can appear resistant, emotionally disengaged, overwhelmed, and paralyzed.

**References:**


Hudson, L., Beilke, S., & Many, M. (2016). “If you brave enough to live it, the least I can do is listen”: Overcoming the consequences of complex trauma. *ZERO TO THREE*, 36(5), 4–11.


Tullberg, E. (April 13, 2018). *Personal communication*.


Adverse Childhood Experiences, Family Risk Factors, and Child Permanency Outcomes of Very Young Children Involved in Safe Babies Court Team™ Sites

June 2018

Key Points

- Adverse childhood experiences (ACEs) are highly prevalent among families participating in Safe Babies Court Team™ (SBCT) sites.
- Seventy percent of children have at least one parent who has experienced four or more ACEs.
- Among children with closed cases at SBCT sites, 83.7% reached permanency within 12 months. This is double the national standard expectations established by the Children’s Bureau (40.5%).
- Children with a parent with the highest ACE score (7 to 10) were more likely to be adopted (43.4%), but there was also a large group that was able to be reunified with their parents (30.2%).
- Even among families with the highest ACEs and risk factors, children can reach permanency and have a family either through adoption or reunification. Parents need support through integrated trauma and substance abuse services.

The SBCT Approach and the QIC-ITCT

In response to the needs of maltreated babies and toddlers entering the child welfare system (CWS), ZERO TO THREE developed the SBCT approach: a collaborative, problem-solving systems-change innovation focused on supporting the health, mental health, and developmental needs of adjudicated babies and toddlers and expediting safe, nurturing permanency outcomes. SBCT offers a structure for systems to work together—the court, child welfare agency, and related child-service organizations—to ensure better outcomes for the youngest children in care and for their families. The structure comprises (1) a Family Team (attorneys, case planner, service providers, and family) that comes together at least monthly to identify and address barriers to reunification, and (2) a community stakeholder team, or Active Court Team, that engages in broader systems reform efforts. In 2014, the Children’s Bureau provided a grant to ZERO TO THREE and its partners to develop the Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-ITCT), which provides technical assistance and training to participating sites. The QIC-ITCT provides access to evidence-based interventions and best practices for individuals and agencies working with the birth-to-3 population. The mission of the QIC-ITCT is to support implementation and build knowledge of effective, collaborative court team interventions that transform child welfare systems for infants, toddlers, and families (see http://www.qicct.org/).
Background

This brief describes factors associated with positive permanency outcomes for the very young children participating in SBCT sites [2]. Parents of young children involved with CWS have long histories of suffering and trauma. Many have experienced a high number of ACEs, stressful or traumatic events that include abuse (physical, emotional, and sexual), neglect (physical and emotional), and household dysfunction (mental illness, separation and divorce, violence, incarcerated relative, and substance abuse) [3]. Families of young children involved with the CWS commonly experience myriad difficulties in adulthood, including parental incarceration, mental health problems, domestic violence, and substance use disorders. The SBCT approach is strengths-based, with the focus on promoting protective factors for these highly vulnerable parents and their children. This includes surrounding the family with caring adults, empowering and supporting parenting competencies, and encouraging the placement of children with family members [4].

Parental ACEs and Risk Factors among Families Involved with the SBCT

In the following section, we present results about parents’ ACEs. These ACEs provide information about the parents’ childhood experiences and family environment prior to their 18th birthday with their caregivers (e.g., child’s grandparents). In contrast, risk factors provide information about the child’s family environment at the time of contact with CWS and the experiences the child has been exposed to or his or her parents have recently gone through.

Among families with a closed CWS case at SBCT sites, most reported having experienced many ACEs. ACEs increase the risk for negative mental and physical outcomes in adulthood, including substance use disorders, domestic violence, teen pregnancy, depression, and mental illness. People who have experienced four or more ACEs have the highest risk of experiencing negative behavioral and mental health outcomes. Of the over 9,000 participants in the original ACE study, 6.2% experienced four or more ACEs [5]. In contrast, among families with a closed CWS case at SBCT sites, 70% of children have at least one parent who has experienced four or more ACEs. Families of young children are also experiencing numerous risk factors at the time of involvement with the CWS, including parental incarceration, mental health problems, and substance use disorders.
ACEs Screening

- Protecting parents’ privacy and building a trusting relationship are fundamental. Information on ACEs should be based on what parents have shared with the family team and only if needed from direct questions to avoid re-traumatizing the parent.
- Community coordinators should introduce questions on the trauma history carefully to parents and in a private setting, acknowledging that questions may be distressing but necessary to provide the right services.

### ACE Scores of Parents in the SBCT/QIC-ITCT Sites

- Mothers: n=127
- Fathers: n=50

<table>
<thead>
<tr>
<th>ACE Score</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>6.3% (A)</td>
<td>8</td>
</tr>
<tr>
<td>1</td>
<td>14.0% (B)</td>
<td>11</td>
</tr>
<tr>
<td>2</td>
<td>10.2% (A)</td>
<td>13</td>
</tr>
<tr>
<td>3</td>
<td>14.0% (B)</td>
<td>11</td>
</tr>
<tr>
<td>4</td>
<td>7.9% (A)</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>8.7% (A)</td>
<td>11</td>
</tr>
<tr>
<td>6</td>
<td>8.0% (B)</td>
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<td>7.1% (A)</td>
<td>10</td>
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<tr>
<td>8</td>
<td>7.1% (A)</td>
<td>10</td>
</tr>
<tr>
<td>9</td>
<td>14.0% (B)</td>
<td>11</td>
</tr>
<tr>
<td>10</td>
<td>15.8% (A)</td>
<td>12</td>
</tr>
</tbody>
</table>

Note: Complete ACE information was available for 77% of mothers and 53% of fathers.

In addition to ACEs, parents also experienced numerous risk factors associated with child abuse and neglect. Among 231 children with a closed CWS case at SBCT sites, over 90% had one or both parents with substance use disorders; close to two thirds had one or both parents with mental health problems; and over half were from a household with domestic violence. Almost all children came from impoverished households; half had a parent who had spent time in jail or prison; and close to two thirds had a young parent (either a parent younger than 25 years old or who began having children before age 18).

The high percentage of SBCT-involved parents with risk factors stands out when compared to reports from a nationally representative sample of children investigated for maltreatment. In that study, caseworkers identified that about 10% of primary caregivers (mostly mothers) had drug abuse problems, 15% had mental health problems, about 28% had experienced domestic violence, and almost 14% had a recent history of arrests [6]. The SBCT data supports concerns about underreporting of these problems.
### Risk Factors among Families in the SBCT/QIC-ITCT Sites
(mothers n=164, fathers n=94, children n=231)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Mothers</th>
<th>Fathers</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous contact with CWS</td>
<td>4.3 (A)</td>
<td>3.2 (B)</td>
<td>3.0 (C)</td>
</tr>
<tr>
<td>Childhood history of abuse and neglect</td>
<td>35.4 (A)</td>
<td>39.8 (C)</td>
<td>18.1 (B)</td>
</tr>
<tr>
<td>Young parent</td>
<td>58.5 (A)</td>
<td>64.5 (C)</td>
<td>43.6 (B)</td>
</tr>
<tr>
<td>Ever in jail</td>
<td>48.9 (B)</td>
<td>52.8 (C)</td>
<td>39.6 (A)</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>90.2 (A)</td>
<td>88.3 (B)</td>
<td>90.5 (C)</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>59.8 (A)</td>
<td>45.7 (B)</td>
<td>61.5 (C)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>54.3 (A)</td>
<td>48.9 (B)</td>
<td>55.4 (C)</td>
</tr>
<tr>
<td>Poverty</td>
<td>99.4 (A)</td>
<td>97.9 (B)</td>
<td>96.5 (C)</td>
</tr>
<tr>
<td>Child with special needs</td>
<td>25.0 (A)</td>
<td>26.6 (B)</td>
<td>20.8 (C)</td>
</tr>
</tbody>
</table>

Note: Green bars [children, marked with (C)] represent the presence of risk factors at the level of the child by combining information from the mother and/or father. “Ever in jail” represents that either the parent was incarcerated as an adult or that there was a major interruption in parent-child contact due to parental incarceration.

### SBCT Solution

As a community engagement and systems-change approach, SBCT focuses on improving how the courts, child welfare agencies, and related child-serving organizations work together, share information, and expedite services for young children in the CWS. The SBCT approach employs best practices in child welfare combined with innovative, collaborative, problem-solving strategies to expedite timely permanence of young children [3]. These include *Judicial Leadership; Concurrent Planning and Limiting Placements; The Foster Parent Intervention: Mentors and Extended Family;* and *Pre-Removal Conferences and Monthly Family Team Meetings.*

For over 90% of families involved with SBCT sites, reunification is the primary permanency goal, defined as the physical return of a child to parents or caretaker. The family teams use concurrent planning, a technique that requires the rapid identification of, and placement with, caregivers who are willing to become the child’s permanent family if reunification with the birth parents is not possible. Family teams strive to support early relationships for the child’s emotional well-being by encouraging a nurturing relationship between child and foster parent and strengthening the relationship between child and parent. In the SBCT approach, judicial leadership is critical for concurrent planning and permanency, both in terms of communicating clear expectations for the family team, as well as setting expectations for parents and caregivers. The stability expectation helps parents understand that the court’s focus is on the child’s urgent need for a permanent family.
Promoting Permanency
“The major emphasis on permanency is itself a critical element affecting child well-being especially of young children, for whom a permanent home is a critical ingredient of healthy social and emotional development. Thus, the requirements to ensure that cases do not languish by using periodic case reviews (no less frequently than once every six months) and permanency hearings (no later than 12 months after entering care) are both surpassed by the Court Teams’ monthly reviews and serve as mechanisms to monitor and ensure service provision to promote healthy development. Federal law also permits states to conduct concurrent planning, a practice used by the SBCT to ensure that babies are moved more quickly to a permanent home.” (p.10) [2]

Foster parents are essential members of the family team. These caregivers must see themselves primarily as supports to reunifying the child and birth parents, and secondarily as the child’s forever family should the need arise. Training and support from the child welfare agency is given prior to and while foster parents are engaged with a child and his or her family. The training and support promote the foster parents’ supportive role with the family, which includes providing loving care for children placed with them, advocating for the children in their homes, and mentoring the biological parents, siblings, and extended family. Emphasis is on placement with related family but not to the detriment of the parents’ ability to successfully reunite with their children. Pre-removal conferences are held prior to the child being placed in foster care. These gatherings include the family, their support system, the case investigator, the foster care case worker, and the community coordinator. A pre-removal conference sets a welcoming tone for parents who may be frightened or confused, and communicates to parents that the goal is reunification, while concurrent planning acts as a safety net in case of need.

In addition, each month, the family, community coordinator, and a team of service providers, attorneys, and child welfare agency staff hold a family team meeting to review the family’s progress and track the referrals made, services received, and barriers encountered. Family team meeting goals are to bring quicker resolution of cases, build trust and communication among those invested in the child’s case, and expedite a family’s access to services. The family team recognizes that many parents of young children who enter the CWS have their own history of trauma. Because the primary goal of the SBCT approach is to help parents and children reunify, parents receive comprehensive medical and mental health assessments including evaluation for their own childhood trauma, prenatal alcohol exposure, substance use disorders, and domestic violence. These services are critical to either support reunification or help parents to gain insight on the urgent needs of young children to have stability and put the needs of the infant or toddler above their own desire to keep their child, which translates into fewer contested termination of parental rights (TPRs).
SBCT Core Components

- Judicial Leadership
- Local Community Coordinator
- Active Court Team Focused on the Big Picture
- Targeting Infants and Toddlers Under the Court’s Jurisdiction
- Valuing Birth Parents
- Concurrent Planning and Limiting Placements
- The Foster Parent Intervention: Mentors and Extended Family
- Pre-Removal Conferences and Monthly Family Team Meetings
- Frequent Family Time (Visitation)
- Continuum of Mental Health Services
- Training and Technical Assistance
- Understanding the Impact of Our Work

http://www.qicct.org/safe-babies-court-teams

How Do We Know the Approach Is Working?

At each SBCT site, the family team works diligently to identify placements for children and support caregivers to minimize changes and expedite permanency. The evaluation team analyzed the data collected on 231 infants and toddlers with a closed child welfare case, from families who were served by family teams supported by the QIC-ITCT from April 2015 through May 2018.

Among children with closed cases, 83.7% reached permanency within 12 months following the definition of Permanency Performance Area 1 (see box on page 7). There were no significant differences for permanency within 12 months by child’s race/ethnicity. Close to half of children were reunified with parents (48.6%), about a third were adopted (32.2%), and 14.0% were placed with a fit and willing relative.

The number of parental ACEs was significantly associated with children reaching permanency in 12 months, the type of permanency (e.g., reunification, adoption), and the status of parental rights. Among children with a parent with the highest ACE score (between 7 and 10), 94.6% reached permanency within 12 months of entering foster care. However, among children of parents with lower ACE scores, 79.6% reached permanency within 12 months if the ACE score was 0 to 3, and 74.3% reached permanency if the ACE score was 4 to 6. These differences are largely explained by the type of permanency outcomes.

Although most children reached permanency within 12 months, permanency outcomes were significantly different for parents with a high ACE score versus parents with a low ACE score. Among children with a parent with the highest ACE score, 30.2% were reunified, whereas 43.4% were adopted. The opposite was the case for children with a parent with the lowest score, as 56.3% of them were reunified and 20.8% were adopted. About a third (37.0%) of parents with the highest ACE score retained parental rights compared to 75.0% among parents with the lowest ACE score.
Permanency Performance Area 1: Permanency in 12 months for children entering foster care.

**Indicator Description:** “Of all children who enter foster care in a 12-month period, what percent discharged to permanency within 12 months of entering foster care?”

**Calculation:** The denominator is the number of children who enter foster care in a 12-month period. The numerator is the number of children in the denominator who discharged to permanency within 12 months of entering foster care and before turning age 18.

This means that if a child discharges from foster care to reunification with parents or other caretakers after a placement setting of a trial home visit during any of the six report periods used for the indicator, any time in that trial home visit that exceeds 30 days is discounted from the length of stay in foster care. In other words, the actual date of discharge to permanency could occur at any time during the three years used to calculate this indicator, and the trial home visit would then be applied to see if it may result in a reduction in the length of time in foster care for the purposes of this data indicator.” [7]

**Parental ACE Scores and Type of Permanency Outcomes (children n=146)**

- **Reunified with parent:**
  - ACE score 0-3: 50.0% (B)
  - ACE score 4-6: 30.2% (C)
  - ACE score 7-10: 18.9% (A)

- **Adopted:**
  - ACE score 0-3: 20.8% (A)
  - ACE score 4-6: 32.4% (B)
  - ACE score 7-10: 43.4% (C)

- **Placed with fit and willing relative:**
  - ACE score 0-3: 14.7% (B)
  - ACE score 4-6: 13.2% (C)
  - ACE score 7-10: 3.0% (B)

- **Other (Guardianship):**
  - ACE score 0-3: 4.2% (A)
  - ACE score 4-6: 13.2% (C)

Although parent ACE scores were significantly associated with children reaching permanency in 12 months, as well as the type of permanency outcome, neither the risk scores at the time of contact with CWS nor the individual risk factors were associated with reaching permanency within 12 months. Risk factors were, however, associated with parental rights. Lower risk scores among parents were significantly associated with fewer parents relinquishing rights and having their rights terminated: over 80% of parents with a risk score between 0 and 3 retained parental rights, whereas only about half of parents with a risk score of 4 or more were able to retain their rights.

“I can’t tell you the number of times I’ve walked out of TPR [termination of parental rights] hearings where the parents’ rights got terminated and they still feel fairly treated, still feel like everyone made every effort they could. There’s a realization that this baby needs more than I can give right now. If they feel like everybody worked hard to try to support them to get what they need—then they can deal with the trauma of losing their parental rights a lot better.”

Court team member

Specific risk factors significantly associated with type of permanency outcomes were parental mental health problems and family domestic violence. In families with parental mental health problems, only about half (52.4%) of parents retained parental rights compared to over two thirds (71.4%) among parents without mental health problems, and children of parents with mental health problems were more likely to be adopted (38.5%) than children of parents without mental health problems (21.5%). In families with domestic violence compared to families without domestic violence, parents were also less likely to retain parental rights (55.5% compared to 63.6%) and children were more likely to be adopted (38.5% compared to 23.9%).

The permenency outcomes of young children participating in SBCT sites are double the national standard expectations established by the Children’s Bureau for this indicator (83.7% reached permanency within 12 months compared to the national standard at 40.5%).

“The SBCT sites work with highly vulnerable families with a history of trauma and suffering and needs that can be very specific to each family. Regardless of the total ACEs and risk scores, or any one specific ACE or risk factor, the lowest percentage among SBCT sites for reaching permanency within 12 months across all analysis of ACEs and risk factors was 74.3%, more than 50% higher than the Children’s Bureau national standard of 40.5%.

“Data from the parents’ representation program shows that [SBCT] children are being returned faster, or achieving permanency faster, less time in foster care, which is also saving the state money.”

Court Improvement Program State Representative
The SBCT approach is flexible and adaptable to different contexts and families. Even among families with the highest ACEs and risk factors, there are positive permanency outcomes for children, as they are adopted in large numbers and, for parents, as they can receive support and reach reunification. The flexibility of the approach is critical for addressing the complex needs of families and young children. The court team works actively to provide community support for young children and their families even when resources may be limited. The focus is on proactively frontloading services and support to have a permanent family that is already in place when reunification is not feasible.

"As far as [how] we used to be, more cases move along quickly, reunification is happening, the SBCT court closes files quicker. This is resulting from the agency and caseworkers working more intensively with the parent, and really focusing on the permanency plan. The obvious change is people learning about services, people embracing the timeline, bonding with parents. You see people that begin to get it, and you see diligence. It is a win-win because you get the services. It makes the caseworkers’ work easier. They see that the community coordinator and her team work for the family, and they embrace it, because it works.”

Court Team Member

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**Parental Risk Scores and Parental Rights Outcomes (parents n=187)**

- **Parent relinquished rights**
  - Risk score 0-3: 14.3%
  - Risk score 4-5: 9.2%
  - Risk score 6-8: 27.8%

- **Parental rights terminated**
  - Risk score 0-3: 3.6%
  - Risk score 4-5: 35.6%
  - Risk score 6-8: 18.1%

- **Parent retained rights**
  - Risk score 0-3: 82.1%
  - Risk score 4-5: 55.2%
  - Risk score 6-8: 54.2%

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**Adverse Childhood Experiences, Family Risk Factors, and Child Permanency Outcomes of Very Young Children Involved in Safe Babies Court Team™ Sites** is part of a series of briefs based on the evaluation of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams.

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References


The Adverse Childhood Experiences of Very Young Children and Their Parents Involved in Infant–Toddler Court Teams

Introduction

The Centers for Disease Control and Prevention-Kaiser Permanente Adverse Childhood Experiences (CDC-Kaiser Permanente ACEs) study—one of the largest investigations of childhood abuse and neglect and later-life health—found that experiences in early childhood were powerful predictors of adult health, functioning, and well-being.¹ As the number of ACEs increases, so does the development of risk factors for disease and other negative outcomes. ACEs are strongly related to well-being throughout the life course.² ACES are stressful or traumatic events, categorized into three areas: abuse (physical, emotional, and sexual), neglect (physical and emotional), and household dysfunction (mental illness, separation and divorce, domestic violence, incarcerated household member, and substance abuse). Later, the original ACEs study was extended to add the stressful traumatic events for young children living in Philadelphia.³ These events include racial discrimination and exposure to community violence. It was one of the first studies to examine ACEs in a racially and socioeconomically diverse urban population. Prevalence of standard ACEs are higher in Philadelphia than in the original Kaiser Permanente population.⁴

By examining adults’ reports of experiences in childhood, the CDC-Kaiser Permanente ACEs study revealed that the majority of children experience 1 or more ACEs, and 25–30% experience 3 or more ACEs.⁵ Focusing on the child welfare population specifically, findings from a study of children either placed in foster care or adopted from foster care indicated that children in foster care are more likely to experience ACEs than children with socioeconomic disadvantages and different family structures.⁶ Results from this study can help to improve our understanding of—and shape policies and practices that address how—children in foster care, an already vulnerable population, are disproportionately exposed to ACEs.⁷

Every experience in early childhood has an influence on a child’s brain development and impacts their social, emotional, and physical health. Positive experiences promote favorable infant and early childhood mental health development, and negative environmental experiences adversely impact brain development.⁸ When young children feel safe, they can venture out from their parents’ arms to explore the world; curiosity is possible only when children have
stable, nurturing relationships with their primary caregivers. Conversely, exposure to negative experiences forces them to activate their fight or flight responses, barring the way to safe exploration and teaching them that the world is a dangerous and frightening place. Researchers, policymakers, and practitioners continue to advance in understanding the long-term impact of early experiences on a young child’s development. We recognize the importance of ensuring that courts and states have the necessary tools to identify and address the underlying challenges faced by young children and families in the child welfare system.

It is important, however, to recognize that trauma and adverse experiences in early childhood do not have to prescribe a child’s future because of the presence of both protective and promotive influences that contribute to resilience. Child characteristics, family factors, and community support all contribute to more positive outcomes following trauma and other adversity. Infants and young children who are better able to regulate their behaviors and emotions are more likely to show resilience in the face of adversity. Families in which there is less stress and in which parents or caregivers can provide consistency, warmth, and support are more likely to have children who are better able to cope and overcome challenges in the face of adversity. Young children need healthy attachment relationships to develop the adaptive resources that help them develop and adjust in school and in life. Further, it is very important to recognize the role that community and social supports play in promoting positive outcomes.

Findings From the Quality Improvement Center for Research-Based Infant–Toddler Court Teams and Safe Babies Court Team™

The Quality Improvement Center for Research-Based Infant–Toddler Court Teams (QIC-CT) is leading an effort in information-sharing and knowledge-building to help ensure that jurisdictions and states have the tools necessary to identify and address the underlying challenges faced by families in the child welfare system and to ensure that infants, toddlers, and families have access to high-quality, evidence-based services. The QIC-CT supports work in 11 sites around the United States to implement and institutionalize an innovative approach, based on the ZERO TO THREE Safe Babies Court Team™ (SBCT) approach. The QIC-CT court teams have focused on the ACEs of very young children in foster care as well as the ACEs of parents. From a prevention standpoint, we work collaboratively to develop intervention and treatment plans that reduce the risk of ACEs in very young children.

It is important to be sensitive when administering the ACEs survey to parents of young children in infant–toddler court teams. Best practices in administering the survey with this population include: ongoing review and gathering of responses for the survey being carried out over time, as a community coordinator or other trusted partner collecting the data learns about new risk factors. The 10 ACEs questions are personal and must be asked in a sensitive and empathetic
manner. Because it takes time to build a trusting relationship, the ACEs questions are better asked over time in the life of the case by someone with whom the parent has developed rapport. It may be that several encounters will be required to obtain the answers to all 10 questions.

The SBCT and QIC-CT court teams collected data from April 2015 through June 2017 on the ACEs scores of children and parents served by the SBCT and the court teams of QIC-CT, using the original 10-question CDC-Kaiser Permanent ACE Study. Data below includes survey responses from 218 parents from 8 states. QIC-CT staff also completed surveys for 313 children, from birth to 3 years old. In creating a protocol for the survey of children’s ACEs for court teams, certain definitions were instituted:

1. The children’s ACE survey completion included prenatal experiences (e.g., parental substance abuse) as well as the children’s experiences after birth.

2. Question #6, *Were your parents ever separated or divorced?*, was interpreted to include all separations between the child and his parents. This includes placement away from the child’s birth parents, abandonment, or parental death as well as the original definition that the child’s parents’ current marital status is divorced or separated. When children were removed at birth, this also counted as an affirmative answer to the question.

ACE Scores of Young Children in Infant–Toddler Court Teams

Once a young child enters the foster care system, they automatically receive a score of two ACEs:

- separation from one or both birth parents and
- some form of abuse or neglect.

A snapshot of young children under 3 years old served by the infant–toddler court teams of the QIC-CT and the SBCT reveals, on average, that these children experience 4.1 ACEs. Of the 313 children who were part of this study, 59% had an ACE score of 4 or higher. (See figure ACE Scores of Children in the SBCT/QIC-CT.)

The most common type of ACEs experienced by young children in our court teams all fall under the “Household Dysfunction” category. These include: parental separation or divorce (89% of children), household substance abuse (79%), and household mental illness (64%). Though involvement in the SBCT will not undo ACE experiences for young children, the SBCT approach provides concrete strategies that support resilience in young children and their families. An infant–toddler court team uses their unique knowledge of their community to find local solutions and interventions that meet the developmental needs of infants and toddlers in foster care.
Connection to trauma-informed services for children and parents who have had these traumatic experiences may help young children achieve more positive developmental outcomes, as children learn to trust and form secure attachments and relationships with their birth parents, foster parents, or both.

(See figure Types of ACESs of Children in the SBCT/QIC-CT.)

ACE Scores of Parents in Infant–Toddler Court Teams

Of the 17,000 participants in the national CDC-Kaiser Permanente ACEs study, 36% experienced zero ACEs, and 26% experienced 1 ACE. In contrast, only 18.8% of the parents of children under 3 years old served by the QIC-CT and SBCT court teams experienced fewer than 2 ACEs. On average, parents experienced 4.6 ACEs. A staggering 63% of parents at QIC-CT and SBCT sites have 4 or more ACEs (see figure ACE Scores of Adults in the SBCT/QIC-CT). The families the court teams work with face an overwhelming number of risk factors in comparison to the general population.
The most common type of ACEs experienced by the parents of young children in our court teams were: parental separation or divorce (80% of parents), household substance abuse (64% of parents), and physical abuse (52% of parents). As we learn more about the trauma histories of parents of young children in the SBCT and QIC-CT court teams, we can continue to understand the importance of ensuring that members of infant–toddler court teams treat all parents with dignity and respect and strive to develop an emotional connection with families that allow for genuine relationships of concern and support. A goal of the SBCT and QIC-CT, in addition to working to achieve timely permanence, is to prevent further abuse and neglect. By addressing the parents’ ACEs in addition to those of the young children, progress can be made in improving short and long-term outcomes for the parents and the children, breaking the intergenerational cycle of abuse and neglect. (See figure Types of ACES of Parents in the SBCT/QIC-CT.)

Implications for Infant–Toddler Court Teams

For young children who, because of experiences of adversity in their homes and communities, have dysregulated behaviors and emotions, we may think that these experiences have set these children on a negative lifelong path. Yet, research shows us that these experiences do not have to dictate a child’s future; when negative early experiences occur concurrently with protective factors, there is an opportunity to promote resilience.¹¹ We have the tools to help families and support systems in providing crucial protective and promotive factors in the lives of very young
children through the SBCT approach. Because families live in communities, we cannot hope to change the lived experience of the child welfare system without changing how we as humans interact with one another in those communities. 

Court teams have the opportunity to help the families we work with by addressing the ACEs of parents and the traumatic stressors present in their lives. Court teams respond to parents’ needs by building trusting, supportive relationships and identifying and building on family strengths. SBCTs are learning laboratories that can drive state and federal policy changes, where professionals can practice a form of collaborative work that is inclusive, welcoming, and non-blaming. By working together to support families, the SBCT communities become a model of democracy and shared responsibility for improving the lives of one another and the families we serve.

Appendix: Definitions of Adverse Childhood Experiences for Children’s Survey Completion in the Infant-Toddler Court Teams

Each question asks you to describe any adverse childhood experience (ACE) that occurred prior to the 18th birthday, which has been defined to include the prenatal period. As you answer each question, pay close attention to the framing of the question as you consider your answer. In the following specific guidance about the ACE questions, additional considerations are included, especially as they apply to children removed at birth.

1. Did a parent or other adult in the household often or very often . . . Swear at you, insult you, put you down, or humiliate you? or act in a way that made you afraid that you might be physically hurt? This is emotional or psychological abuse. Answer “yes” if parent reports psychological aggression, such as threatening the child or calling him names.

2. Did a parent or other adult in the household often or very often . . . Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? This is physical abuse. Answer “yes” if a parent reports severe assault or caseworker reports physical abuse, such as shaking an infant or hitting an older child.

3. Did an adult or person at least 5 years older than you ever . . . Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? This is sexual abuse. Answer “yes” if a parent or caseworker reports sexual abuse or forced sex reported by the child.
4. Did you often or very often feel that . . . No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? This is emotional or psychological neglect. Answer “yes” if caregiver reports that in the past 12 months she was so caught up with problems that she was not able to show or tell her child the she loved him, or shows indifference toward the child, or lacks appreciation for the child, or is unable to describe the child and support his uniqueness.

5. Did you often or very often feel that . . . You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? This is physical or medical neglect. Answer “yes” if a parent reports child neglect or the caseworker reports failure to supervise or provide for the child.

6. Were your parents ever separated or divorced? This is parental separation or divorce. Answer “yes” if the child is placed out of home currently or at baseline, or the caseworker reports abandonment, or caregiver’s current marital status is divorced or separated, or the mother or father is deceased. For children removed at birth, answer “yes.”

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? This is domestic or intimate partner violence. Answer “yes” if the caregiver or caseworker reports any domestic violence such as slapping, hitting, or kicking (includes both male and female caregivers who reported domestic violence). Answer “yes” for children removed at birth if the mother was assaulted by her partner during the pregnancy.

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs? This is household substance abuse. Answer “yes” if the caseworker reports active alcohol or drug abuse by the primary or secondary caregiver, or caregiver reports current alcohol abuse. For children removed at birth, answer “yes” if the mother used alcohol or drugs during pregnancy.

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? This is household mental illness. Answer “yes” if caseworker reports a caregiver having a serious mental health problem, or elevated mental health symptoms. For children removed at birth, answer “yes” if the mother was depressed or has a diagnosed mental illness, or attempted suicide during the pregnancy.

10. Did a household member go to prison? This is incarceration of a member of the child’s household. Answer “yes” if the caregiver reports spending time in prison as a result of an arrest, or a parent is currently in jail or a detention center. For children removed at birth, answer “yes” if the mother was incarcerated during her pregnancy. For all other children, include the pre- and postnatal periods.
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Contact Us

For resources from the Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-CT), please visit www.qicct.org. For inquiries on the QIC-CT, contact: QIC-CT@zerotothree.org.

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i. www.cdc.gov/violenceprevention/acestudy/about.html
ii. www.cdc.gov/violenceprevention/acestudy/index.html
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viii. www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health


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The Core Components of the Safe Babies Court Team™ Approach

ZERO TO THREE’s Safe Babies Court Teams (SBCTs) focus on concrete strategies that allow the professionals who interact most directly with families to improve the parents’ and their children’s experience of the child welfare system. The SBCT approach is based on 12 core components that articulate a developmentally sensitive way to respond to child maltreatment of infants and toddlers. Although we have always focused on foster and birth parents (newly added as Core Components 5 and 7), we have not previously carried that focus into the core components. Carried across all 12 core components is the SBCT aspiration to address the poverty, trauma, and racism that most of our families confront. Every one of the 12 core components contributes to our racial equity and human dignity platform.

Each SBCT works to implement all 12 components locally, using their unique knowledge of their community to find local solutions that meet the developmental needs of infants and toddlers in foster care.

1. Judicial Leadership: Before there is an SBCT, there is a judge or a child welfare agency leader who is tired of seeing the children become the parents and then the grandparents of babies in foster care, who is passionate about doing right by babies, and who recognizes the importance of the child’s first 3 years. They recognize the value in reforming the child welfare system’s response to the youngest children as an initial step in avoiding the next generation of child maltreatment. From the bench, the judges set the tone of dignity and respect. Their demeanor reflects an understanding of how traumatic experiences contribute to the parents’ behavior in hearings and interactions with social services. Judges set an expectation that hearings are conducted in a caring and thoughtful manner, leading the effort to reduce the adversarial nature of court proceedings. The judges keep everyone focused on achieving timely permanency and resolving the issues that brought families into the system. This approach reduces the stress level of both families and professionals in the court. Off the bench, judges also know that their best efforts are insufficient if they are not combined with the work of the whole community. Local judges in SBCT communities are the catalysts for change because of their unique position of authority in the processing of child welfare cases.

2. Local Community Coordinator: In each SBCT community, a local Community Coordinator with child development expertise works with the judge to lead the SBCT. The Community Coordinator, with technical assistance provided by ZERO TO THREE, coordinates services and resources for infants and toddlers and their families within the local community. In addition, the Community Coordinator is responsible for staffing the stakeholder team (see Core Component 3), recruiting new members to the stakeholder team, entering data about the families served into the SBCT database, and representing the Court Team in various community efforts as well as the national SBCT learning community. Experience has taught us that the Community Coordinator should be employed full-time. Because of the multiple responsibilities of the position that include developing the community team and resources, the SBCT should adhere to a caseload limit of no more than 20 open cases at any one time. Saturating the work with more than 20 families per coordinator dilutes the quality of work done with each family.

3. Active Court Team Focused on the Big Picture: The SBCT is made up of key community stakeholders who commit to restructuring the way the community responds to the needs of infants and toddlers who are maltreated. The SBCT meets monthly to learn about the services available in the community, review data, identify gaps in services, and discuss issues and patterns raised by the cases that members of the SBCT are monitoring (see Core Component 8). Participation in the SBCT is by open invitation. It is anticipated that the diversity of agencies represented will expand over time.

4. Targeting Infants and Toddlers Under the Court’s Jurisdiction: Comprehensive services are offered to each child, including screening for developmental delays and disabilities, medical care delivered in a medical home, and mental health services that focus on the parent–child relationship.

5. Valuing Birth Parents: Because the first permanency goal is to help parents and children reunify, SBCTs must respond to the needs of the birth parents and the wide variety of traumatic stressors present in the parents’ lives. The families served by SBCTs face an overwhelming number of risk factors in comparison with the general population. Almost all of the parents of young children who enter the child welfare system have suffered their own history of trauma (Hudson, Beilke, & Many, 2016; Van Der Kolk, 2014). There are many forms of prejudice that families in the child welfare system confront because they are poor; unmarried; lesbian, gay, bisexual, or transgender;
adhere to non-Christian religious beliefs; or lack education. People of color bear the brunt of this oppression (American Psychological Association, 2016). Members of SBCTs must treat all parents with dignity and respect to develop an emotional connection with families that permit us to build genuine relationships of concern and support.

6. Concurrent Planning and Limiting Placements: From the baby’s point of view, it would be ideal if the person who agrees to take physical custody of the child when she is removed from her parents’ care would also agree to become the child’s permanent parent if the birth parents are unable to overcome the challenges that led to the need for a foster care placement. Very young children make sense of their world within the context of their relationships with a few cherished caregivers. All too often the transition into foster care carries with it several transfers between foster homes.

Concurrent planning places equal emphasis on supporting a second permanent family in the event that reunification is ruled out. It needs to begin at removal. To be successful, the team must support a mindset about fostering that values birth parents, understands the importance of placement stability, and recognizes the complicated dynamics that can come into play between birth and foster parents. Regardless of the final permanency outcome for the child—reunification, guardianship, or adoption—a relationship would ideally continue between the birth and foster parents after the child welfare case closes.

7. The Foster Parent Intervention: Mentors and Extended Family: Referred to by some experts as the primary intervention for children in foster care (C. Zeanah, personal communication, April 24, 2015), foster parents play a pivotal role in determining how safe and nurtured young foster children feel. Their role is multifaceted (Shauffer, 2012):
   a. To provide loving care for children placed with them.
   b. To advocate for the children in their homes.
   c. To nurture healthy relationships between the children in their care and birth parents, siblings, and extended family.

Balancing these roles requires training and support from the child welfare agency prior to and—as important—while foster parents are engaged with a child and his family. They should be regarded as respected members of the SBCT who participate in family team meetings, court hearings, and community training.

8. Pre-Removal Conferences and Monthly Family Team Meetings: Every day that babies spend in foster care limbo is a day we should be trying to resolve the issues that led to the child’s removal from home. With pre-removal conferences, we can begin our work before the child is removed from the home. Structured in much the same way family team meetings are organized, the parents are invited and asked to bring with them anyone they consider to be members of their support network. The meeting is facilitated by a trained mediator, either someone engaged by the child welfare agency or the Community Coordinator. The pre-removal conference sets the tone for the family team meetings that occur monthly. Parents and their chosen circle of support are key participants in these meetings.

9. Frequent Family Time (Visitation): The SBCT Project sees family time as a critical way to help the child and parents experience one another as loving partners in their relationship. Each family has their own strengths and challenges when it comes to spending time together, and plans for supporting their relationship must be formed on an individualized basis. Very young children become attached to their parents whether the parents are able to provide consistent loving care or not. Although the quality of that attachment may be insecure or even disorganized, separating a young child from her parents is still painful (Goldsmith, Oppenheim, & Wanlass, 2004). The goal of family time is to permit the child and parent to keep the other a living presence in their lives and to improve the parent’s responsiveness to the child’s needs. Research has found a correlation between the frequency of family time and the length of time it takes for the child to reach permanency: having more planned visiting days each week was linked to the likelihood that children will achieve permanency within a year; each additional visit tripled the odds (Potter & Klein-Rothschild, 2002).

10. Continuum of Mental Health Services: Infants and toddlers who have experienced trauma may benefit from mental health services that work with them and their parents and foster parents to learn to trust again and form secure attachments and relationships with their birth parents and foster parents. Parents who maltreat their very young children need some level of intervention to help them understand their children’s needs and learn ways to build strong supportive bonds. The intensity of the intervention should mirror the specific characteristics of the parent and child as well as the level of preexisting trauma in their relationship and in the parent’s own childhood experiences. In order of intensity, recommended interventions include the following:

An assessment of the parent–child relationship. Relationship assessments include two primary procedures (Lieberman & Van Horn, 2007): a structured interactional play assessment that reveals how the caregiver behaves with the child and an interview with the adult to understand the adult’s “working model of the child.” This allows the clinical evaluator to assess the adult’s ability to provide appropriate care to the child.

Teachable moments. Taking advantage of in-the-moment opportunities to help parents successfully respond to their child’s behavior.

Visit coaching. Visit coaches can come from a range of professions including child welfare caseworkers, in-home service providers, and Court Appointed Special Advocate volunteers. They work closely with the parents to make each visit a good experience.

Psychoeducational parenting intervention. In individual sessions with parents and their young child, a trained professional shares information on child development and how best to meet the child’s needs while assisting the parents in using newly acquired information and skills.
Child–Parent Psychotherapy. In Child–Parent Psychopathy, the clinician seeks to heal the relationship between the child and the parent by helping the parent develop a realistic assessment of the child’s needs and abilities. In determining the number of families referred for Child–Parent Psychopathy, the SBCT family teams will need to work closely with the mental health clinicians providing services to SBCT families to avoid exceeding capacity.

11. Training and Technical Assistance: ZERO TO THREE staff and consultants provide training and technical assistance to the SBCT community on topics such as infant and toddler development; parenting interventions; services available to foster children in the community; children and trauma; as well as parental substance abuse, domestic violence, mental illness, and poverty. Through weekly team meetings and individual supervisory calls, SBCT Project leadership staff provide support and direction to each of the Community Coordinators. By participating in ZERO TO THREE’s annual Scientific Meeting and Annual Conference and in the SBCT annual Cross Sites meeting, the Community Coordinators, judges, and key members of the SBCTs are integrated into the larger framework of ZERO TO THREE’s efforts on behalf of infants and toddlers.

12. Understanding the Impact of Our Work: Each SBCT evaluates its work. The approach is focused on bringing key participants into continuous quality improvement and evaluation planning. Continuous quality improvement is a process for identifying areas of strength to build on in future work and challenges to address through deliberate action.

References


Hudson, L., Beilke, S., & Many, M. (2016). “If you brave enough to live it, the least I can do is listen”: Overcoming the consequences of complex trauma. ZERO TO THREE Journal, 36, 4–11.


ZERO TO THREE is pleased to share news of an exciting new e-Learning resource to support enhanced practice with very young children and their families in child abuse and neglect cases: Putting the Science of Early Childhood to Work in the Courtroom: A Series for Judges and Attorneys.

These high-quality, interactive online learning modules bring the law, science, and evidence-based practice together into one highly accessible and engaging resource for the busy legal professional—providing judges and attorneys with the information and strategies they need to secure a bright future for the young children who come before the court. Each of the eight 45-minute modules in this series concentrates on key issues in child welfare law and ways to enhance court practice in cases involving very young children:

- Strengthening Relationships: Promoting Child Well-Being
- Understanding the Impact of Trauma on Parents
- Meeting Parents Where They Are: Helping Parents to Move Forward
- Equity and Equality for Children and Families
- The Trauma-Responsive Court
- A Healing Perspective on Substance Use Disorders
- The Power of Collaboration
- Achieving Timely Permanency Begins on Day One

Developed by ZERO TO THREE’s Quality Improvement Center for Research-Based Infant Toddler Court Teams—a partnership with the National Council of Juvenile and Family Court Judges, the Center for the Study of Social Policy, and RTI International—the content was developed in close consultation with judges, attorneys, court improvement staff, and national experts from across the country. This educational opportunity, which is available at no cost, offers both new and experienced judges and attorneys a journey through self-directed learning activities and videos. The engaging curriculum presents reflections, insights, and practice tips from experienced peers along with information about best practices from experts in the field.

This exciting new resource is available at the following websites:

- ZERO TO THREE: www.zerotothree.org/learningcenter

For more information, please contact Janie Huddleston, Director of the National Infant-Toddler Court Program, at jhuddleston@zerotothree.org.

The Quality Improvement Center for Research-Based Infant Toddler Court Teams (2014-2018) was funded through the U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau, Grant #90CA1821-01-01. The contents of this publication do not necessarily reflect the views or policies of the funders, nor does the mention of trade names, commercial products, or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain.
INTRODUCTION: This Plan of Safe Care (POSC) is being developed to ensure that necessary services and supports are in place for the mother, infant and family upon discharge from the birthing hospital. The POSC is developed by gathering information from the mother and her family, from the birthing hospital medical record and social worker notes, as well as input from community partners involved in supporting the mother and infant. The Family Assessment Form may be used as an information gathering tool to assist with the preparation of the POSC. A copy of this POSC will be shared with the identified “Plan Participants” in Section C of this document with the consent of the family within 48 hours after infant is discharged from the hospital.

A. FAMILY INFORMATION          DATE: ______________________

INFANT
Infant’s Name (as it appears on birth certificate): __________________________________________________________ DOB: ____________ Gender: _____
Birth Hospital: ______________________________________________________________________________________________________

PARENT(S)
Mother’s Full Name: ___________________________________________________________ DOB: __________________________
Street Address: __________________________________________________________________ City: _________________ State: _______ Zip: __________
Contact/Cell Number: __________________________________________________________
Mother’s Employer: ______________________________________________________________ Employer Contact/Number: ___________________________

Father’s Full Name: ______________________________________________________________ DOB: __________________________
Street Address: __________________________________________________________________ City: ________________ State: _______ Zip: __________
Contact/Cell Number: __________________________________________________________
Father’s Employer: ______________________________________________________________ Employer Contact/Number: ___________________________
SECONDARY CAREGIVER(S) (If one parent is not involved):

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Relationship to Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

SUPPORT PERSON(S) for Parents and/or Child

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Relationship to Parent(s) and/or Child</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

SIBLING(S) of Child

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Resides with? (Name/address/City/State/Zip)</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
B. PLAN OF SAFE CARE COORDINATOR ("POSC Coordinator")

*The primary role of the POSC Coordinator is the preparation, implementation and oversight of the POSC for the family. The POSC Coordinator will be responsible for ensuring appropriate referrals for services are made for the infant and family. The POSC Coordinator will act as the primary point of contact for the family and Plan Participants during the development and implementation period. The POSC Coordinator will share information, with informed consent, with the Plan Participants.

POSC Coordinator’s Name: ____________________________________________________________

Phone: ______________________  Email: ________________________________________________

Fax: _________________________

POSC Coordinator’s Supervisor’s Name: ________________________________________________

Phone: ______________________  Email: ________________________________________________

Fax: _________________________

POSC Coordinator’s Agency Name: _____________________________________________________
C. PLAN PARTICIPANTS for Infant and Family Care

*The Plan Participants are the partners involved in the development and implementation of the POSC. All identified Plan Participants below will receive a copy of this POSC from the POSC Coordinator within 48 hours after the hospital Plan of Safe Care Discharge Meeting.

1. Birthing Hospital and Social Worker Name: ____________________________________________
   Phone: ____________________

2. DFS/Child Welfare Worker Name: ____________________________________________
   Phone: ____________________

3. Infant's Primary Care Doctor Name: ____________________________________________
   Phone: ____________________  Next Appointment Date: ____________________

4. Infant’s Specialist Physician Name: ____________________________________________
   Phone: ____________________  Next Appointment Date: ____________________

5. Home Visiting Nurse Agency and Provider Name: __________________
   Phone: ____________________  Next Appointment Date: ____________________

6. Mother’s PCP/OB/GYN Name: ____________________________________________
   Phone: ____________________  Next Appointment Date: ____________________

7. Mother’s SUD or MAT Treatment Provider Name: __________________
   Phone: ____________________  Next Appointment Date: ____________________

8. Father’s SUD or MAT Treatment Provider Name: __________________
   Phone: ____________________  Next Appointment Date: ____________________

9. Mother’s Mental Health Treatment Provider Name: __________________
   Phone: ____________________  Next Appointment Date: ____________________
10. Father’s Mental Health Treatment Provider Name: ________________________________________________________________

Phone: _____________________  Next Appointment Date: __________________________________________________________

11. Peer Recovery Coach Name: ________________________________________________________________________________

Phone: _____________________  Next Appointment Date: _________________________________________________________

12. Other: _____________________________________________________________________________________________

Phone: _____________________  Next Appointment Date: _________________________________________________________

D. IDENTIFIED NEEDS, RISKS AND INTERVENTIONS FOR THE FAMILY

*Based upon the information gathered by the POSC Coordinator during the Family Assessment phase, the following section identifies the needs of the infant, mother, father or other caregiver, and the referrals that are being made for appropriate services and treatment for the family.

1. INFANT RISKS/NEEDS

REFERRALS MADE BY POSC COORDINATOR AT HOSPITAL DISCHARGE

a) Exposure/Withdrawal Symptoms

Reason for Referral: ____________________________________________________________

Referred to: ________________________________________________________________

Referral Contact Person and Phone: _____________________________________________

Date Referred: ____________________________

b) Developmental Needs/Child Development Watch/Smart Start

Reason for Referral: ____________________________________________________________

Agency Referred to: ____________________________________________________________

Agency Contact Person and Phone: _____________________________________________

Date Referred: ________________________________________________________________
c) Other Medical Conditions
   Reason for Referral: ____________________________________________________________
   Medical Facility Referred to: ____________________________________________________
   Medical Contact Person and Phone: _____________________________________________
   Date Referred: __________________________________________________________________
   Special Medical Equipment needed? If so, type of equipment? _________________________
   Special Medical Equipment training needed? _______________________________________
   If so, date training was completed by parents/caregivers: ____________________________

d) Infant Sleeping Arrangements:
   Type of sleeping arrangements for infant in the home?
   Crib: ______ Pack-n-Play: ______ Bassinet: ______ Other: _________________________
   Parents/Caregivers were provided Infant Safe Sleeping education on this date: ____________
   Agency/person(s) who provided Infant Safe Sleeping education to parents/caregivers?
   ____________________________________________________________
   Parents/Caregivers acknowledge understanding of Infant Safe Sleeping education:
   ____________________________________________________________
   Parents/Caregivers Initials Here: _________________________________________________

e) Other Infant Needs/Risks
   Reason for Referral: ____________________________________________________________
   Agency/Person Referred to: ______________________________________________________
   Contact Person and Phone: ______________________________________________________
   Date Referred: __________________________________________________________________
2. MOTHER’S NEEDS

REFERRALS MADE BY POSC COORDINATOR

a) Substance Use/Abuse
Reason for Referral: ________________________________________________________________
Currently Engaged in Treatment? If so, name of Current Provider: ____________________________
   If not, Agency Referred to: ____________________________________________________________
   Agency Contact Person and Phone: __________________________________________________________
   Date Referred: _________________________________________________________________________

b) Alcohol Use/Abuse
Reason for Referral: ________________________________________________________________
Currently Engaged in Treatment? If so, name of Current Provider: ____________________________
   If not, Agency Referred to: ____________________________________________________________
   Agency Contact Person and Phone: __________________________________________________________
   Date Referred: _________________________________________________________________________

c) Mental/Behavioral Health
Reason for Referral: ________________________________________________________________
Currently Engaged in Treatment? If so, name of Current Provider: ____________________________
   If not, Agency Referred to: ____________________________________________________________
   Agency Contact Person and Phone: __________________________________________________________
   Date Referred: _________________________________________________________________________

d) Parenting Skills/Attachment/Bonding
Reason for Referral: ________________________________________________________________
Agency Referred to: ____________________________________________________________________
Agency Contact Person and Phone: __________________________________________________________
**e) Family Planning Needs**

Agency Referred to: 

Agency Contact Person and Phone: 

Date Referred: 

---

**f) Basic Needs Housing/Food/Transportation**

Reason for Referral: 

Agency Referred to: 

Agency Contact Person and Phone: 

Date Referred: 

---

**g) Other**

Describe: 

Agency Referred to: 

Agency Contact Person and Phone: 

Date Referred: 
3. FATHER’S (or Other Caregiver’s) NEEDS  REFERRALS MADE BY POSC COORDINATOR

a) Substance Use/Abuse  
Reason for Referral: ________________________________________________________________
Currently Engaged in Treatment? If so, name of Current Provider: ___________________________
   If not, Agency Referred to: ___________________________________________________________
   Agency Contact Person and Phone: ___________________________________________________
   Date Referred: ______________________________________________________________________

b) Alcohol Use/Abuse  
Reason for Referral: ________________________________________________________________
Currently Engaged in Treatment? If so, name of Current Provider: ___________________________
   If not, Agency Referred to: ___________________________________________________________
   Agency Contact Person and Phone: ___________________________________________________
   Date Referred: ______________________________________________________________________

c) Mental/Behavioral Health  
Reason for Referral: ________________________________________________________________
Currently Engaged in Treatment? If so, name of Current Provider: ___________________________
   If not, Agency Referred to: ___________________________________________________________
   Agency Contact Person and Phone: ___________________________________________________
   Date Referred: ______________________________________________________________________

d) Parenting Skills/Attachment/Bonding  
Reason for Referral: ________________________________________________________________
10

Agency Referred to: ________________________________________________________________
Agency Contact Person and Phone: _________________________________________________
Date Referred: ___________________________________________________________________

e) Family Planning Needs
Agency Referred to: ________________________________________________________________
Agency Contact Person and Phone: _________________________________________________
Date Referred: ___________________________________________________________________

f) Basic Needs Housing/Food/Transportation
Reason for Referral: ________________________________________________________________
Agency Referred to: ________________________________________________________________
Agency Contact Person and Phone: _________________________________________________
Date Referred: ___________________________________________________________________

g) Other
Reason for Referral: ________________________________________________________________
Agency Referred to: ________________________________________________________________
Agency Contact Person and Phone: _________________________________________________
Date Referred: ___________________________________________________________________
### E. OTHER SUPPORT SERVICES FOR FAMILY

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>REFERRALS MADE BY POSC COORDINATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Home Visiting Nursing Program</td>
<td>Date Referred: ____________________</td>
</tr>
<tr>
<td></td>
<td>Agency Referred to: __________________</td>
</tr>
<tr>
<td></td>
<td>Agency Contact Name and Phone: __________________</td>
</tr>
<tr>
<td>b) WIC</td>
<td>Date Referred: ____________________</td>
</tr>
<tr>
<td></td>
<td>Agency Referred to: __________________</td>
</tr>
<tr>
<td></td>
<td>Agency Contact Name and Phone: __________________</td>
</tr>
<tr>
<td>c) Employment/Training</td>
<td>Date Referred: ____________________</td>
</tr>
<tr>
<td></td>
<td>Agency Referred to: __________________</td>
</tr>
<tr>
<td></td>
<td>Agency Contact Name and Phone: __________________</td>
</tr>
<tr>
<td>d) Financial Assistance</td>
<td>Date Referred: ____________________</td>
</tr>
<tr>
<td></td>
<td>Agency Referred to: __________________</td>
</tr>
<tr>
<td></td>
<td>Agency Contact Name and Phone: __________________</td>
</tr>
<tr>
<td>e) Parenting Class</td>
<td>Date Referred: ____________________</td>
</tr>
<tr>
<td></td>
<td>Agency Referred to: __________________</td>
</tr>
<tr>
<td></td>
<td>Agency Contact Name and Phone: __________________</td>
</tr>
</tbody>
</table>
f) Managed Care Organization

Date Referred: ________________________________________________________________

Agency Contact Name and Phone: ________________________________________________

---

g) Other

Date Referred: ________________________________________________________________

Agency Referred to: ____________________________________________________________

Agency Contact Name and #: ____________________________________________________

---

Hospitl Education Provided to Mother/Father or other Caregivers (check all that apply):

- Safe Sleeping
- Newborn Safety
- SIDS
- NAS Withdrawal Symptoms and Management
- Abusive Head Trauma
- Family Planning
- Infant Feeding
- Other: ____ ____________________________
F. DISCHARGE AND FOLLOW UP

Date of Discharge for Mother: ______________________________________________________________________________________________________

Date of Discharge for Infant: _________________________________________________________________________________________________________

   Infant Discharged to whom (primary caregiver(s)): _________________________________________________________________________________

   Discharge destination (primary caregiver(s) address): _______________________________________________________________________________

   Secondary/Part-time destination (name of caregiver and address):

       Frequency that infant will reside/visit at Secondary/Part-time address: ________________________________________________________________

DFS Child Safety Agreement in addition to POSC? ________________________________________________________________

   If yes, provide details: _________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________

Explain Frequency of Contact by Plan of Safe Care Coordinator and Plan Participants with the Family (ie.weekly): ______________________________

__________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________

Date of Next Multidisciplinary Meeting (in person or via teleconference) with Plan Participants to monitor POSC progress and challenges: _______________

__________________________________________________________________________________________________________________________

Plan of Safe Care Progress/Challenges/Additional Needs: ________________________________________________________________
G. CONSENT FOR INFORMATION SHARING

By signing below, Mother, Father or other caregiver(s) acknowledge that the Plan of Safe Care has been prepared, reviewed and thoroughly discussed. It is understood that medical information will be shared/disclosed with the Plan Participants (Section C) under this written consent as provided by HIPPA (45 CFR 160, 164). It is also understood that substance use treatment information will be shared/disclosed with the Plan Participants under this written consent per 42 CFR Part 2. The Mother, Father or other caregiver(s) hereby consent to the sharing of the POSC with the Plan Participants.

The Plan Participants will regularly communicate and share information to ensure that timely referrals for services are made by the POSC Coordinator and that the appropriate services are delivered to the family. The POSC Coordinator and Plan Participants agree to ensure confidentiality of the information received through the POSC and agree to only share information with the identified Plan Participants.

The POSC Coordinator hereby confirms that the Division of Family Services has been notified of the infant’s birth, this Plan of Safe Care has been prepared for the infant and family and a copy of the Plan has been provided to the Plan Participants listed in Section C of this document with mother’s consent.

Plan of Safe Care Coordinator: _________________________________ Date _______________
Supervisor: _________________________________________________ Date _______________
Parent Signature: ___________________________________________ Date _______________
Parent Signature: ___________________________________________ Date _______________
Other Caregiver: ___________________________________________ Date _______________
Other Support Person: _________________________________________ Date _______________
Other plan participant: _________________________________________ Date _______________
Other plan participant: _________________________________________ Date _______________

(Version: 9/2018)
Plan of Safe Care (POSC) for Mothers and Infants

Handle with C.A.R.E. Template

Mother’s Name: ____________________ EDD: _______ Child’s Name: ____________________ Birth Date: _______

Date POSC initiated: ____________ POSC Monitor: __________________________________________

A Plan of Safe Care is a guide developed by service providers and their clients to ensure mothers and other caregivers have the skills and resources necessary to care for infants who were substance exposed during their mother’s pregnancy. Each woman and infant’s needs vary. The service needs addressed in this Plan of Safe Care parallel the requirements set forth in the Substance Abuse Prevention and Treatment Block Grant (SAPT) for treating pregnant and parenting women who use substances.

To promote the best outcomes, a Plan of Safe Care (POSC) should include input from all service providers involved in the mother and infant’s care such as: OB/GYNs, Doctors, Nurse Practitioners, Midwives, Opioid Treatment Programs, Behavioral Health Providers, Child Welfare Providers, Home Visitors, and Part C Early Intervention. The POSC should be shared with each provider and, together, they should determine which provider will assume responsibility for managing and monitoring the plan with the client. Depending upon the mother and infant’s needs and wishes, this could be the medical provider, behavioral health clinician, home visitor or the child welfare provider. Please be sure to indicate any services that were recommended but declined by the family.

<table>
<thead>
<tr>
<th>MOTHER’S HEALTH CARE</th>
<th>Describe Mother’s Plan (include WHO, WHEN, WHERE)</th>
<th>Referral/Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Prenatal Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s Postpartum and Other Medical Care</td>
<td></td>
<td></td>
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<tr>
<td>Coverage for Mother’s Medical Care (e.g. FAMIS, Medicaid, private insurance, etc.)</td>
<td></td>
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<tr>
<td>Does Mother have a Delivery Plan that addresses location, transportation, personal needs, medication at birth, breastfeeding etc.</td>
<td></td>
<td></td>
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<tr>
<td>Nutrition Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plans for Breastfeeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tbody>
</table>
### BEHAVIORAL HEALTH SERVICES FOR MOTHER

<table>
<thead>
<tr>
<th>Describe Mother’s Plan (include WHO, WHEN, WHERE)</th>
<th>Referral/Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Assessment and Treatment</td>
<td></td>
</tr>
<tr>
<td>Substance Use Assessment and Treatment</td>
<td></td>
</tr>
<tr>
<td>Medication Assisted Treatment (medication management for MAT &amp;/or psychotropic medicines)</td>
<td></td>
</tr>
<tr>
<td>Domestic Violence Assessment and Services</td>
<td></td>
</tr>
<tr>
<td>Trauma Assessment and Services</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

### BEHAVIORAL HEALTH SERVICES FOR OTHER INDIVIDUALS WHO PROVIDE CARE FOR THE CHILD

<table>
<thead>
<tr>
<th>Identify Caregiver, Describe Plan(include WHO, WHEN, WHERE)</th>
<th>Referral/Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for mother’s partner /significant other</td>
<td></td>
</tr>
<tr>
<td>Services for other caregivers</td>
<td></td>
</tr>
</tbody>
</table>

### PARENTING

<table>
<thead>
<tr>
<th>What information/ guidance has been provided</th>
<th>Referral/Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Sleep Environment</td>
<td></td>
</tr>
<tr>
<td>Anticipatory guidance regarding Neonatal Abstinence Syndrome (NAS)</td>
<td></td>
</tr>
<tr>
<td>Anticipatory guidance regarding Fetal Alcohol Spectrum Disorder (FASD)</td>
<td></td>
</tr>
<tr>
<td>Strategies and techniques for caring for a substance exposed infant (SEI)</td>
<td></td>
</tr>
<tr>
<td>Education regarding the importance of attachment and bonding</td>
<td></td>
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</tbody>
</table>
## Plan of Safe Care (POSC) for Mothers and Infants

### FAMILY'S LIVING NEEDS

<table>
<thead>
<tr>
<th></th>
<th>Plan (include WHO, WHEN, WHERE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food/Nutrition/WIC</td>
<td></td>
<td></td>
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<tr>
<td>Transportation</td>
<td></td>
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<tr>
<td>Other</td>
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</tbody>
</table>

### INFANT/CHILD’S HEALTH AND WELFARE (0 – 4 years)

<table>
<thead>
<tr>
<th></th>
<th>Plan (include WHO, WHEN, WHERE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Care/Medical Home</td>
<td></td>
<td></td>
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<tr>
<td>Specialty Care Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child’s basic needs post-delivery (e.g. diapers, formula, clothing, crib, car seat, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage for Child’s Medical Care (e.g. FAMIS, Medicaid, private insurance, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>Plans for Child Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-discharge Supports</td>
<td></td>
<td></td>
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<tr>
<td>Nutrition/WIC</td>
<td></td>
<td></td>
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</tbody>
</table>
Plan of Safe Care (POSC) for Mothers and Infants

<table>
<thead>
<tr>
<th>Plan (include WHO, WHEN, WHERE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protective Services</td>
<td></td>
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<tr>
<td>Developmental Screening/Part C Services</td>
<td></td>
</tr>
<tr>
<td>Attachment and Bonding Services</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

**SUPPORT SYSTEM**

<table>
<thead>
<tr>
<th>Plan (include WHO, WHEN, WHERE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Supports</td>
<td></td>
</tr>
<tr>
<td>Recovery Supports</td>
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</tr>
<tr>
<td>Formal Support Systems</td>
<td></td>
</tr>
<tr>
<td>Information Sharing</td>
<td></td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>

*11/8/2017*
18th ABA National Conference on Children & the Law, April 9-10, 2019

Workshop Session: Improving Permanency Outcomes for Children and Families Impacted by Trauma and Serious Adversity: Lessons Learned from Infant-Toddler Court Teams

Recommended Readings & Resources:


**Key Resources on CARA/Plans of Safe Care:**
Casey Family Programs. (November, 2017). *Information Packet: What are infant plans of safe care, and some examples of state responses to infants affected by substance abuse?*

National Center on Substance Abuse and Child Welfare. (March, 2018). *A planning guide: Steps to support a comprehensive approach to plans of safe care (DRAFT).*

[https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf](https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf)

**For information about Infant-Toddler Court Teams and the SBCT approach, please explore:**
- ZERO TO THREE: [https://www.zerotothree.org/search?q=safe+babies+court+team](https://www.zerotothree.org/search?q=safe+babies+court+team)
- Quality Improvement Center for Infant-Toddler Court Teams: [http://www.qicct.org/](http://www.qicct.org/)