chapter 3

Addressing Early Mental Health and Developmental Needs

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Factors that Influence Social-Emotional Development of Young Children

- Understand how child maltreatment affects children's development.
- Ensure placements for very young children provide long-term stability and promote healthy attachments.

Mental Health Assessment and Services

- Order an immediate screening of the child's mental health issues.
- Require a screening to identify developmental delays and disorders.
- Ensure the comprehensive mental health assessment is initiated within 30-60 days of placement.
- Order a reassessment of the child's mental health status during placement.
- Ensure a continuum of services is offered to each child.
- Ensure frequent parent-child contact.
- Ensure frequent sibling contact.
- Ensure the mental health and emotional needs of the parent(s) are assessed and appropriate services are provided.
- Order a determination of the intensity and type of services required to meet the family's needs.
- Order an assessment to determine whether the child and parent would benefit from Child-Parent Psychotherapy.

- Order an assessment of whether the child and parent would benefit from Parent-Child Interaction Therapy (PCIT).
- Ensure services respond to the needs of different ethnic and cultural groups.

Early Care and Education

- Ensure children participate in positive early childhood learning experiences.
- Carefully consider the availability and quality of early care and education settings.

From birth, babies look to trusted adults to meet their needs. When their needs are met, babies thrive. When their needs are not met, their social-emotional development (mental health) is compromised. In either case, babies' brains are learning what to expect from the world, and whatever happens during the first three years becomes part of the brain's hard wiring. The zero-to-three age range is the time when the greatest amount of development occurs in the brain.

Even though the brain is constantly growing, changing, and forming new connections during early childhood, recovering lost connections becomes much harder with age. Babies are born with just a portion of the connections they will later develop. Through their relationships with caregivers and trusted adults who talk to, play with, and comfort them, the brain will build many connections. In fact, a newborn's brain produces many more connections than will be needed during childhood. The connections that are not used or needed become weaker and are eventually tossed away, or pruned from the brain.

Research shows that removing a child from a neglectful home after age four offers little opportunity to recover the initial attachment.[1] That is why early maltreatment is potentially so damaging. The sooner a child is able to develop a consistent, positive attachment with a primary caregiver, the more likely he will develop the confidence and intellectual curiosity to succeed throughout childhood and as an adult. The key to healthy social and emotional development is positive and consistent early experiences with loving caregivers. Supportive interventions for children and their parents and quality early child care and educational experiences are also important to promoting children's positive mental health.

As a judge, you can guard the mental health of very young children by making sure that:

- placement decisions are made wisely at the outset that promote long-term stability and healthy child-caregiver attachments,
- ties are maintained with birth parents and siblings through frequent quality visits, and
- permanency decisions respect the bonds children have forged in out-of-home care.

Factors that Influence Social-Emotional Development of Young Children

Understand how child maltreatment affects children's development.

In very young children, the terms *social-emotional development* and *infant mental health* are used interchangeably. Social-emotional development describes "the

Common Mental Health and Developmental Disorders of Infancy and Early Childhood

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) was first published in 1994 by Zero To Three to address the need for a systematic, developmentally based approach to the classification of mental health and developmental disorders in the first four years of life. The DC:0-3R was published in 2005 and builds on the tradition of the first version. DC:0-3R uses a multiaxial system with five major classifications of disorders and they are:

- **Axis I:** The infant's primary diagnosis. Examples are posttraumatic stress disorder, affective disorders and eating behavior disorders.
- **Axis II:** Disorders related to the caregiver-child relationship. Examples of categories include angry/hostile, over-/underinvolved, verbally, physically, or sexually abusive relationship disorders.
- **Axis III:** Medical and/or developmental conditions including developmental language disorder, failure to thrive, and cerebral palsy.
- **Axis IV:** Acute and chronic stressors in the child's environment. Examples are parental psychopathology and parental conflict.
- **Axis V:** The young child's current functional and emotional level of adaptation.

Source:
Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3). Washington, DC: Zero to Three Press, 1994; *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R).* Washington, DC: Zero to Three Press, 2005.

developing capacity of the child from birth through five years of age to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and learn—all in the context of family, community, and culture."[2]

Healthy emotional and psychological development of infants and young children requires that the child have a relationship with a nurturing, protective adult who fosters trust and security. This is an **attachment relationship**. A young child forms attachments during the period of early brain development, which sets the framework for emotional development. The professional literature[3] identifies four types of attachment relationships:[4]

- **Secure attachment:** The child trusts that her parents are consistently available. When the child is frightened or unsure about something, she

Autism Spectrum Disorders

What are Autism Spectrum Disorders?

Autism Spectrum Disorders (ASD), most commonly diagnosed in young children, fall in the category of difficulty in relating and communicating.[1] An estimated 1 in 150 children are on the autism spectrum, which has prompted researchers to describe the disorder as "an urgent public health issue."[2] Typically diagnosed by three years of age, ASD can be recognized in children as young as two years. Although symptoms present differently in individual children, many will manifest problems in social interaction, verbal and nonverbal communication, and repetitive behaviors or interests.[3]

General Indicators of ASD

- **Social Indicators:** Typically, developing infants are born ready to be in relationships with adults and primary caregivers. The parent-infant relationship helps form the foundation for healthy infant and toddler social-emotional development. Some very young children with ASD have difficulty interacting and sustaining eye contact with parents and caregivers. As these young children grow and develop, their passiveness, self-isolation, and resistance to human affection often becomes more pronounced. They may also become attached to a particular toy or object to the point that if the toy or object is moved or lost the child will become very upset, lose control, and have difficulty calming down. These children may:
  - not smile very often,
  - seem hearing impaired,
  - lose social skills apparent earlier in development, and
  - crave rituals and/or order to their activities.

- **Communication Problems:** One of the first sounds very young infants make is babbling. By the first year babbling typically develops into words. Some children diagnosed with ASD never speak, others babble for the first few months and then stop. Still others are delayed in developing language. Some children develop echolalia, a language disorder in which the young child parrots everything he/she hears. Although many children repeat everything they hear, this phase usually ends around three years of age. Many ASD children:
  - do not respond to their names, and
  - lose language skills apparent earlier in development.

Any parent or foster caregiver who suspects a problem with a young child should seek Early Intervention screening and a diagnosis as soon as possible. The American Academy of Pediatrics recommends autism-specific screenings at 18 months with a follow-up at 24 months, and whenever a concern is raised (in addition to general developmental screenings at 9, 18, and 30 months).[4] Judges should ask whether such screening has

occurred. Early screening and diagnosis is important for ASD children because the sooner a child is diagnosed, the sooner services can begin to support them.

Sources:

1. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R).* Washington, DC: Zero to Three Press, 2005.

2. Johns Hopkins Bloomberg School of Public Health. "CDC Releases New Data on the Prevalence of Autism Spectrum Disorders: First and Largest Multi-site Study Provides Baseline for Future Comparisons." *Public Health News Center*, 2007. Available at www.jhsph.edu/publichealthnews/articles/2007/lee_autism.html.

3. U.S. Department of Health and Human Services. *Autism Spectrum Disorders: Pervasive Developmental Disorders.* National Institutes of Health, National Institute of Mental Health, NIH Publication No. 08-5511, 2004. Available at www.nimh.nih.gov/health/publications/autism/complete-publication.shtml.

4. Hagan J.F., J.S. Shaw and P.M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3d ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008, 226.

looks to her parents for reassurance. If the parent is calm, the child is no longer frightened. She may move closer to the parent to touch base but then will return to whatever activity she was engaged in before the threat.

- **Anxious-ambivalent attachment:** The child cannot count on his parents to respond consistently. Sometimes the parent is nurturing and sometimes she is not. The child uses two coping strategies interchangeably—clinginess and feigned independence—to demonstrate his insecurity.
- **Anxious-avoidant insecure attachment:** The child has learned that the parent is not there for her. She behaves as though she has no need for the parent's attention.
- **Disorganized attachment:** This form of attachment is associated with children who have been physically abused and is the most difficult to treat. Such a child has no strategy for dealing with his parents' failure to protect and nurture him. He attempts proximity with his parent in odd ways such as approaching her backwards or simply falling in a heap near her.

Insecure attachment underlies later mental health problems, substance addiction, homelessness, and criminal activity.[5] Especially for children in foster care, who often have unstable relationships with adults, understanding and promoting attachment is critical to ensuring healthy emotional and mental development.

Infants and toddlers living with families dealing with substance use disorders are also at risk for developing mental health disorders.[6] For example, they may cry for long periods, seem unable to soothe themselves or be soothed, have trouble sleeping and eating, and withdraw from adults and peers. These children find

Biological Factors Affecting Social-Emotional Development

- **Premature Birth:** Any birth that occurs before the 37th week of pregnancy is considered preterm. The more prematurely a baby is born the greater the health risks. Babies born very prematurely often have breathing, digestive, and brain problems and are at high risk for death in the first few days of life. Premature babies may continue to have developmental delays and learning problems that will affect them throughout their lives.
- **Low Birth Weight and Small for Gestational Age:** Infants weighing under 5½ pounds at birth are *low birth weight* and are at increased risk for other health problems and developmental delays.[1] *Small for gestational age* infants have birth weights below the third percentile for gestational age. Very small infants have great difficulty regulating their behavior in response to changes in emotional stimulation. A fussy baby is normally soothed when a parent gently holds him and rocks, or talks softly to her and gently rubs her back, but very small infants are not able to benefit from these soothing techniques and their emotional distress continues unabated. This early regulatory difficulty may be linked to the later diagnosis of attention deficit hyperactivity disorder.[2]
- **Neurobehavioral Problems:** During the first few days of life, drug-exposed infants experience tremors and irritability.[3] They may also have diarrhea, vomiting, and even seizures. Some newborns are lethargic, and many are easily distracted and overstimulated. Others display poor quality of movement and self-regulation.

Sources:

1. Bada, H. S. et al. "Gestational Cocaine Exposure and Intrauterine Growth: Maternal Lifestyle Study." *Obstetrics & Gynecology* 100, 2002, 916–924.

2. Committee on Integrating the Science of Early Childhood Development, National Research Council and Institute of Medicine. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Edited by Shonkoff, J.P and D.A. Phillips. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press, 2000, 349.

3. Lester, B. M. et al. "Methamphetamine Exposure: A Rural Early Intervention Challenge." *Zero To Three* 26(4), 2006, 30–36.

it difficult to develop and sustain strong connections with adults and others, leading to attachment disorders that may affect their ability to form relationships, take risks, explore the world around them, and learn.[7]

Researchers estimate that 30 to 70% of the children witnessing domestic violence also experience child abuse as a result.[8] The impact on young children can be devastating, as many never learn to expect their parents to protect them and ensure their well-being.[9] Because the parents cannot make the child safe, and indeed, contribute to the child's insecurity, the child is caught in a terrible dilemma: try to stay away from parents who might harm him or seek parental comfort and

protection when it is unclear whether the parents will provide them. Children exposed to this kind of stress are likely to have a disorganized attachment relationship with their parents.[10] The child's response to this violence can lead to a clinical diagnosis of traumatic stress disorder, which includes these symptoms:

- experiencing the traumatic events over and over through ritualistic play, flashbacks, and nightmares;
- becoming distressed when exposed to anything that reminds the child of the trauma;
- losing previously acquired skills (e.g., a child who had been toilet trained has repeated accidents);
- blunting personality: the child stops expressing emotion, interacting with people, or carrying out normal play activities;
- becoming hypervigilent: the child is easily startled, cannot relax or fall asleep, and wakes up frequently at night;
- displaying behavioral symptoms that appear after the traumatic events (e.g., aggression toward people or animals, separation anxiety, other new fears).

We would like to believe it is never too late to rehabilitate a child who has suffered harmful early childhood experiences. However, the science of early childhood tells us that the initial attachment is critical to protect against future inadequacies in relationship building and behavioral control. When children experience long periods without forming this initial attachment, or repeatedly begin and end relationships, they become less and less likely to achieve it.

Ensure placements for very young children provide long-term stability and promote healthy attachments.

Stable placements with loving adults and predictable nurturing routines promote healthy attachments for very young children. By the time child protective services (CPS) intervenes, these essentials are likely to be lacking. Helping the child overcome the maltreatment that brought CPS into the picture requires careful planning, and the child needs to be protected from multiple moves between caregivers. To do this, extended family members need to be identified as close to the removal as possible, ideally before the child is removed. Ask caseworkers to describe efforts to identify extended family caregivers in the first week after the case comes to them.

In the event that extended family members are not available or not appropriate as caregivers at the time of removal, a foster-to-adopt home should be selected. Placements should be evaluated to ensure that they support the mental health

Red Flags[1]

Children who are too young to speak communicate in other ways. Even very young infants tell us when they are suffering. In their first year of life, children react to trauma through the disruption of normal biological rhythms and sensorimotor responses outside of what would typically be expected.[2] Mental health problems are often reflected in physiologic responses to stress and a pattern of behavior that includes multiple episodes or symptoms. They should be treated seriously.

An infant under chronic stress may respond with:

- apathy—lose interest in the world (caregivers cannot elicit a smile);
- poor feeding—refusal to eat or an insatiable appetite (failure to thrive and morbid obesity are possible outcomes);
- develop symptoms like vomiting or skin rashes for which there is no detectable diagnosis;
- withdrawal.

More acute stress may lead to various responses:

- inconsolable crying;
- temper tantrums;
- aggressive behaviors;
- inattention and withdrawal.

A young child's response to stress may include:

- excessive day dreaming;
- disengagement;
- opposition;
- defiance.

Repeated experiences can lead to dysregulation of the areas of the brain that control motor activity and anxiety. Children can consequently display:

- motor hyperactivity;
- out-of-control and accident-prone behavior, or overly cautious movements and activities;
- anxiety;
- mood swings;
- impulsive behavior;
- sleep problems;
- caring for self, siblings, or parent beyond what is expected for such a young child;
- taking responsibility for abusive behavior in play ("If only I hadn't skinned my knee, Daddy wouldn't have hit Mommy."); and

- oversexualized behavior (excessive masturbation, inappropriate touching, or body rubbing).

Sources:

1. Adapted from American Academy of Pediatrics, Committee on Early Childhood, 2000.

2. Lieberman, A.F et al. "Violence in Infancy and Early Childhood: Relationship-Based Treatment and Evaluation." *Interventions for Children Exposed to Violence.* Edited by A.F. Lieberman and R. DeMartino. New Brunswick, NJ: Johnson & Johnson Pediatric Institute, 2006, 65-83.

needs of young children. However, foster parents need special training to understand their dual roles as coach to the parents when reunification is the permanency goal, and as adoptive parents if the biological parents are not able to overcome the problems that led them into the child welfare system. Ask about the training provided to the foster parents to prepare them to care for very young children and about supportive services to help the family address the child's emotional needs.

Make sure all parties understand that placement decisions are being closely examined and any changes in placement will be reviewed in court. Also ensure concurrent permanency planning begins on day one to engage both parents and other potential permanency resources in supporting the child's healthy development. Cases should progress without delay when a permanency plan changes.

Effect of Cognitive and Developmental Delays on Young Children's Mental Health

While the effect of insecure attachment on the social-emotional development of very young children is significant, cognitive and developmental delays are other factors that can play a major role. Before children are born, their parents are already influencing their lives. If their mothers drink alcohol, take drugs (either recreational or prescription), smoke cigarettes, fail to eat enough healthy food, are exposed to chronic stress, or are victims of violence or environmental toxins, the children are at an elevated risk for several developmental challenges that affect their social-emotional development. Common biological problems in babies that often lead to developmental delays are premature birth, low birth weight, and neurobehavioral problems. Cognitive problems in toddlers and young children such as autism can lead to difficult or insecure attachments with caregivers and other trusted adults. For parents who have looked forward to nurturing a

relationship with their infant or toddler, these signs can be very upsetting and cause parents and very young children much tension and stress. Parents who expected to bond with an infant or toddler who appears nonresponsive may feel deeply disappointed and at a loss as to how to respond.

Mental Health Assessment and Services

Order an immediate screening of the child's mental health issues.

The initial mental health screening should occur within 24 hours of removal. The primary purpose is to identify and provide services for any emergency mental health needs. Any biological factors affecting very young children's mental health should be evaluated during the initial mental health assessment and follow-up screenings. Young children who are removed from their caregivers may require an immediate intervention to address acute separation issues. Early efforts to prevent, identify, and support mental health issues are crucial for young children entering foster care. Whenever removal occurs, responding to the child's needs first requires a comprehensive evaluation of their social-emotional health and development. Quality assessments are key to uncovering early signs of emotional and mental distress so that services can begin to address them. Treatment and interventions should be trauma-informed and evidence-based.

The American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA) recommend an immediate mental health screening followed by a comprehensive mental health evaluation for all children who are removed from their primary caregivers due to suspected abuse, neglect, or caregiver impairment.[11] A qualified mental health professional, such as a psychiatric nurse practitioner, who uses recognized clinical tools and has training and experience with very young children should conduct the evaluation.

Require a screening to identify developmental delays and disorders.

The Child Abuse Prevention and Treatment Act of 2003 (CAPTA) requires that children who are the subjects of substantiated child maltreatment complaints receive a screening to identify developmental delays. If the child has developmental delays, she is eligible for a wide range of services authorized by Part C of the Individuals with Disabilities Education Act (IDEA) (see Part C box). Part C screening provides a thorough picture of a child's developmental status. Evaluating the child's social-emotional health is one important component of that assessment that may be overlooked if the agency responsible for implementation lacks

Part C of the Individuals with Disabilities Education Act[1]

Congress established the Part C program under the IDEA in 1986 to address an "urgent and substantial need." The purpose of Part C is to:

- enhance the development of infants and toddlers with disabilities;
- reduce education costs by reducing the need for special education through early intervention services;
- minimize the likelihood of institutionalization; and
- enhance the capacity of families to meet their children's needs.

Amendments to the Child Abuse and Prevention Treatment Act (CAPTA) from 2003 require states to develop procedures to ensure that all children under age three who are involved in a substantiated case of abuse or neglect are referred to Part C services.

The IDEA amendments of 2004 require Part C services for all children who have been maltreated or exposed to prenatal substance and alcohol use or domestic violence. This legislation opened a window of opportunity for getting developmental assessments and treatment for infants and toddlers who have been abused or neglected. However, although Part C is a federal requirement, many local jurisdictions are not yet aware of the Part C program in their states.

For eligible children, Part C services include:[2]

- family training, counseling, and home visits;
- nursing, health, and nutrition services;
- service coordination;
- medical services for diagnostic or evaluation purposes;
- occupational and physical therapy;
- psychological and social work services;
- vision, orientation and mobility services;
- speech-language pathology services;
- transportation services; and
- age-appropriate special education instruction.

To learn more about Part C of the IDEA, visit:
www.childwelfare.gov/systemwide/service_array/development/childwelfare.cfm

Sources:

1. Hudson, L. et al. *Healing the Youngest Children: Model Court-Community Partnerships*. Washington, DC: American Bar Association Center on Children and the Law & Zero to Three Policy Center, 2007.

2. Santucci, R. et al. *Special Education: Grant Programs Designed to Serve Children Ages 0-5*. Washington, DC: United States General Accounting Office, 2002, 8. Available at www.gao.gov/new.items/d02394.pdf.

expertise in infant mental health. If a thorough Part C assessment is available, a separate mental health assessment may not be necessary.

The American Academy of Pediatrics (AAP) recommends that pediatricians screen all children for developmental disorders at every pediatric visit.[12] When developmental risks are identified, the health care provider should administer a developmental screening tool and determine whether referrals for further evaluation or services are necessary. In addition to routine surveillance, the AAP recommends all children, irrespective of risk for developmental concerns, undergo formal developmental screening at 9, 18, and 30 month visits. Whenever any screening tool identifies potential issues, referrals for further evaluation and services should be made.

Children receiving common early intervention services (e.g., speech, information processing, and other cognitive and motor functions) have a higher risk for behavioral and mental health disorders.[13] When mental health services are provided under Part C, "relationship-based and family-focused intervention strategies [should be used] by early intervention personnel, regardless of professional discipline or the service being provided."[14] Strategies include:

- working with the parent and child together;
- educating parents about things they can expect in their child's behavior;
- building on parents' strengths to enhance their ability to care for their child;
- offering opportunities for the parent and child to interact positively; and
- helping the parent explore their feelings about the child and about being a parent.[15]

Ensure the comprehensive mental health assessment is initiated within 30-60 days of placement.

Typically, when a child is removed from the caregivers and placed in out-of-home care, he is suddenly separated from all things familiar—his home, community, educational setting, caregivers, family, and friends. This experience causes grief that can impair new attachments and the success of the out-of-home placement. Ensuring an early and comprehensive evaluation of a child's mental health needs by a professional familiar with the social and emotional needs of children in care will help address the young child's distress. Ask about the results of the mental health screening that was done before placement. If one has not been completed, order one.

A comprehensive assessment should occur within 30-60 days of placement. The timing of this evaluation should be guided by any mental health needs identified in the initial screening. The initial evaluation and the comprehensive assessment

should focus on the potential psychological consequences of removal, with or without the presence of symptoms that support a psychiatric diagnosis.

While the focus of this chapter is mental health, it bears repeating that a full assessment should include a thorough physical exam and developmental evaluation. Delays in cognitive and motor functioning can be clues to previous maltreatment. For example, an infant who cannot track objects with her eyes may have suffered an eye injury.[16]

Learning about infants and toddlers occurs most successfully in conditions that create the least stress for them. Assessments of very young children should occur in familiar settings, whenever possible. The child should never be separated from the primary caregiver (e.g., foster parent, birth parent, kinship care provider) during the evaluation. A thorough assessment should be conducted over two or three sessions to accommodate the child's rapidly changing moods, health, and comfort.

Many instruments and procedures are used to evaluate young children. These instruments are used together to paint a complete picture of the child's mental health. The differing approaches highlight:

- infant development and functioning
- the social-emotional domain
- the child's adaptive skills
- parent-child interaction

Order a reassessment of the child's mental health status during placement.

During placement, the emotional and mental health needs of children in foster care will change, varying with the child's age, developmental stage, and circumstances. For this reason, children's emotional and mental health status should be periodically reassessed during placement. For children with particular mental health needs, reassessment should occur at appropriate intervals. An assessment occurring very soon after placement may portray the child as having very different behaviors than one conducted after the child has had time to adapt to the changed situation.

Consistent surveillance is required to detect developmental delays early. Health providers who know about the developmental needs of children play a key role in identifying potential problems for maltreated children. Young children who have been maltreated should receive a full mental health evaluation no later than one month after entering care[17] and every six months thereafter. These assessments should address the effects of maltreatment and the quality of the child's placement experience. The evaluators should be looking at how the child

Commonly Used Developmental Screening Tools

Developmental Screening Tools Using Information from Parents

- **Ages & Stages Questionnaires (ASQ) Second Edition**
  The ASQ uses drawings and simple directions to help parents elicit and indicate children's language, personal-social, motor, and cognition skills. The ASQ is tied to well-child visits. A newly developed Ages and Stages Questionnaire: Social Emotional (ASQ:SE) helps screen for emotional and behavioral problems in children 6–60 months of age.

- **Parents' Evaluation of Developmental Status (PEDS)**
  PEDS is a 10-question screening and surveillance tool designed to detect and address a wide range of developmental issues including behavioral and mental health problems. Parents can complete it in just a few minutes, and it promotes parent-provider collaboration and family-centered practice. PEDS identifies when to refer, screen further or refer for additional screening, or monitor development, behavior, and academic progress. Research shows use of PEDS improves positive parenting practices and satisfaction with services.

- **PEDS: Developmental Milestones (PEDS:DM)**
  PEDS:DM uses six-to-eight items per well-visit that address different developmental domains: fine motor, gross motor, expressive language, receptive language, self-help, social-emotional, and for older children reading and math. The PEDS:DM can be used with or without PEDS but in combination better helps meet the AAP's 2006 policy statement on early detection.

- **Infant-Toddler Checklist for Language and Communication**
  Parents complete 24 multiple-choice questions that focus on social aspects of their child's language development. Scores are produced for the child's social, speech, and symbolic communication skills. It does not screen for motor milestones.

Developmental Screens Requiring Direct Elicitation of Children's Skills

- **Bayley Infant Neurodevelopmental Screener (BINS)**
  The BINS assesses neurological processes (reflexes and tone); neurodevelopmental skills (movement and symmetry); and developmental accomplishments (imitation, and language).

- **Brigance Screens-II**
  Separate forms each cover a 12-month age range to screen speech-language, motor, readiness, and general knowledge skills, and for the youngest age group,

social-emotional skills. All screens use direct elicitation and observation except the Infant and Toddler Screen, which can be administered by parent report. This screen is widely used in educational settings.

- **Battelle Developmental Inventory Screening Test (BDIST)**
  BDIST uses a combination of direct assessment, observation, and parental interview to screen receptive and expressive language, fine and gross motor, adaptive, personal-social, and cognitive/academic skills.

Behavioral/Emotional/Mental Health Screening Tools

- **Eyberg Child Behavior Inventory (ECBI)/Sutter Eyberg Student Behavior Inventory Revised (SESBI-R)**
  The ECBI consists of 36 short statements of common acting-out behaviors. Parents rate each item for frequency of occurrence (referred to as intensity) on a one–to-seven scale and then indicate whether the behavior is a problem for them. A single score is produced to suggest the presence of disruptive, externalizing behavior problems (e.g., disorders of attention, conduct, oppositional-defiance). The SESBI-R works in a similar way but uses teachers as the informant.

- **Pediatric Symptom Checklist (PSC)**
  The PSC consists of 35 short statements of externalizing (conduct, attention, etc.) and internalizing (depression, anxiety, adjustment, etc.) problem behaviors.

Sources:

Smith, P.K. "Chapter 3: Early Intervention Using Standardized Developmental Screening Tools." *Enhancing Child Development Services in Medicaid Managed Care; A Best Clinical and Administrative Practices Toolkit for Medicaid*. Hamilton, NJ: Center for Health Care Strategies, Inc., 2005. Available at www.chcs.org/usr_doc/Toolkit.pdf;

Frances P. Glascoe, MD. "Commonly Used Screening Tools." *Developmental Behavioral Pediatrics Online* (AAP). Available at www.dbpeds.org/articles/detail.cfm?textid=539.

expresses emotions, his ability to regulate himself (e.g., Can he calm himself after a disappointment?), his self awareness, and his relationships with the primary caregivers in his life.

Ensure a continuum of services is offered to each child.

Identifying mental health needs is the first step in promoting the emotional and mental health of young children in care. Given their complex prior experiences, and the diversity of placement options, children's needs are best met through a complement of mental health services. Services should permit the child to remain in the least restrictive, but also safe, community-based environment and should encourage *voluntary* family participation at all stages.[18]

All children should receive individualized service planning to address all their needs including their mental health and emotional needs. Plans should include:

- services that focus on the interests, values, and goals of the child and family;
- targeted assessment of the mental health needs of the child and services and supports to help the family support the child;
- a concurrent permanency plan to reduce the need for multiple placement changes by preparing foster parents to serve as adoptive parents if reunification is not possible;
- informal and formal services such as visit coaching or child-parent psychotherapy, and opportunities to participate in community activities (e.g., Early Head Start, faith-based organizations);
- assessments of progress toward identified goals.

Review the child's individualized service plan to ensure it incorporates supports that meet identified needs. Services should continue when a child is reunified with his family or another permanency plan is implemented. If no services have been required while the child is in care, his needs should be reassessed at each hearing and any necessary services should begin at that time.

Ensure frequent parent-child contact.[19]

Professionals working with very young children in foster care often do not understand the extent of the child's distress over being removed from the parent and placed in a strange environment. Remember that very young children grieve the loss of a relationship. Even though the parent has maltreated the child, she or he is the only parent the child has known, and separation evokes strong and painful emotional reactions.[20] The younger the child and the longer the period of uncertainty and separation from the primary caregiver, the greater the risk of harm to the child.[21] Maintaining consistent contact between the child and his or her parents and siblings is critical unless visits would harm the child.[22] In fact, parent-child contact is the number one indicator of reunification.[23] Family contact and interaction is important and the relationship between the foster family and biological family can be crucial.

Because physical proximity with the caregiver is central to the attachment process for infants and toddlers,[24] an infant should ideally spend time with the parent(s) daily, and a toddler should see the parent(s) at least every two to three days.[25] To reduce the trauma of sudden separation, the first parent-child visit should occur as soon as possible and no later than 48 hours after the child is removed from the home.[26]

Visits should promote parent-child attachment and be an opportunity to model good parenting skills. The length and frequency of visits should reflect the child's developmental stages and gradually increase as the parent shows she is able to respond to her child's cues in consistent and nurturing ways, soothe her child, and attend to her child's needs. During the initial phase, limiting visits to one-to-two hours allows the parent to experience small successes without becoming overwhelmed. By the transition phase, as the family approaches reunification, unsupervised all-day, overnight, and weekend visits should be completed.[27]

A young child's emotional dysregulation following a visit does not necessarily mean the parent did something harmful during the visit.[28] Visitation can be extremely upsetting for children, and it is important to understand the developmental context of their feelings and behaviors. Very young children cannot understand the separation, and they tend to respond with bewilderment, sadness, and grief. During visits, they may cling or cry, act out, or withdraw from their parent. At the end of a visit, when another separation is imminent, they may become confused, sad, or angry. Following visits, infants and toddlers may show regressive behaviors, depression, physical symptoms, or behavioral problems. Foster caregivers may need information to help them understand and support young children who are distressed after a visit.

Parents also find visits to be a time of emotional upheaval, particularly during the first phase of placement. Parents often experience pain and sadness resulting from the separation. They may feel shame, guilt, depression, denial that there is a problem, anger, and/or worry about the child. During the first visits, the parent is likely to be awkward, tense, and uncertain. Visit coaches, caseworkers, and foster parents should help the parent process her emotions and help her interact with her child.[29]

Ensure frequent sibling contact.

The Fostering Connections to Success and Increasing Adoptions Act of 2008[30] addresses many issues that promote permanency and affect the health and well-being of very young children in foster care, including placing greater priority on keeping siblings together. While placements that can accommodate a very young child's siblings should be sought, it may be necessary to separate siblings due to the special needs or circumstances of the very young child. When siblings are not placed together, the importance of siblings to the young child should not be minimized, especially if there is an established bond. Ensure frequent sibling visits and opportunities to maintain the sibling bond, especially for toddlers and preschoolers who may perceive their older siblings as caregivers.

Ensure the mental health and emotional needs of the parent(s) are assessed and appropriate services are provided.

Because children's early social-emotional development depends on their parents' health and well-being,[31] issues that undermine the parents' sense of safety and belonging will harm the young child's mental health. Infants react to trauma as it is manifested through their parents' lack of availability to provide them nurturing care.[32] Promoting a family-centered approach to mental health assessments and services will uncover many family needs that can be addressed early in the child welfare case.

Children thrive to the extent that their parents provide consistent nurturing care. Parents whose lives are consumed by substance abuse, mental illness, domestic violence, a history of childhood trauma, compromised cognitive functioning, or poverty cannot provide the care their very young children need because they are often distracted by their own issues. With proper interventions and support, they can address these problems and work toward resuming care of their children.

Substance Abuse

Parents with addiction problems may be unable to provide consistent emotional and psychological attention to infants and toddlers because they are preoccupied by their chemical addiction. Primary caregivers who are chemically dependent are likely to have experienced maltreatment as children.[33] They are often unable to provide the comfort, security, and consistent care infants and toddlers need to regulate their behaviors and emotions. Parents with addiction issues are also likely to have been exposed to alcohol in utero which brings with it a host of possible disabilities (e.g., fetal alcohol spectrum disorders; neurobehavioral problems). Parents with addiction problems should complete a parenting course focused on these issues.

Mental Illness

Parents with mental illnesses run the gamut. Many are competent and manage their parenting responsibilities appropriately and without help, while others are good parents with some assistance. Some lack sufficient parenting skills and others are abusive, neglectful, or both.[34] Psychopathology among parents of young children is often linked to maltreatment. For new parents, postpartum depression, post traumatic stress disorder, depression, and anxiety can interfere with their ability to care for their newborns. Maternal depression and other psychiatric problems (e.g., hostile personality, explosiveness) are linked to abuse of infants.[35] Research documents high rates of psychopathology among biological parents who

maltreat their young children. Children of psychotic parents often experience confusion over reality. If no other caregiver is available, they can get lost in the psychotic world of the one available parent. More recently, high rates of psychiatric illness have been identified among foster and kinship parents.[36]

Infants with chronically depressed mothers will often withdraw from social interactions, jeopardizing their social-emotional development. As they get older, these children are likely to lack self control, behave aggressively towards other children, and experience school difficulties that can lead to grade retention and dropping out of school.[37]

If services to the parents have not begun, order them to begin before the next court hearing to comply with ASFA's reasonable efforts requirements. When reunification is planned, ask whether the parents' mental health needs are being successfully addressed as part of the case plan.

When evaluating the ability of parents struggling with mental illness to safely parent their young children, ask the following questions and refer to *A Judicial Checklist for Children and Youth Exposed to Violence*:[38]

- Does the parent demonstrate poor reality testing (a person's ability to differentiate between the external and internal worlds) or worrisome patterns of denial?
- Does the parent have a mental illness, including a character disorder, such that the capacity to nurture is severely impaired?
- If there is a psychotic diagnosis: what is the need for treatment, the ability to benefit from treatment, and the effect of medication?
- Is the parent willing to be treated?
- If the parent has a mental illness, is this worsened by close contact with the infant or by demands to meet parental responsibilities (e.g., delusional thinking centering on the infant)?
- If the parent has a history of psychosis, is the infant at the center of the parent's delusional thinking or do the infant's needs trigger difficulty for the parent?[39]

Family Violence

Parents facing personal violence (or the threat of it) from an intimate partner are often distracted from caring appropriately for their young children. They have low self-esteem and tend to suffer from depression. Researchers estimate that as many as 75% of the parents who abuse or neglect their children were themselves maltreated in childhood.[40] Their experiences as children impair their ability to appropriately care for their own young children because they never learned to form healthy attachments. Child-parent psychotherapy, discussed later in this chapter,

attempts to uncover the parent's own childhood trauma as the therapist works with both parent and child to broker a mutually enjoyable relationship.

When domestic violence is a factor in the child protection case,[41] case plans must address the unique needs of each family member, including the batterer and the adult and child victims.[42] In determining placement, respect the autonomy of the nonoffending parent and support her ability to provide a safe and nurturing home for the children.[43] Batterers must be held accountable for their actions. They should have a separate case plan that requires them to stop all forms of abuse toward any family member, abide by all court orders, and participate in counseling and educational programs designed for domestic batterers.[44]

Low Cognitive Functioning

Parents with low IQs face challenges caring for their children. If their intelligence is too compromised, they may not be capable of understanding and supporting their children's needs.[45] They also may not receive the support they need themselves to parent effectively. In assessing a parent's ability to care for an infant, questions about their ability to provide responsive caregiving help determine their ability to support their infant's mental health. An important consideration for parents with diminished cognitive functioning is FASD, the single greatest cause of nongenetic mental retardation. The IQ deficit is compounded by other neurological deficits that impair the victims' ability to follow directions or learn from their mistakes.[46] Proper diagnosis can lead to developing a case plan for the parent and child that permits them to live safely together.

Poverty

Poverty is the single most important predictor of neglect.[47] Living in poverty adds tremendous stress and interferes with the parents' ability to care for their young children. Poverty puts mothers at high risk for depression, post traumatic stress disorder, and for difficulties establishing nurturing relationships with their very young children.[48] Among these mothers' greatest challenges are creating a safe environment, and providing food and a place to live for themselves and their children.

Order a determination of the intensity and type of services required to meet the family's needs.

Case plans should refer parents to parenting programs that have been evaluated and found effective. Whenever possible, programs that target parents' special needs should be used. Programs exist for parents with substance abuse issues, parents of young children, and fathers. Avoid parenting classes taught by instructors who lecture parents about parenting. Rather, seek programs that allow

Incredible Years and the Strengthening Families Program

The following two programs meet established criteria for effectiveness in helping families address their special needs:

- **Incredible Years** offers training to help parents and teachers intervene in children's conduct problems when they are very young and develop their social competence. Curricula are available that address children in the general population, children experiencing behavior problems, and children with mental health diagnoses like attention deficit hyperactivity disorder. The experience of the teachers is related to the intensity of the intervention (e.g., therapists and teachers offer the curriculum for children with mental health diagnoses).
- **The Strengthening Families Program** was developed for families at risk for maltreatment. The program has developed specialized curricula for families with various cultural backgrounds (e.g., Asian and Pacific Islanders, American Indians). Like the Incredible Years, their curricula are specific to children of various ages, including a curriculum for parents and their three-to-five year olds. Although they do not yet have a curriculum for babies and toddlers, it is a model worth considering because of its curricula in Spanish, with cultural sensitivity for a wide range of ethnically diverse populations, and its extensive use with families dealing with child maltreatment.

Source: Substance Abuse and Mental Health Services Administration. National Registry of Evidence-Based Programs and Practices, 2008. Available at www.nationalregistry.samhsa.gov/submit.htm.

parents to practice new skills. The Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services has established a national registry of research-based parenting interventions that may or may not target parents with substance abuse issues (www.nationalregistry.samhsa.gov/index.htm). Programs must show, at a minimum, that:

- they achieve positive outcomes in mental health and/or substance use behavior among individuals, communities, or populations;
- proven program results are documented in a peer-reviewed publication or a comprehensive evaluation report;
- guidance on implementing the program (e.g., manuals, process guides, tools, training materials) is available to the public to aid dissemination.[49]

Among programs listed are the Incredible Years and the Strengthening Families Program. Several others with an established research base have requested

review by the national registry. These include Child-Parent Psychotherapy and the Nurturing Parenting Program. Each intervention focuses on special populations (e.g., families with substance abuse issues, young children).

Effective programs share certain characteristics:[50] (1) regular in-class opportunities for the parent and child to practice the information they are receiving; and (2) assessments of the parent's skills and emotional relationship with the child before the classes begin and again at the end.

Order an assessment to determine whether the child and parent would benefit from Child-Parent Psychotherapy.[51]

This intervention focuses jointly on the parent and infant. Child-Parent Psychotherapy (CPP) for mothers, fathers, and their infants and toddlers (birth to three) helps the parent read, interpret, and respond to the infant's cues. A therapist serves as a guide for the parent, helping her understand what the baby might be feeling and how the parent's needs might influence her responses to the baby.[52] Roleplaying with the infant also allows the parent to uncover traumatic experiences from his own childhood and to look at interactions from the young child's point of view.[53]

Parents also receive concrete assistance, such as transportation to appointments or a school function of an older sibling. The therapist helps with life problems such as housing that interfere with the parent's ability to focus on the clinical aspect of CPP. The therapist's positive regard for the parent in these very tangible ways helps the parent heal negative experiences with attachment figures from his or her own childhood.

Positive outcomes for those who complete CPP include:

- improved perceptions of the baby by the parent;
- improved socioemotional functioning;
- stronger parent-child relationship;
- secure attachment between parent and child; and
- improved mental health of parent.[54]

Order an assessment of whether the child and parent would benefit from Parent-Child Interaction Therapy (PCIT).[55]

This therapy was designed for two-to-six year olds with disruptive behavioral characteristics of oppositional-defiant or conduct disorder, and children with insecure attachment. It is a short-term intervention (10 to 16 weekly sessions). At first it emphasizes improving the parent-child relationship. Once certain therapeutic

goals are reached, the emphasis shifts to implementing consistent discipline with the child.

PCIT is effective except when the mother is highly critical or severely depressed or when the parents are abusing drugs, experiencing severe marital discord or psychopathology.[56] Some evidence suggests that the family's relationship with the therapist is more predictive of treatment outcome than any specific therapeutic techniques. While concrete assistance with life tasks is not part of the therapeutic design, "Prinz and Miller (1994) found that families whose treatment focused exclusively on parent training and child behavior dropped out more often than families who had opportunities to discuss life concerns beyond child management, particularly among families facing greater adversity."[57]

Ensure services respond to the needs of different ethnic and cultural groups.

Little data describes effective mental health interventions for children who are not white and middle class. Ethnic minorities are less likely to begin a mental health intervention or complete treatment once therapy has begun. Practical considerations make it difficult for these families to attend regular sessions (e.g., transportation, cost). Beyond these practical barriers to participation, ethnic minority families often do not perceive services as culturally appropriate for them.[58] Case management, like that provided in CPP, is an important way to help poor and ethnic minority families meet very basic needs like housing and sufficient food.[59]

Some ethnic and cultural groups often have beliefs about child rearing that do not conform to mainstream expectations. Extended family, broadly defined to include people with whom the child has a family-like relationship, play an important role in many cultures.[60] In some cultures the autonomy that is promoted among young middle class white American children is not encouraged; rather children are encouraged to conform to standards established by adults.[61]

In cases involving Native American families, make sure the provisions of the Indian Child Welfare Act are followed. In every case you can ask parents if they feel they have been treated with respect. Ask attorneys and caseworkers to bring cultural factors to the court's attention, such as a family's reluctance to seek a blood transfusion for a severely anemic child. To enhance your ability to respond appropriately to diverse families, organize or participate in judicial training in cultural competence that addresses the diverse cultures represented in your jurisdiction.

Early Care and Education

Ensure children participate in positive early childhood learning experiences.

Early childhood is a time of intense growth and development in all areas, including rapid changes in motor development, cognition, and emotions.[62] All young children need positive early learning experiences to foster their intellectual, social, and emotional development and to lay the foundation for later school success. Infants and toddlers who have been abused or neglected need additional supports to promote their healthy growth and development and overcome adverse outcomes.

Early care and education encompasses nursery schools, prekindergarten programs, family child care homes, preschools, Head Start and Early Head Start, and care provided by families, friends, and neighbors. Care providers include private nonprofit agencies, for-profit companies, faith-based organizations, public schools, and in-home providers.

Early care and education programs and services are used in the child welfare setting for:

- an enrichment experience for the child;
- child care so foster parents or relative caregivers can work outside the home;
- respite care to allow caregivers time away from the children to care for themselves (e.g., when a parent has mental or physical illness issues that need to be addressed);
- oversight to allow the court or child welfare agency to watch for maltreatment in the home (biological or substitute caregiver's);
- a neutral professional setting for visitation with parent coaching;
- an opportunity for the child to be involved in consistent peer relationships and receive sensory and cognitive support that might not be available at home.

Referrals or court orders specifying early care and education programs should weigh the potential benefits and drawbacks.

Benefits:

- **Early relationships.** Early childhood education programs that promote small groups, continuity of caregivers, and individualized care can help young children who have been abused and neglected develop essential early relationships that are associated with adaptive social development.[63]

- **Caregiver support.** High-quality early care and education programs can also support foster, kinship, and biological parents by directing them to other support systems, providing information, and connecting them with other parents who can offer advice and support.[64] Comprehensive early childhood programs like Early Head Start combine home visitation and comprehensive center-based services that also provide opportunities for the parent to learn and model supportive parenting strategies.
- **Specialized services for children.** Early care and education programs can provide the specialized services that very young children in the child welfare system need, including opportunities for enhanced social-emotional health and development. In addition, therapeutic child care programs that address issues faced by abused and neglected children can ensure that these young children are receiving specialized treatment and attention.

Drawbacks:

- **Staff training.** Child care is only as good as the teachers who staff the program.[65] If staff has not received adequate training, children under their care will not receive the quality experiences that promote their healthy development.
- **Quality.** While there has been no definitive study of the quality of care available for infants and toddlers, research shows that much available care is not optimal.[66] Placing a very young child in a low or poor quality child care situation may cause further harm to a child already suffering from developmental or mental health issues as a result of abuse or neglect.
- **Staff turnover.** Even the best programs struggle with staff turnover due to very low wages. High rates of staff turnover—nearly 40% per year, nationally—mean that the warm, caring relationship between a child and teacher is frequently disrupted. The result is poor quality care and children who show lower language and social skills.[67] This instability prevents babies and toddlers from developing secure attachments to their child care providers.[68]

Carefully consider the availability and quality of early care and education settings.

Consider the following factors when deciding to place a child in an early care and education setting:

- **Can the foster parent stay home with the child?** This is typically a better option for very young children if the foster parent provides nurturing, developmentally appropriate care. Opportunities for enriched

learning experiences can be sought through facilitated play groups, museum programs, and in-home services for developmentally delayed children. The foster parent should receive training in developmental milestones and in appropriate ways to engage young children from birth and beyond so they can enrich the home environment.

- **If not, what type of program would best meet the child's needs?** Early Head Start focuses on the child in the context of his family and works to involve families. Traditional child care programs may play no role in families' lives beyond providing care for the child each day. Care provided by a neighbor may give the foster parent flexibility and provide the child with individualized care, assuming the quality of the neighbor's care is closely examined and verified (e.g., proper licensing, training, and experience).
- **How many hours per day and days per week should the child attend?** Limiting the number of hours away from the child's primary caregiver will make the transition easier for the child within a regular schedule (e.g., Monday, Wednesday, and Friday from 9:00 until 12:00).
- **Will the child be assigned to one specific primary teacher who is present most of the child's day in care?** Expanding the circle of primary caregivers to include one teacher in a safe and engaging learning environment is positive for maltreated children. Less than this level of personalized attention has the potential to add to the child's existing confusion and sense of powerlessness.
- **Does the program provide in-home services where the child and parent receive individual attention and guidance?** This training helps parents apply loving strategies to their relationships with their children.
- **Can the child care program be used as a location for visits between noncustodial parents and their young children?** Holding visits in a familiar setting makes the experience less stressful for the child. Depending how child care staff handles the visits, parent and child can engage in supported interactions and classroom activities that will strengthen their relationship and better equip the parent to care for the child.
- **Who pays for the care?** Some of the most significant issues regarding early care and education relate to access and capacity of the programs to enroll children. For example, Early Head Start is a federal entitlement program. Families whose incomes fall below the federal definition of poverty are eligible to enroll. However, due to limited funding only 3%

of eligible infants and toddlers are able to participate.[69] Public preschool programs are part-day programs that are typically offered free to children living in the school's community. Some states grant eligibility for state subsidized child care when children come into contact with the child welfare system. State child care subsidy programs are administered by multiple agencies across the 50 states. Eligibility requirements differ as do state funds available to support children in care.

Conclusion

During infancy and early childhood, the child's brain develops its capacity for trust, self-esteem, conscience, empathy, problem solving, focused learning, and self control.[70] While research continues to reveal what a child needs for healthy development throughout this period, much is already known:[71]

- All children have the capacity to learn and experience feelings from birth.
- Creating nurturing and secure early environments is essential to healthy development.
- Parental health and well-being affects children's development.
- Early and focused interventions can increase the chances of positive developmental outcomes when early childhood is disrupted.

Well-conceived interventions can minimize or even reverse the effects of damaging early childhood experiences. By arming yourself with the science of early childhood and learning about effective interventions, you can improve the outcomes for the children under your court's jurisdiction.

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