QUESTIONS

EVERY JUDGE AND LAWYER SHOULD ASK ABOUT **INFANTS AND TODDLERS** IN THE CHILD WELFARE SYSTEM

NCJFCJ est. 1937
NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES
WWW.NCJFCJ.ORG

CELEBRATING 80 YEARS 1937-2017

Brief Originally Authored in 2002 by:

Joy D. Osofsky, Ph.D., Candice Maze, JD, Judge Cindy S. Lederman, Justice Martha P. Grace, and Sheryl Dicker, JD

Brief Updated in 2017 by:

Joy D. Osofsky, Ph.D.
Professor, Departments of Pediatrics and Psychiatry, Louisiana State University Health Sciences Center

Judge Constance Cohen (Ret.)
Consultant, Quality Improvement Center for Research-Based Infant Toddler Court Teams, ZERO TO THREE

Janie Huddleston
Director, Quality Improvement Center for Research-Based Infant Toddler Court Teams, ZERO TO THREE

Lucy Hudson, MS
Director, Safe Babies Court Teams Project Demonstration Director, Quality Improvement Center for Research-Based Infant Toddler Court Teams, ZERO TO THREE

Karen Zavora, JD
Program Attorney, National Council of Juvenile and Family Court Judges

Marva Lewis, Ph.D.
Associate Professor, Tulane University, School of Social Work

With substantial assistance from **Christina Cullen**, **Crystal Duarte**, and **Sarah Ray** of the National Council of Juvenile and Family Court Judges.

With gratitude to **Kristopher Kaliebe, MD**, Department of Psychiatry, Louisiana State University Health Sciences Center, for providing information on psychotropic medications and **Rizwan Shah, MD**, ZERO TO THREE Board Member, for contributions to the Physical Health section.

This **Technical Assistance Brief** is a publication of the National Council of Juvenile and Family Court Judges and ZERO TO THREE. The original 2002 brief was funded by Grant Nos. 96-CT-NX-0001 and 95-JS-FX-K002 from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. The 2017 update of this brief was made possible by Grant No. 90CA1821-01-01 from the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The contents of this publication do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Department of Health and Human Services, the U.S. Department of Justice, or the National Council of Juvenile and Family Court Judges.

NCJFCJ est. 1937
NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES
WWW.NCJFCJ.ORG

OJJDP Office of Juvenile Justice and Delinquency Prevention
Office of Justice Programs ♦ U.S. Department of Justice

Children's Bureau

Quality Improvement Center *for* Research-Based Infant-Toddler Court Teams

INTRODUCTION

Infants and young children placed in out-of-home care under the supervision of the court often have complicated and serious physical, mental health, and developmental problems, so much so that the American Academy of Pediatrics (AAP) has classified this population as one with special health care needs.[1] The bench card included with this publication was developed for use by judges, attorneys, child advocates, and other child welfare professionals in meeting the wide range of needs of this vulnerable population.[2]

PHYSICAL HEALTH

Has the child received a comprehensive initial assessment and ongoing health assessments?

All children should receive a comprehensive physical examination that addresses all aspects of the child's health within twenty-four (24) hours of placement.[3] Under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of federal Medicaid law, children should receive the comprehensive assessment in order to establish a baseline for a child's health status, evaluate whether the child has received necessary immunizations, and identify the need for further screening, treatment, and referral to specialists.[4] A health care provider (pediatrician or family practice physician) knowledgeable about the

health care problems of children in out-of-home placements should perform the examination.[5]

The initial medical screen should identify health conditions that require prompt medical attention such as acute illnesses, chronic diseases requiring therapy, signs of abuse or neglect, signs of infection or communicable diseases, hygiene or nutritional problems, and significant developmental or mental health disturbances. The screen should also identify health conditions that should be considered in making placement decisions.[6]

Because children may be victimized in out-of-home placements or during visits, continued monitoring for signs and symptoms of abuse and neglect while in care is also essential. Medical screening for child abuse should be a part of every medical encounter with children in care.[7] Such care should be comprehensive, coordinated, continuous, and family-supported.

Growth should be monitored carefully with regular measurements of head circumference, height, and weight for children under the age of three. An infant should have a "well-baby" examination by 2-4 weeks of age and may need to be seen each month until 6 months of age. Between the ages of 6 months and two years, a child should be seen by a health care provider every 3 months.[8]

Are the child's immunizations complete and up-to-date for his or her age?

Complete, up-to-date immunizations provide the best defense against many childhood diseases that can cause devastating effects. Immunization status is an important measure of vulnerability to childhood illness and can reveal whether the child has had access to basic health care. Immunizations are recommended at two, four, six, and 12 months of age with basic immunizations completed by two years of age.[9]

Has the child received a hearing and vision screening?

Undetected hearing loss during infancy and early childhood interferes with the development of speech and language skills and can have deleterious effects on overall development, especially learning. Hearing loss during early childhood can result from childhood diseases, significant head trauma, environmental factors such as excessive noise exposure, and insufficient attention paid to health problems that may affect hearing. Because children in care often lack a consistent caregiver who can observe their development and note areas of concern, they should receive ongoing evaluations of hearing, speech, and language development.[10]

Vision screening is also an essential part of preventative health care for children. Early detection and treatment increase the likelihood that a child's vision will develop normally, and, if necessary, the child will receive corrective devices. Due to the higher incidence of vision and hearing problems in this population, children in out-of-home placements should have age-appropriate hearing and vision screenings completed at entry into care and at every preventive health visit.[11]

Has the child received regular dental screenings and follow-up services?

Examination of the oral cavity by the primary health care provider is an important part of the comprehensive health assessment. Evidence of abuse or neglect in the oral cavity may be an issue in dependency cases.

Every year, thousands of children between one and four years old suffer from extensive tooth decay caused by sugary liquids – especially bottles given during the night. Children living below the poverty level have twice the rate of tooth decay as children from higher income levels.[12] Therefore, the American Academy of Pediatrics

recommends that children be referred for their first dental evaluation by one year of age.[13] Children with healthy mouths derive more nutrition from the food they eat, learn to speak more easily, and have a better chance of achieving good health.

Early dental care can also prevent decay in primary ("baby") teeth.[14] The American Academy of Pediatric Dentistry recommends that before the age of one year, a child's basic dental care be addressed during routine "well-baby" visits with a primary care provider, with referral to a dentist if necessary. For children older than one year, the Academy recommends a check-up at least twice a year with a dental professional. Daily brushing should begin before a child's first tooth erupts.[15]

Has the child been screened for lead exposure?

Children who have limited access to health care are especially vulnerable to the harmful effects of lead. Ingested or inhaled lead can damage a child's brain, kidneys, and blood-forming organs and may lead to behavioral and developmental problems.[16] Screening is important to ensure that poisoned children are identified and treated and their environments remediated. The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend lead-poisoning screening at 1 and 2 years of age. The CDC also recommends targeted screening based on risk assessment during pediatric visits for all other children.[17,18]

Has the child been screened for communicable diseases?

The circumstances associated with the necessity for out-of-home placement – such as prenatal drug exposure, poverty, parental substance abuse, poor housing conditions, and inadequate access to health care – can increase a child's risk of exposure to communicable diseases such as HIV/AIDS, congenital syphilis, hepatitis B and C, tuberculosis, and other sexually or mother-to-child transmitted infections. Newly placed children should be screened for these diseases at their comprehensive health assessment.[19]

Does the child have allergies?

Children under the age of three typically do not experience seasonal allergies but may suffer from exposure to environmental allergens (e.g., second-hand smoke, mold, fabrics) and from drug and food allergies. Reactions can be severe. It is important for the health care provider to be informed of any allergy symptoms for appropriate follow-up. The health care provider will also need to be advised of any prescription or over-the-counter medications, vitamins, or supplements the child receives.

Does the child have a "medical home" where he or she can receive coordinated, comprehensive, continuous health care?

All children in out-of-home care

should have a secure "medical home." A medical home is a single-point-of-contact health care provider specializing in pediatrics who oversees their primary care and periodic reassessments of physical, developmental, and emotional health, and who can make this information available as needed.[20] The medical home should be aware of and monitor all medications, vitamins, and other supplements that the child receives.

The medical home should oversee the child's care across the various agencies and systems, including early childhood services, early intervention services, education, medical, and mental health. Family-supportive care requires sharing the child's health information with the child's caregivers and providing caregivers with education and training programs in order to meet the needs of the child.

Because children in care often have multiple, complex health care needs that demand a high level of medical sophistication, evaluations should be conducted by qualified teams whenever possible to minimize the trauma of multiple examinations and interviews, maximize documentation, and ensure appropriate treatment and referrals.[21]

What type of medical and dental insurance does the child have? Is it sufficient?

Children who have been removed from the care of a parent need insurance coverage to ensure immediate access to health care and assessments. If the child had been covered under Title XIX (Medicaid)[22] prior to the removal, it is critical to provide the enrollment information to the caretaker right away to avoid delays in meeting the child's needs. Children who were not previously served by Medicaid will likely be eligible for this coverage upon removal. It may be necessary to direct someone to apply for coverage.

In some cases where the child does not qualify for Medicaid, there may be another option for coverage. The State Children's Health Insurance Program (SCHIP) – now known as the Children's Health Insurance Program (CHIP)[23]– is a program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance for families with children.[24] CHIP was designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. The statutory authority for CHIP is under Title XXI of the Social Security Act.[25]

Parents often lose Title XIX (Medicaid) coverage when their children are removed from their care by court order. Loss of coverage can create obstacles to accessing medical, dental, and mental health services, which, in turn, may impede reunification. States are given flexibility in designing their CHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use

CHIP funds to cover the parents of children receiving benefits from both CHIP and Medicaid, pregnant women, and other adults.

How will the need for emergency care be met?

Children in out-of-home care need a reliable concurrent plan for emergency care. Parents may be unavailable to authorize medically necessary treatment on short notice. The judge should enter appropriate orders consistent with respective state laws to ensure that there is no question as to which persons and/or agencies are authorized to obtain medical care for the child.

DEVELOPMENTAL HEALTH

Has the child received a developmental evaluation by a provider trained in child development?

Healthy development for young children in out-of-home placements, like all other children, is supported by nurturance from caregivers that includes consistent emotional availability, reciprocity, and routines. Children in out-of-home care often exhibit substantial delays in cognition, language, and behavior. In fact, one half of the children in out-of-home care show developmental delay that is approximately four to five times the rate of delay found in children in the general population.[26] Early evaluation can identify developmental problems and can help caregivers better understand and address the child's needs.

Developmental evaluations provide young children who have identified delays with access to two federal entitlement programs:

- The Early Intervention Program for Infants and Toddlers with Disabilities, also known as Part C of the Individuals with Disabilities Education Improvement Act (IDEA) [20 U.S.C. § 1400 et seq. (2004)], and
- The Preschool Special Education Grants Program for children with disabilities between the ages of three and five, also known as Section 619 of IDEA [20 U.S.C. § 1400 et seq. (2004)].[27]

Are the child and his or her family receiving the necessary early intervention services, e.g., speech therapy, occupational therapy, educational interventions, family support?

Finding help for young children may prevent further developmental delays, improve the quality of family life, and possibly increase opportunities for reunification. Substantial evidence indicates that early intervention is most effective during the first three years of life, when the brain is establishing the foundation for all developmental, social, and cognitive domains.[28,29,30] "The course of development can be altered in early childhood by effective interventions

that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes."[31] If developmental delays are not addressed early, children more frequently perform poorly in school. They may have difficulty understanding and expressing language, show how they are feeling with difficult behaviors rather than words, misunderstand social cues, and display poor judgment.

Early intervention provides an array of services including hearing and vision screening, occupational, speech, physical therapy, and special instruction for the child, as well as family support services to enable parents to enhance their child's development. Such services can help children benefit from a more successful and satisfying educational experience because they learn more skills and have a greater capacity to understand, learn, and express themselves using language, which can also improve peer relationships.[32]

> *"The course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes."*
>
> ***From Neurons to Neighborhoods: The Science of Early Childhood Development***

Children in out-of-home placements can be referred for early intervention and special education services by parents, health care workers, social service workers, or schools. Early intervention services are an entitlement for all foster children from birth to three years and their families as part of Part C, IDEA. Both biological and foster families can receive Early Intervention Family Support Services to enhance a child's development.

MENTAL HEALTH

Has the child received a mental health screening, assessment, or evaluation?

Infants and young children enter out-of-home placements with adverse life experiences: physical, emotional, and sexual abuse, neglect, exposure to family violence, parental substance abuse, serious mental illness, homelessness, or chronic poverty.[33,34] Once children are placed, in addition to their early traumatic experiences, they must cope with the separation and loss of their family members and the uncertainty of out-of-home care. The cumulative effects of these traumatic experiences can lead to emotional issues that require an initial screening, and sometimes, an assessment or evaluation by a mental health professional trained in working with infants and young children.[35] Compared with children from the same socioeconomic background, children in the child welfare system

have much higher rates of serious emotional and behavioral problems.[36] It is important to provide evaluations for these children and evidence-based intervention and treatment services, when needed, in order to address early difficulties and prevent even more serious problems later.

Young children exhibiting extreme behavioral and emotional dysregulation that is beyond normal limits for their developmental level may signal the need for a mental health assessment, neuropsychological evaluation, and/or an educational evaluation to determine services that will be most helpful. Many of the symptoms associated with juvenile emotional and behavioral health problems can be identified early and helped if addressed right away. In addition, more serious problems can often be prevented. The American Academy of Child and Adolescent Psychiatry recommends assessments for infants who exhibit extreme fussiness, feeding and sleeping problems, and failure to thrive. For toddlers, the Academy recommends assessments for children exhibiting aggressive, defiant, impulsive, and hyperactive behaviors, withdrawal, extreme sadness, and sleep and eating disorders.[37,38]

Is the child receiving necessary infant or early childhood mental health services?

The incidence of emotional, behavioral, and developmental problems among children in out-of-home care is three to six times greater than children in the general population.[39,40] Children with emotional and behavioral problems have a reduced likelihood of reunification or adoption.[41] Children with externalizing problems e.g., aggression and acting out, have the lowest probability of exiting out-of-home care.[42] During infancy and early childhood, the foundations are laid for the development of trusting relationships, self-esteem, conscience, empathy, problem solving, focused learning, and impulse control.[43]

To promote and facilitate permanency, children identified with mental health problems should receive care from a mental health professional trained in infant mental health who can develop a treatment plan for the child and their caregivers based on evidence-based and promising practices to strengthen the child's emotional and behavioral well-being. Services may include clinical intervention, home visiting, early care and education, early

intervention services, and parental guidance that includes learning the importance of routines, good nutrition, exercise, and consistent caregiver emotional availability and support for young children.

Is the child receiving any psychotropic medications? Has a behavioral intervention been implemented? What additional interventions are being used?

The use of medication to treat behavioral and emotional difficulties in children has become increasingly common as the first line of response, rather than considering behavioral and/or parenting interventions. Further, an increasing number of younger children, including those less than 6 years old, are now being prescribed psychiatric or psychotropic medication.[44] Rates of medication use are higher for children in out-of-home care and for abused children.[45] While the benefits of medication may outweigh the risks in certain circumstances, especially when utilized under close supervision and combined with other therapies, research data regarding the use of psychotropic medications in younger children is sparse. A major concern is the potential harm of medications for the developing brain in younger children.[46] At the time of this publication, no psychotropic medications are approved for children under age 3.

Using medication as the first line of response to calm or "chemically restrain" these children might lead to a decreased likelihood that other, even more effective behavioral interventions will be utilized. Unfortunately, many child-serving systems, including both social service and medical systems, are often not well coordinated and have not put mechanisms in place to provide the full range of family supports and other services needed most by these vulnerable young children.

A further concern includes the risks regarding exposure to psychiatric medications from the mother during pregnancy or lactation, and additionally subsequent discontinuation syndromes in neonates and infants. As controlled experiments are not ethical or feasible in these populations, the risks remain uncertain, but concerning.

FETAL ALCOHOL SPECTRUM DISORDERS (FASD)[47]

Is there any evidence to suggest that the mother of the child drank alcohol or used drugs during pregnancy?

Prenatal exposure to alcohol is an issue that affects children in all socioeconomic classes and child welfare-involved children are no exception. Almost 4 million babies are born in the U.S. each year and it is estimated that 40,000 of them will display deficits or impairments associated with prenatal alcohol

exposure at some time during childhood or adolescence.[48]

A large proportion of child welfare cases involve alcohol and other drugs, making it critical that system professionals are educated about the effects of prenatal alcohol exposure and resources available in their communities to support families. A meta-analysis of children in out-of-home care settings, such as foster care, concluded that about 16.9% of these children may be affected by Fetal Alcohol Spectrum Disorders, or "FASD."[49]

Prenatal alcohol exposure can lead to a wide range of physical, mental, behavioral, and learning deficits, which all fall under the umbrella of FASD. While damage to the fetus depends on the quantity, frequency, and timing of alcohol exposure, alcohol can cause damage to the fetus's developing brain at any time during pregnancy.[50] The resulting brain-related problems can disrupt normal development, learning, memory, problem solving, attention span, judgment, control of emotions, impulsivity, communication, and daily life skills such as feeding, bathing, and even telling time.[51] Due to these deficits, as well as the many possible physical consequences of prenatal alcohol exposure, the American Academy of Pediatrics has classified infants and children with FASD as "special needs children."[52] See the two accompanying tables for lists of cognitive and behavioral symptoms in infants and young children.[53] For a more complete list of characteristic symptoms, see the American Academy of Pediatrics FASD Toolkit.[54]

FASD SYMPTOMS IN CHILDREN UNDER 1 YEAR OF AGE

- Developmental delays in motor, language, and social skills
- Difficulty sleeping and being calmed
- Chaotic disorganized play
- Difficulty adapting to changes in routine and environmental events

FASD SYMPTOMS IN CHILDREN 1-4 YEARS OF AGE

- Global developmental delays
- Sleep problems
- Reduced verbal fluency
- Difficulty with multiple step plans
- Lack of coordinated motor skills
- Disorganized and inflexible behavior
- Overreaction to environmental stressors

Has the child been assessed for FASD? If FASD is indicated, what services are being offered to the child and caregivers?

Unfortunately, FASD often remains undiagnosed due to lack of awareness among health and mental health professionals and the significant overlap between symptoms of FASD and other neurodevelopmental disorders, such as ADHD.[55] Foster and adopted children are especially vulnerable to a missed diagnosis, with one study finding a missed diagnosis rate of 80.1%.[56]

If a judge or lawyer has any reason to believe a child may have FASD or that the mother may have used drugs or alcohol during pregnancy, they should notify those responsible for the child's welfare and request an evaluation of the child by an expert trained to diagnose FASD. A good place to start for screening young children is a Part C assessment under the Individuals with Disabilities Education Act (IDEA). For children under three years old, Part C offers services such as health management, speech therapy, occupational therapy, and special education services. Children over three years old may be referred to programs under Part B of IDEA. It is also important to note that deficits caused by FASD may not be apparent in infants or children until they are much older, making screening and re-screening appropriate for children who may have FASD.

The importance of diagnosing children with FASD in the dependency system cannot be underscored enough. Early diagnosis and access to appropriate services can help prevent the need for removal, establish appropriate placement and services, reduce the likelihood of multiple failed placements, and better prepare biological parents and out-of-home caregivers to meet the needs of the child.[57]

MORE ON FETAL ALCOHOL SPECTRUM DISORDERS

Read the ***Fetal Alcohol Spectrum Disorders: Implications for Juvenile and Family Court Judges*** *technical assistance brief at:* www.ncjfcj.org/FASD-Guide.

EXPOSURE TO DOMESTIC VIOLENCE

Has the child been exposed to domestic violence? What are the consequences of violence exposure for the child?

Domestic violence and child maltreatment often co-occur in families, with some studies indicating overlaps ranging from 30% to 70%.[58] Children in families experiencing domestic violence may also be experiencing incest or child sexual abuse,[60] or may be injured during the violence, or forced to watch

the abuse.[59] Children exposed to domestic violence suffer emotional, behavioral, and cognitive difficulties as a result of the exposure.[61] Identifying domestic violence exposure may be a critical context for understanding a parent's protective behaviors, inability to cooperate with service plans, or reactions including fear, anger, or despondency.

Has an assessment been initiated or mental health services been provided to the child exposed to domestic violence?

The first step to understanding a child's exposure to domestic violence is to ensure that social services has properly screened the case for domestic violence. The U.S. Department of Health and Human Services (HHS) recommends that child protection agencies screen for domestic violence on "every child abuse and neglect report received by the agency."[62] Assessments should continue for the life of a case: "Assessments are snapshots in time… The agency should not rely on one individual assessment, but instead conduct a series of assessments."[63]

If a child has been exposed to domestic violence, the child's case plan must include services tailored to address their individual needs, including mental health services if needed. Services for children should focus on safety and well-being, and be trauma-informed and developmentally appropriate.[64]

FOCUS ON COMMUNITY VIOLENCE

Community violence can also have adverse effects on infants and toddlers. Witnessing violence in the home or community can cause a variety of emotional and behavioral problems, including excessive irritability, immature behavior, sleep disturbances, emotional distress, fears of being alone, and regression in toileting and language. Having a strong relationship with a competent, caring adult, whether a parent or out-of-home caregiver, is the most important factor in helping infants and children with exposure to violence.

For more information, read **The Impact of Violence on Children** by Joy D. Osofksy at: www.princeton.edu/futureofchildren/publications/docs/09_03_2.pdf.

Can the child be kept safe and together with the non-offending parent? Is there a safety plan in place to address domestic violence concerns related to the family, co-parenting, and visitation?

The most significant factors influencing a child's resilience is his or her ability to remain connected to a protective parent. Likewise, one of the best ways to ensure a child's safety is to help the adult victim increase her safety.[65] Social services should work with the non-offending parent to create a safety plan and provide the victim

support to ensure that she is able to keep herself and her children safe.[66] This may include supports that do not appear—on the surface—to be about safety, such as housing, child care, transportation, or access to health care.

While there are male victims of domestic violence, the Department of Justice estimates that 85% of the victims of domestic violence are women.

Bureau of Justice Statistics, Crime Data Brief: Intimate Partner Violence, 1993-2001.

In cases where domestic violence is a significant concern, "the removal of the child from the home is usually unnecessary."[67] With proper services, social services can keep the child in the care of the non-offending parent and prevent the child from experiencing the trauma of removal and placement in out-of-home care. Services should focus on the safety and stability of the adult victim and her child and may include safety planning and assisting the victim with safe housing, transportation, protective orders, and child care.[68]

Domestic violence and the resulting trauma can impact the victim by affecting mental health or substance use and, in turn, influence the victim's parenting. If so, social services should help the adult victim with services to address mental health and/or substance abuse. In cases with serious mental health or substance abuse

issues, the intervention may include inpatient mental services that allow the adult victim and child to remain together.[69] In addition, courts can order the offending parent to stay out of the home and into appropriate domestic violence treatment to ensure that the adult victim and child remain safe together.[70]

Safety is also a concern during visitation with the offending parent and the child's case plan should address and account for the child's safety during visitation. In addition, courts can support the safety of children by providing appropriate services to the batterer to address the violence, such as batterer intervention programs. The court can also hold batterers accountable for not following through with required interventions.[71] If a child is placed in the care of relatives or a foster family, social services should also screen those families for domestic violence to ensure the child does not experience additional violence while in care.[72]

MORE ON DOMESTIC VIOLENCE

Download NCJFCJ publications on domestic violence at: www.ncjfcj.org/resource-library/publications/domestic-violence

Visit the Resource Center on Domestic Violence: Child Protection and Custody at: www.rcdvcpc.org

TRAUMA AND PARENTING

Has a parent experienced unusual challenges related to poverty, childhood abuse, interpersonal violence, substance abuse, mental health disorders, and/or historical trauma?

It is well known that large numbers of young children who enter out-of-home care have a history of exposure to multiple and chronic traumas that can affect their behaviors, emotions, and cognitive functioning. Less attention is paid, however, to the mental health needs of their parent(s) who have also been traumatized[73] and have found both adaptive and maladaptive ways to cope with their stress.[74,75,76]

It should be recognized that the success of child welfare services depends in part on the willingness of parents to work with providers and create a safe home for their children. All trauma, including the family's ethnic, racial, or cultural experience of historical trauma, may impact parenting practices with young children.[77] The effect trauma may have on the parents' ability to engage with service providers and child-serving systems is of particular significance. Research has highlighted the low levels of service engagement among parents and found that untreated maternal trauma was associated with unstable affect and difficulty trusting service providers. Compounding the difficulties of engaging parents in treatment, some of the evidence-based interventions available to children in the child welfare system do not directly address issues of parental trauma.[78]

In addition to trauma, substance and alcohol abuse is another parental issue that often needs to be addressed. The substance abuse treatment community now treats drug and alcohol addiction as a medical condition that is often associated with childhood trauma.[79] In child

welfare cases where substance abuse is a factor, the courts have the opportunity to support parents in managing their addiction through treatment that recognizes and addresses underlying trauma. By addressing trauma experienced by parents, courts can help keep families together.

FAMILY TIME

How often are the child, parent(s), and siblings spending time together?

Family time is critical for child well-being and increases the likelihood of a quick reunification.[80] Regular and frequent family time not only promotes healthy attachment and reduces the negative impact of separation, but research shows that for each additional visit per week, the odds of the child achieving permanency within a year are tripled.[81]

Very young children become attached to their parents whether the parents are able to provide consistent loving care or not. While the quality of that attachment may be insecure or even disorganized, separating a young child from his parents is still painful.[82] The desired goal of supported family time is to nurture the relationship between parent and child and to address any challenges to developing the attachment. The child's out-of-home caregivers should be critical allies in assisting the child and his parents in maintaining or building a healthy, loving relationship.

While judges should ensure that family time is part of every case plan, it is the job of the family team to create an individualized visitation plan that provides the level of contact and support, ranging from unsupervised family time to intensive mental health interventions, that will promote the most positive outcome for the child and the family. 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. Plans should include all siblings in family visits when possible and visits should be unsupervised unless there is objective evidence suggesting that the child and/or siblings will be unsafe in an unsupervised setting.

Family time should be as unrestricted as possible, while maintaining the child's safety, to help preserve the child's attachment to the parents. If the parents seem unaware of what their child is capable of at a specific developmental stage or are unable to overcome their own trauma history to focus on the child, therapeutic supervision of visits should be considered. When there has been serious physical or emotional abuse, parent-child contact should proceed only under the care of an experienced mental health clinician who can determine whether contact is beneficial for the child. In some instances, parent-child contact can further damage the child. If this is the case, sibling time apart from parental family time should be considered.

However, if the parent is able to become consistently nurturing, the court should consider more relaxed supervision, more frequent family time, and including siblings in the visits.

Parents whose children have been placed in out-of-home care need frequent contact to maintain optimism about reunification. The court can focus attention on increasing the time children and parents spend together by expanding the opportunities (e.g., doctor's appointments, Part C screenings, other health services) and the locations (e.g., the foster home, the birth parents' home). The court can also encourage other contact, such as phone and video calls, emails, and text and picture messaging. Placement with family members, where appropriate, can also allow daily supervised contact that begins with breakfast and ends after the parent has put the child to bed for the night.

Because parents who abuse or neglect their children may lack positive parenting models, the professionals working under the court's jurisdiction should identify strategies to improve the parents' ability to respond appropriately to their children's needs. An approach that has been used successfully is an organized internship program for social work graduate students to provide ongoing coaching for parents during visits. Foster parents can be another critical source of support for positive parent-child contact.

EDUCATIONAL/ CHILD CARE SETTING

Is the child enrolled in an early childhood program that supports both cognitive and social/emotional development?

Every experience in the lives of infants and toddlers teaches them how the world works. Their most important teachers are the adults with whom they live. When an out-of-home caregiver expresses an interest in keeping a young child at home with them, this is often the best option. If the caregiver works outside the home or there is some other reason that the child would benefit from spending their days in child care, it is important to identify a family child care home or a child care center that supports the child's healthy development.

Early care and education programs can support the child's development if they meet certain criteria[83]:

- Each child is matched with one staff person who serves as the child's primary caregiver.
- The child's classroom includes 1 skilled adult caregiver for every 3 or 4 infants and toddlers up to 21 months or every 4 to 6 toddlers 21 to 36 months old.[84]
- Classes are no bigger than 6 to 8 children for infants, and 8 to 12 for toddlers.[85]
- The care-giving staff experiences minimal turnover so that

children can develop trusting relationships with their teachers.

- The staff works in partnership with the children's parents to provide consistent support to the children at home and at school.
- The staff of the program is well prepared, participates in ongoing professional development, and receives adequate compensation.

These criteria are met by only a small percentage of all the programs available, however, placing a very young child in a low or poor quality setting may exacerbate harm to a child already suffering from developmental or mental health issues as a result of abuse or neglect. For this reason, it is critical that programs be vetted thoroughly and that an individualized assessment be done to meet the child's needs.

When compared with children attending regular child care, children who participate in *high quality* early childhood programs with comprehensive education, family, and health services, have higher rates of high school completion, lower rates of dropping out of school, lower rates of juvenile arrest, and fewer violent arrests.[86] Educational programs such as Early Head Start focus on the child in the context of the family. Not all child care programs include a family focus; however, this approach is especially important to families with child welfare involvement.

If it is determined that a young child will participate in a formal early childhood program outside the home, limiting the number of hours away from the child's primary caregiver, and maintaining a regular schedule (e.g. Monday, Wednesday and Friday from 9:00 a.m. to 12:00 p.m.) eases transitions. It is also important to assign the child to one specific primary teacher who can establish a predictable and healthy relationship with the child. Personalized, consistent attention is critical to ensure that the experience does not add to a young child's distrust and sense of powerlessness.

Although considerable research has indicated that *high quality* early education has a positive impact on school and life achievement, it is often a better option for very young children to remain in the consistent care of their out-of-home caregivers or kinship care provider if that person can provide nurturing, developmentally appropriate care. Facilitated play groups, community programs, and in-home services can augment learning experiences. The

caregiver should have access to and receive training in developmental milestones and appropriate ways to engage young children in order to enrich the home environment.

Does the staff have a working knowledge of trauma-informed practices as they relate to children in child welfare in order to minimize or eliminate changes in the child care or educational setting and support the child and the family?

Most children are placed in out-of-home care because of abuse or neglect occurring within the context of parental substance abuse, extreme poverty, mental illness, homelessness, domestic violence, chronic stress, and physical disease. A disproportionate number of children placed in out-of-home care come from families with the fewest psychosocial and financial resources and extended sources of support.[87] For all of these reasons, it is very important that all of the adults caring for the child be knowledgeable about the impact of trauma and loss on infants and toddlers. It is also important that they are willing and able to work with the child's family and that they are knowledgeable about the impact the parents' history of trauma can have on their relationships with their young children.

PLACEMENT

Is the child placed with caregivers knowledgeable about the social and emotional needs of infants and toddlers in out-of-home placements, especially young children who have been abused, exposed to domestic violence, trauma, other adverse childhood experiences, or neglected?

Do the caregivers have access to information and support related to the child's unique needs?

Are the out-of-home caregivers able to identify problem behaviors in the child and seek appropriate services?

Childhood abuse increases the odds of future delinquency by 59 percent and adult criminality by 28 percent.[88] Maltreated infants and toddlers are at risk for insecure attachment, poor self-development, and psychopathology.[89,90] Children in out-of-home placements often exhibit a variety of problems which may be beyond the skills of persons without special knowledge or training. Therefore, foster parents need and should receive information about the child's history and needs as well as appropriate training.[91] Early interventions are key to minimizing the long-term and permanent effects of traumatic events on the developing brain and on behavioral and emotional development.[92] (It is imperative that caregivers seek treatment for their children and

themselves as soon as possible.)

To what extent are the birth parents and out-of-home caregivers sharing parenting and updating each other on any changes in routine?

Birth parents and out-of-home caregivers should receive support to work together to ensure the child's needs are met consistently and without delay. If possible, out-of-home caregivers should serve as mentors and role models for birth parents. Caregivers should be encouraged to supervise parenting time with the birth parents. Shared parenting time is an effective way to support the child's opportunity to build trust and reduce confusion concerning relationships.

Are all efforts being made to place the child with appropriate family members?

Is there reason to believe the child could be a member of or could be eligible to be a member of a federally recognized tribe?

Traditional out-of-home care should be considered only when no fit and willing blood relatives or fictive kin are available to care for the child. Not only do most states require placement with a fit and willing relative before considering foster care, but in 2008, federal legislation enacted the Fostering Connections to Success and Increasing Adoptions Act (PL 110-351), requires notification of all known relatives within thirty days of a removal to facilitate family placement. Additionally, the Adoption and Safe Families Act of 1997 (PL 105-89) requires courts to assure that reasonable efforts are made to maintain sibling contact.

FOCUS ON ICWA

Congress passed the Indian Child Welfare Act of 1978 (ICWA) to address the disproportionate rate of removal of Indian children from their homes and their placement with non-Indian families. Judges and lawyers should be aware that ICWA establishes special procedures and substantive safeguards to protect the interests of Indian children and families. To prevent Indian children from unnecessarily being placed in foster care, the courts should identify at the earliest possible time whether ICWA applies to the child and follow the procedural and substantive requirements set out in ICWA.

Read the NCJFCJ Resolution in Support of the Full Implementation of the Indian Child Welfare Act at: http://www.ncjfcj.org/sites/default/files/FNL_ICWA_Resolution_07132013.pdf

Download NCJFCJ publications on ICWA at: www.ncjfcj.org/resource-library/publications/tribal-work-and-icwa

Further, if the child is eligible for the protections of the Indian Child Welfare Act (PL 95-608) originally

enacted in 1978, there are stringent placement preference requirements to which courts must adhere. It is important that the judge asks whether ICWA applies in every child custody proceeding as soon as possible. If there is reason to believe the child could be a member of or could be eligible to be a member of a federally recognized tribe, the court should treat the child as an Indian child unless and until it is determined that the child is not an Indian child.

Family members and fictive kin with whom the child already has a healthy relationship offer the child a long-term connection to the family of origin. Family placement offers increased stability and lower likelihood of behavioral problems. It also keeps the child culturally connected.[93]

It is important to ensure that the child welfare agency initiates any necessary home studies and/or Interstate Compact for Placement of Children (ICPC) procedures as early as possible.[94] The court should also evaluate progress toward completing these processes at every hearing to avoid delays in decision-making and to expedite access to financial and therapeutic resources.

Are all efforts being made to keep the child in one consistent placement and to minimize disruptions in the child's relationships and placements?

An adverse prenatal environment, parental depression or stress, drug exposure, malnutrition, neglect, abuse, or physical or emotional trauma can negatively impact a child's subsequent development. Therefore, it is essential that all children, especially young children, are able to live in a nurturing, supportive, and stimulating environment.[95] It is crucial to try to keep children in one, consistent, supportive placement so that they can develop positive secure attachment relationships. Effective concurrent planning from day one aims to make the first placement in out-of-home care the last placement if reunification is not possible.[96]

The most important component for a young child to develop into a a psychologically healthy human being, is to have a relationship with an adult who is nurturing, protective, and fosters trust and security. Attachment between a young child and at least one primary caregiver is essential to the development of emotional security and social conscience.[97]

What happens during the first months and years of life matters tremendously because this period of development provides an indelible blueprint for adult well-being. This period also sets either a sturdy or fragile stage for what follows because early relationships form the basis for all later relationships.[98,99]

REDUCING DISPROPORTIONATE REPRESENTATION IN THE CHILD WELFARE SYSTEM

Children of color and their families are directly and adversely impacted by disproportionate representation and racial disparities in outcomes in the child welfare system. The extensive findings from research show that these disparities take an emotional toll on young children, their families, and ultimately our society. The National Council of Juvenile and Family Court Judges (NCJFCJ) and the Quality Improvement Center for Research-Based Infant Toddler Court Teams (QIC-CT) are committed to supporting judges and attorneys in reducing and eliminating disproportionate representation and disparate outcomes for children and families of color in the child welfare system.

Judges and attorneys can take a leadership role by understanding and examining implicit bias, educating themselves and their colleagues about race as a social and legal construct, and identifying and replacing policies and practices that may perpetuate racial disparities. For more information and strategies, see the NCJFCJ's publications below.

Read the NCJFCJ Resolution Regarding Disproportionate Representation of Minority Children at: http://www.ncjfcj.org/sites/default/files/resolution.disproportionaterepresentation.pdf

To learn about the NCJFCJ's Courts Catalyzing Change Initiative, including questions judges and lawyers should ask, see ***Right from the Start: The CCC Preliminary Protective Hearing Bench Card*** *at: http://www.ncjfcj.org/resource-library/publications/right-start-courts-catalyzing-change-preliminary-protective-hearing-0*

ENDNOTES

1 Szilagyi, M. A., Rosen, D.S., Rubin, D., & Zlotnik, S. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*, 136 (4), 1142-1166. Retrieved from http://pediatrics.aappublications.org/content/136/4/e1131.

2 Several of the questions follow the format of and contain excerpts from "A Checklist for the Healthy Development of Infants in Foster Care" from Dicker, S. & Gordon, E. (2004). *Ensuring the healthy development of infants in foster care: A guide for judges, advocates and child welfare professionals*. New York State Permanent Judicial Commission on Justice for Children.

3 Task Force on Health Care for Children in Foster Care (2005). *Fostering health: Health care for children and adolescents in foster care*. New York: American Academy of Pediatrics. Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf.

4 42 U.S.C. Section 1396(a)(10) and (43) (2016); 42 U.S.C. Section 1396d(a)(4)(B) and 1396(r)(2016).

5 Task Force, *supra* note 3.

6 Task Force, *supra* note 3.

7 Task Force, *supra* note 3.

8 Szilagyi, *supra* note 1.

9 American Academy of Pediatrics (2016) Recommendations for preventive pediatric health care. *Pediatrics*, 137(1).

10 Buz Harlor Jr., A.D. & Bower, C. (2009). Hearing assessment in infants and children: Recommendations beyond neonatal screening. *Pediatrics*, 124 (4). Retrieved from http://pediatrics.aappublications.org/content/124/4/1252#T1.

11 Szilagyi, *supra* note 1.

12 Dye, B.A., Xianfen Li, M.S., Thornton-Evans, G. (2012). *Oral health disparities as determined by selected Healthy People 2020 oral health objectives for the United States, 2009-2010*. Data Brief, 104. Washington, D.C.; U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/products/databriefs/db104.htm.

13 American Academy of Pediatrics (2014). Maintaining and improving the oral health of young children. *Pediatrics*, 134, 1224-1229. Retrieved from http://pediatrics.aappublications.org/content/134/6/1224.

14 Dental Caries (Tooth Decay) in Children (Age 2-11). (2014). Retrieved from http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/DentalCariesChildren2to11.htm.

15 American Academy of Pediatrics, *supra* note 12.

16 Tarragó, O. (2010). *Lead toxicity. Case studies in environmental medicine*. Washington, D.C.: U.S. Department of Health and Human Services, Agency for Toxic Substances and Disease Registry. Retrieved from http://www.atsdr.cdc.gov/csem/lead/docs/lead.pdf.

17 American Academy of Pediatrics, Committee on Environmental Health. (2016). Prevention of childhood lead toxicity. *Pediatrics*, 138 (1). Retrieved from http://pediatrics.aappublications.org/content/138/1/e20161493.

18 Center for Disease Control and Prevention, Advisory Committee on Childhood Lead Poisoning Prevention. (2012). Low level lead exposure harms children: A renewed call for primary

prevention. Atlanta, GA: Center for Disease Control and Prevention. Retrieved from http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf.

19 Szilagyi, *supra* note 1.

20 Szilagyi, *supra* note 1.

21 Task Force, *Supra* note 3.

22 42 U.S.C. § 1396v (2016).

23 Children's Health Insurance Program (CHIP). Retrieved from https://www.medicaid.gov/chip/chip-program-information.html.

24 Sultz, H. & Young K. M. (2013). *Health care USA: Understanding its organization and delivery*. Sudbury, MA: Jones and Bartlett.

25 42 U.S.C. § 1397aa-1397m (2016).

26 Dicker, S. & Gordon, E. (2000). Connecting healthy development and permanency: A pivotal role for child welfare professionals. *Permanency Planning Today*, 1(1), 12-15.

27 U.S. Department of Education. (2004). Building the legacy: IDEA 2004. Retrieved from http://idea.ed.gov/explore/view/p/%2Croot%2Cstatute%2C.

28 Thompson, R.A. (2001). Development in the first years of life. *The Future of Children*, 1(1) 21-33.

29 Fox, S. E., Levitt, P., & Nelson, C. A. (2010). How the timing of quality of early experiences influence the development of brain architecture. *Child Development*, 81, 28-40.

30 Center on the Developing Child at Harvard University. Retrieved from http://developingchild.harvard.edu/.

31 Shonkoff, J. P. & Phillips, D. A. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, D.C: National Academy Press. Retrieved from http://www.nap.edu/catalog/9824/from-neurons-to-neighborhoods-the-science-of-early-childhood-development.

32 Dicker, *supra* note 26.

33 Centers for Disease Control and Prevention. (2016). Adverse childhood experiences (ACEs). Retrieved from https://www.cdc.gov/violenceprevention/acestudy/.

34 Child Trends. (2013). Adverse experiences. Retrieved from http://www.childtrends.org/indicators/adverse-experiences/.

35 Szilagyi, *supra* note 1.

36 Lee, T., Fouras, G., & Brown, R. (2015). Practice parameter for the assessment of youth involved with the child welfare system. *Journal of the American Academy of Child & Adolescent Psychiatry*. 54(6), 502-517. Retrieved from: http://www.jaacap.com/article/S0890-8567(15)00148-3/pdf.

37 Gleason, M. K. & Zeanah, C. (2016) Assessing infants and toddlers. In M.K. Dulcan (Ed.), *Dulcan's textbook of child and adolescent psychiatry* (2nd ed.). Arlington, VA: American Psychiatric Association Publishing.

38 Carter, A. S., Briggs-Gowan, M., & Davis, N. O. (2004). Assessment of young children's social-emotional development and psychopathology: Recent advances and recommendations for practice. *Journal of Child Psychology and Psychiatry*, 45(1), 109–134. Retrieved from http://onlinelibrary.wiley.com/doi/10.1046/j.0021-9630.2003.00316.x/abstract.

39 Osofsky, J. D., & Lieberman, A. (2011). Systems of care for infants and young children: A call for integrating a mental health perspective. *American Psychologist*, 66(2), 120-128.

[40] Marsenich, L. (2002). *Evidence-based practices in mental health services for foster youth.* Sacramento, CA: California Institute for Mental Health.

[41] Jones Harden, B. (2004). Safety and stability for foster children: A developmental perspective. *The Future of Children*, 14(1) 31-48.

[42] *Ibid.*

[43] Greenough, W., Gunnar, M., Emde, N., Massinga, R., & Shonkoff, J. (2001). The impact of the caregiving environment on young children's development: Different ways of knowing. *ZERO TO THREE*, 21, 16-23.

[44] *Turning attention to ADHD: U.S. medication trends for attention deficit hyperactivity disorder.* (2014). Express Scripts Lab. Retrieved from http://lab.express-scripts.com/lab/insights/industry-updates/report-turning-attention-to-adhd.

[45] Visser, S. N., Bitsko, R. H., et al. (2015). Treatment of attention-deficit/hyperactivity disorder among children with special health care needs. J*ournal of Pediatrics,* 166 (6) 1423-30. Retrieved from http://www.jpeds.com/pb/assets/raw/Health%20Advance/journals/ympd/Visser.pdf.

[46] Smith, B. L. (2012). Inappropriate prescribing. *Monitor on Psychology*, 43(6) 36.

[47] Section adapted from *Fetal alcohol spectrum disorders: Implications for juvenile and family court judges* (2015). Technical assistance brief. Reno, NV: National Council of Juvenile and Family Court Judges. Retrieved from http://www.ncjfcj.org/sites/default/files/NCJFCJ%20FASD%20Guide%20Final-09062016.pdf.

[48] *Ibid.*

[49] Lange, S., Shield, K., Rehm, J., and Popova, S. (2013). Prevalence of fetal alcohol spectrum disorders in child care settings: a meta-analysis. *Pediatrics*, 132(4):e980-95.doi:0.1542/peds.203-0066.Epub 2013 Sep 9.

[50] Centers for Disease Control and Prevention. (2005). Notice to readers: Surgeon General's advisory on alcohol use in pregnancy. *Morbidity Mortal Weekly Report*, 54(9), 229.

[51] Mattson, S. N., Crocker, N., & Nguyen, T. T. (2011). Fetal alcohol spectrum disorders: Neuropsychological and behavioral features. *Neuropsychology Review*, 21(2), 81-100. Doi: 10.1007/s11065-011-9167-9.

[52] As adopted in 1998 by the American Academy of Pediatrics (AAP), children with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. This definition originally was proposed in McPherson, M., et al. (1998). A new definition of children with special healthcare needs. *Pediatrics*, 102(1), 137-139.

[53] Hagan, Jr. J.F. , Balachova, T., Bertrand, J., Chasnoff, I., Dang, E., Fernandez-Baca, D., Kable, J., Kosofsky, B., Senturias, Y.N., Singh, N., Sloane, M., Weitzman, C., & Zubler, J., on behalf of ND-PAE Workgroup American Academy of Pediatrics. (2016). Neurobehavioral disorder associated with prenatal alcohol exposure. Pediatrics 138(4) October 2016:e0151553.

[54] American Academy of Pediatrics FASD Toolkit, available at www.aap.org/fasd, offers additional support for pediatric medical home clinicians in the identification, diagnosis and/or referral of affected children.

[55] Kable, J. A., et al. (in press). Neurobehavioral disorder associated with prenatal alcohol syndrome (ND-PAE): DSM-5 diagnosis. *Child Psychiatry & Human Development*.

[56] Chasnoff, I., Wells, A., & King, L. (2015). Misdiagnosis and missed diagnoses in foster and adopted children with prenatal alcohol exposure. *Pediatrics*, 135(2), 264-270, DOI: 10.1542/peds.2014-2171.

[57] Lange, S., Shield, K., Rehn, J., & Popova, S. (2013). Prevalence of fetal alcohol spectrum disorders in child care settings: A meta-analysis. *Pediatrics*, 132(4), 980-95.

[58] Summers, A. (2006). *Children's exposure to domestic violence: A guide to research and resources*. 26-27. Reno, NV: National Council of Juvenile & Family Court Judges.

[59] Bancroft, L. & Silverman, J. G. (2002). *The batterer as parent: Addressing the impact of domestic violence on family dynamics*. 84-97. Thousand Oaks, CA: Sage Publications.

[60] Weithorn, L. A. (2001). Protecting children from exposure to domestic violence: The use and abuse of child maltreatment statutes. *Hastings Law Journal*, 53(1) 82.

[61] Futures Without Violence. (2013). *The facts on children's exposure to intimate partner violence*. Retrieved from https://www.futureswithoutviolence.org/userfiles/file/Fact%20sheet%20on%20Children%20Exposed%20to%20IPV%202013.pdf.

[62] Bragg, H. L. (2003). *Child protection in families experiencing domestic violence*. Washington, DC: U.S. Department of Health and Humans Services. 36.

[63] *Checklist to promote perpetrator accountability in dependency cases involving domestic violence*. (2011). Reno, NV: National Council of Juvenile and Family Court Judges.

[64] U.S. Department of Justice. (2012). Evidence-based practices for children exposed to violence: A selection from federal databases. Retrieved from http://www.nccadv.org/images/pdfs/CEDVFEDERALEvidence-Based-Practices-Matrix_2011.pdf.

[65] Goodmark, L. (2008). *Reasonable efforts checklist for dependency cases involving domestic violence*. Reno, NV: National Council of Juvenile and Family Court Judges.

[66] Rennison, C. M. (2003). *Bureau of justice statistics, Crime data brief: Intimate partner violence, 1993-2001*. Washington, DC: U.S. Department of Justice.

[67] Schechter, S. & Edleson, J. (1999). *Effective intervention in domestic violence & child maltreatment cases: Guidelines for policy and practice*. Reno, NV: National Council of Juvenile and Family Court Judges.

[68] Schechter, *supra* note 67, page 20 and Goodmark, *supra* note 65, page 28.

[69] Goodmark, *supra* note 65, page 28.

[70] Schechter, *supra* note 67, page 20.

[71] Schechter, *supra* note 67.

[72] Goodmark, *supra* note 65, page 29.

[73] ACEs, *supra* note 33.

[74] Appleyard, K. & Osofsky, J. D. (2003) Parenting after trauma: Supporting parents and caregivers in the treatment of children impacted by violence. *Infant Mental Health Journal,* 24, 113-125.

[75] Osofsky, J. D. (2011). (Ed). *Clinical work with traumatized young children*. New York: Guilford Publishers.

[76] Sullivan, K. M., Murray, K. J., & Ake, G. S. (2015) Trauma-informed care for children in the child welfare system: An

initial evaluation of a trauma-informed parenting workshop. *Child Maltreatment*, 10, DOI:10.1177/1077559515615961.

77 Lewis, M. L., Norona, C. R., McConnico, N., & Thomas, K. (2013). Colorism, a legacy of historical trauma in parent-child relationships: Clinical, research, & personal perspectives. *ZERO TO THREE* Journal, 34(2), 11-23.

78 *Ibid*.

79 U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2016). Chapter 2. The neurobiology of substance use, misuse, and addiction. *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. Washington, DC: HHS, pp. 2-21 to 2-22.

80 Smiagra, M. (2007). Visitation and infants and toddlers in foster care: What judges and attorneys need to know. ABA Center on Children and the Law and ZERO TO THREE Policy Center.

81 Potter, C.C., Klein-Rothschild, S. (2002). Getting home on time: Predicting timely permanence for young children. *Child Welfare*, 81(2), 123-150.

82 Goldsmith, D., Oppenheim, D., & Wanlass, J. (2004). Separation and reunification: Using attachment theory and research to inform decisions affecting the placements of children in foster care. *Juvenile and Family Court Journal*. Reno, NV: National Council of Juvenile and Family Court Judges.

83 Copple, C., Bredekamp, S., Koralek, D., & Charner, K. (ed.s) (2013). *Developmentally appropriate practice: Focus on infants and toddlers*. Washington, D.C.: National Association for the Education of Young Children.

84 National Association for the Education of Young Children (2013). T*eacher-child ratios within group size*. Retrieved from http://www.naeyc.org/academy/files/academy/file/Teacher_Child_Ratio_Chart.pdf.

85 *Ibid*.

86 Yoshikawa, H., Weiland, C., et al (2013). Investing in our future: The evidence base on preschool education. Retrieved on June 20, 2016 from http://fcd-us.org/sites/default/files/Evidence%20Base%20on%20Preschool%20Education%20FINAL.pdf.

87 Smithgall, C., DeCoursey, J., Yang, D-H., & Haseltine, L. (2012). *Parents' pasts and families' futures: Using family assessments to inform perspectives on reasonable efforts and reunification*. Chicago, IL: Chapin Hall at the University of Chicago.

88 Widom, C. S., Maxfield, M. G. (2001). An update on the "Cycle of violence." *National Institute of Justice Research in Brief*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/184894.pdf.

89 Stronach, E. P., Toth, S.L., Rogosch, F., Oshri, A., Manly, J.T., & Cicchetti, D. (2011). Child maltreatment, attachment security, and internal representations of mother and mother-child relationships. Child Maltreatment, 16(2): 137-45. doi: 10.1177/1077559511398294.

90 Widom, C. S. (2000). Motivations and mechanisms in the "Cycle of violence." In D. Hansen (Ed.), *Motivation and child maltreatment: Nebraska Symposium on Motivation*, Vol. 46: 1-37.

91 National Foster Parent Association. *Position statement 115.03*. Retrieved from http://nfpaonline.org/positionstatements#ps115.03.

92 Carnegie Task Force on Meeting the Needs of Young Children. (1994). *Starting points: Meeting the needs of*

our youngest children. New York, NY: Carnegie Corporation.

93 Rubin, D. M., Downes, K. J., O'Reilly, A. L. R., Mekonnen, R., Luan, X., & Localio, R. (2008). The impact of kinship care on behavioral well-being for children in out-of-home care. *Archives of Pediatrics & Adolescent Medicine*, 162(6), 550–556. doi.org/10.1001/archpedi.162.6.550

94 As authorized by PL 95-452; refer to individual state's statute.

95 Stronach, *supra* note 92.

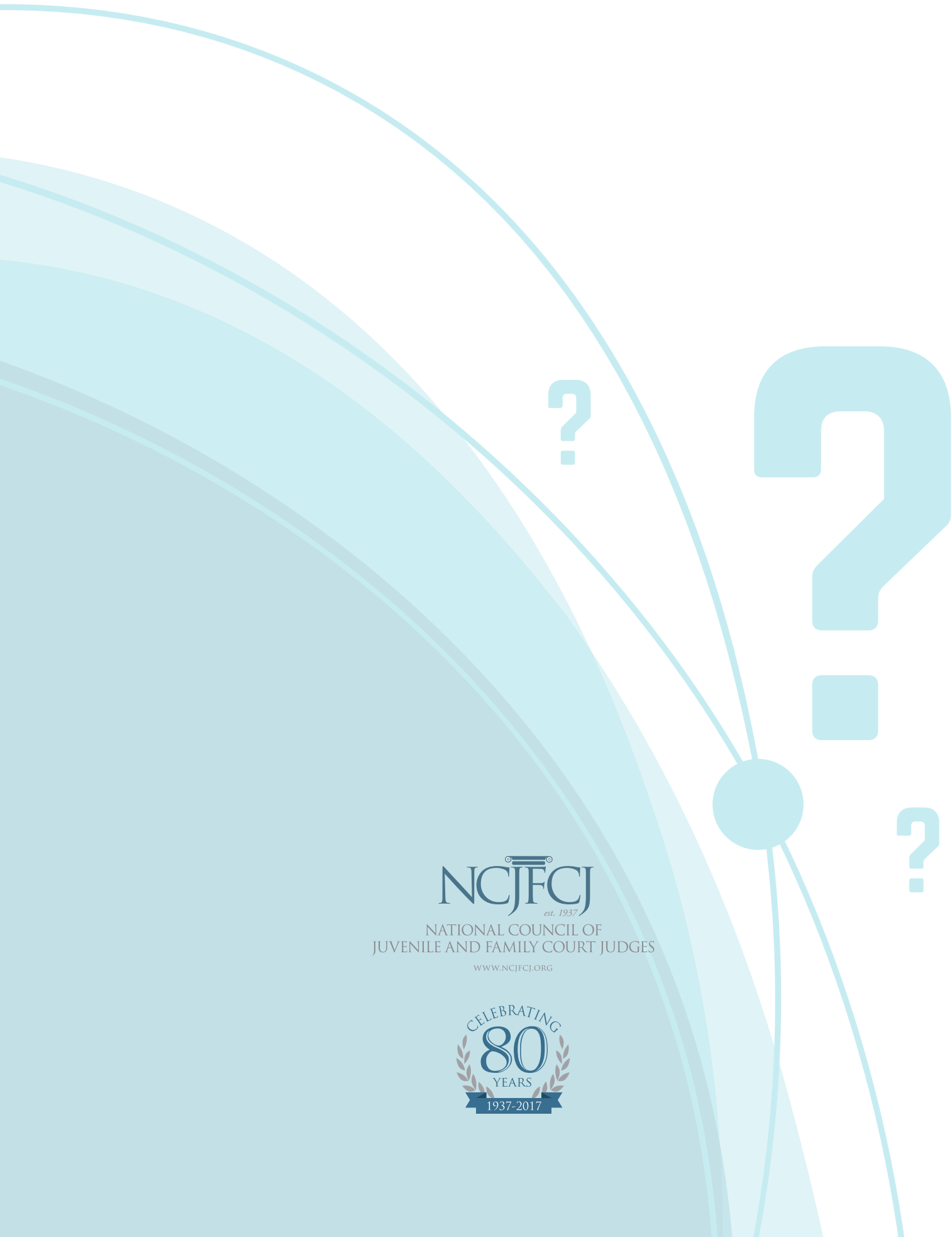
96 Child Welfare Information Gateway. (2012). *Concurrent planning: What the evidence shows*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubs/issue-briefs/concurrent-evidence/.

97 Stronach, *supra* note 92.

98 Emde, R. N. (1991). The wonder of our complex enterprise – steps enabled by attachment and the effects of relationships on relationships. *Infant Mental Health Journal*, 12(3), 163-172.

99 Shonkoff, *supra* note 31.

NOTES



NCJFCJ
est. 1937
NATIONAL COUNCIL OF
JUVENILE AND FAMILY COURT JUDGES
WWW.NCJFCJ.ORG

CELEBRATING
80
YEARS
1937-2017