ZFive Recommendations:
Addressing the social-emotional needs of children 0-5 with a substantiated finding of abuse or neglect or in need of services in Mecklenburg County

Prepared by The Lee Institute and ZFive

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Collaborating for strong communities.

ZFive is a collaborative of professionals in Mecklenburg County who are building a community of support for the social and emotional health of children 0-5.

The Lee Institute provides project management support to ZFive. The Lee Institute is a nonprofit organization that serves people, organizations, and the community through leadership development, design and management of collaborative projects, support of community collaboration, and citizen involvement.

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EXECUTIVE SUMMARY

The ZFive working group (ZFive) has developed a set of recommendations for how Mecklenburg County can best identify and address the social and emotional health needs of children 0-5 with a substantiated finding of abuse or neglect or in need of services. This charge stems from the request from Grayce Crockett, Director of Mecklenburg County Area Mental Health and Paul Risk, Director of Mecklenburg County Youth and Family Services (YFS) for a practical model for early identification and intervention for this very vulnerable group of young children.

ZFive adopted the following principles to guide this work:

- Recognize the interplay among all areas of early childhood development; consider physical, cognitive, communication, motor and self-help as well as social and emotional needs.
- Design a model that builds on what already exists within the child welfare system, rather than seeking to redesign the system.
- Focus on change during the investigation phase at YFS while children's needs are first being assessed.
- Introduce only screening tools that have been proven reliable and valid.
- Integrate a solid foundation of knowledge for caseworkers about what is outside of 'typical' development for a young child.

A review of the literature supports the urgency of attention to the social and emotional development of young children, especially maltreated children younger than age 5. Infants and toddlers constitute one of the fastest growing maltreated groups in child welfare services. (Wulczyn, Barth, Yuan, Jones-Harden, & Landsverk, 2005).

Young children can and do experience serious emotional problems that can have lasting effects. (National Scientific Council on the Developing Child, 2008) Young children are exquisitely sensitive to neglect and abuse; research tells us that trauma distorts the brain. Failure to identify and effectively respond to these needs results in costly implications for these children, their families and society at large. The emerging science of brain architecture underscores the importance of early intervention. Children who have learned to face the world expecting chaos, unpredictability, violence, and frightening experiences often act in a persistent state of alarm. They are quick to be startled, aroused, angry, defiant, and fearful or withdrawn. Findings from brain research have determined that chemical activity in their brains is often atypical and areas of their brain are often severely affected by this level of mistreatment. These young children will most likely form the long-lasting response of "freeze, flight, or fight" when they have experienced or are experiencing actions that are threatening and hurtful. As a community, we are presented with a window of opportunity for early intervention, especially when young children are referred to YFS.

In its exploration of models, ZFive interviewed eight YFS caseworkers and supervisors, and twelve bio- and foster parents; reviewed a set of randomly

pulled YFS cases (case mapping); and looked into experiences of other states that have implemented developmental screenings in child welfare settings. ZFive used this research to prepare recommendations, a summary of which is provided below.

Training: Elevate the knowledge base of all YFS caseworkers, supervisors and foster parents through ongoing training in child development – especially through actual case situations. Implement guidelines and tools, such as a risk factor checklist or decision tree to supplement the process of child and family risk assessment.

Formal Screening: At a *minimum*, implement screening in all areas of development with standardized instruments for all children birth through five that have a substantiated finding or are in need of services. Implement a triage and referral system to provide follow-up for those children who show areas of need on developmental screens.

Personnel: Imbed both a Developmental Specialist within each YFS geo-district to provide screening and referral services and an Infant Mental Health (IMH) Specialist within each YFS geo-district to provide training and case consultation. This represents a total of seven new positions in addition to the IMH specialist role that Kristin Tenney-Blackwell holds in geo-district 1. All eight positions need to be full time.

Implementation: Fund a Developmental Specialist in geo-district 1 as a first step to fully develop and model the dyad proposed for each geo-district. Phase in the remaining positions by geo-district. Build in an evaluation component to track both process and outcomes. Implement guidelines, training and tools specific to child development *in conjunction with and not in place of* the creation of new positions in geo-districts, thus avoiding the substitution of these resources for the specialists themselves. Lessons learned from other sites have found that tools and training do little to improve upon the situation in the absence of ongoing IMH experts to train, reinforce, consult, and coach.

Intervention and Treatment: Assure that caseworkers and supervisors refer children to Children's Developmental Services at the Carlton Watkins Center, Charlotte-Mecklenburg Schools, MeckLink and young children mental health providers, as appropriate, for determination of eligibility for early intervention, special education and mental health services. Consider researching service approaches such as Multidimensional Treatment Foster Care (MTFC) which has been designed to support preschool-aged children and foster parents. Explore continued linkages between YFS staff and the provider community to further the support base for workers, children and families. Continue support of ZFive's future endeavors, such as its interactive provider list, decision tree and website, its mentoring initiatives and possibly a professional endorsement process promoting and recognizing development of specialties in early childhood.

BACKGROUND AND CHARGE

In the July 2009 report completed on behalf of ZFive, Natalie Conner, Ph.D. provided her observations and recommendations regarding the social and emotional health needs of Mecklenburg County's most vulnerable young children: 0-5 year olds with substantiated findings of abuse or neglect. Among her observations, she reported that:

- "Young child victims of abuse and neglect in Mecklenburg County do not receive mental health evaluation or treatment under the auspices of the existing public service system."
- "Children have no consistent adult representing their best interests throughout the term of the state's guardianship."
- "Children's comprehensive assessments across entities lack uniformity in protocol and instrumentation, and give scant attention to mental health functioning."

Included in her report were recommendations that child-serving agencies improve their understanding of the current system and its gaps; identify the ideal service delivery system based on best practices; introduce reliable and valid instruments to assess risk, mental health needs, and to monitor progress in treatment; and identify "shovel-ready" agencies with the vision, commitment, and capacity to educate case managers to serve this population.

Over the course of the last six months, progress has been made in the following areas:

- Alexander Youth Network (AYN) applied to and has received funding from Smart Start of Mecklenburg County to continue the IMH specialist position imbedded in YFS Geo-District 1.
- Area Mental Health (AMH) and Youth and Family Services (YFS) have stated their intention to fund a second IMH position in Geo-District 1 to complement and build upon the work of the IMH specialist. Their actual ability to fund this position remains in question at this time.
- Three additional licensed professionals have completed their work with mentor Laverne Fesperman, LCSW, bringing the total number of mentee "graduates" to seven and thus expanding the supply of providers focusing on children under 5.
- AYN also received Smart Start funding starting July 1, 2010 to continue to engage Laverne in the mentoring of individuals on its staff and possibly that of Thompson Child and Family Focus (TCFF).
- AYN has become designated as a critical access behavioral health agency by the state; TCFF is in the process of becoming designated. This designation will allow them to provide enhanced mental health services in the community to children age three and above.
- ZFive is in the process of expanding its IMH provider list to include agencies and updating the listing of individual practitioners.
- ZFive has developed a decision tree for parents and other caregivers seeking direction for what might be a mental health issue for their child. The decision tree will become an interactive feature on the ZFive website, providing snapshots of certain resources, providers and links to more information.

- In partnership with AHEC, thanks to Smart Start funding to AHEC, ZFive will be organizing a young child mental health training series with the first event next fall. The CDSA has made stimulus funds available for a training this spring to launch the series. Each training will be geared to a broad audience and with no registration fee.
- AMH and YFS charged the ZFive Working Group with the task of developing a set of recommendations and a model for how Mecklenburg County can best identify and address the social and emotional health needs of children 0-5 with a substantiated finding of abuse or neglect or in need of services. This charge stems from appreciation on the part of Grayce Crockett and Paul Risk of the need for early identification and intervention for these vulnerable children and the impracticality of referring all of these children for evaluation in the absence of effective screening. Recognizing that the model is likely to require funding that may not be available at this time, they requested that ZFive not shy away from solid ideas surrounding evidence-based and best practice just because of projected costs.

This report focuses on ZFive's response to this specific charge, including guiding principles, an overview of the current situation, a brief literature review and assessment of practices elsewhere, and a description of the model with recommendations for implementation. In preparing this report, ZFive recognizes the extraordinary opportunity presented by Grayce and Paul to help shape the continuum of care for Mecklenburg County's most vulnerable young children.

GUIDING PRINCIPLES

The ZFive Working Group adopted the following principles to ground its design of a practical model for identifying and responding to the social and emotional health needs of children 0-5 with a substantiated finding of abuse or neglect.

- First, the group decided not to limit its thinking to children's social and emotional needs. In young children, there is tremendous interplay between all areas of development. In its exploration of models, the group would consider all areas of children's development: physical, cognitive, communication, motor, and self-help as well as social and emotional.
- Second, the group determined that in the interest of practicality it would design a model that builds on what already exists within the child welfare system, rather than seeking to redesign the system.
- With early intervention in mind, the group decided to focus on change during the investigation phase at YFS while children's needs are first being assessed.
- Introduction of new screening tools would include only those that have been determined to be reliable and valid.
- It is very important for YFS caseworkers and supervisors to have a solid foundation of knowledge about what's outside of 'typical' development for a young child. In the current system, it seems as though much is driven by the belief systems and personal values of the caseworkers, rather than an empirically sound body of knowledge.

LITERATURE REVIEW

The following literature review summarizes the key points guiding the work of ZFive and provides the backdrop for the recommendations contained in this report. Highlighted are some of the most common problems that maltreated young children experience as well as the literature findings for this population.

Recent publications support the urgency surrounding attention to the development of young children, especially maltreated children younger than age 5 - an especially vulnerable group. Failure to identify and effectively respond to these needs results in costly implications for these children, their families and society at large. The emerging science of brain architecture underscores the importance of early intervention.

As a community, we are presented with a window of opportunity for early intervention, especially when young children are referred to YFS. Experts have argued that very young children are particularly susceptible to the trauma of maltreatment because they rely on others for their basic survival and do not have the sophisticated capabilities to inform others, run or protect themselves from abuse and neglect (Smyke, Wajda-Johnston, & Zeanah, 2004). In 2005, approximately 3.6 million children were investigated by child welfare agencies in the United States for possible maltreatment. About 899,000 of these children were confirmed as victims, and child protective services agencies sought to put in place the appropriate services to support the child and family. Of these victims, nearly a third were age 3 or under (Health and Human Services, 2007).

Infants and young children also represent the largest proportion of children entering care and a relatively large proportion of the foster care population (24% according to the U.S. Department of Health and Human Services, 2008). Moreover, evidence suggests that approximately 21% will experience subsequent maltreatment (Palusci, Smith, & Paneth, 2005). Infants and toddlers ultimately constitute one of the fastest growing maltreated groups in Child Welfare Services (Wulczyn, Barth, Yuan, Jones-Harden, & Landsverk, 2005).

Young children can and do experience serious emotional problems that are comparable in severity to what we observe in older children and adults and can have lasting effects. (National Scientific Council on the Developing Child, 2008). Understanding of the crucial nature of the early years of life in establishing the fragile or sturdy foundations upon which later development is built has increased greatly in recent years (Shonkoff & Phillips, 2000). The quality of care received during this period strongly influences not only early development (McCain & Mustard, 2002) but extends into adulthood (Shonkoff & Phillips, 2000).

Young children are exquisitely sensitive to neglect and abuse; research tells us that trauma distorts the brain. Children who have learned to face the world expecting chaos, unpredictability, violence, and frightening experiences often act in a persistent state of alarm. They are quick to be startled, aroused, angry, defiant, and fearful or withdrawn. Findings from brain research have determined

that chemical activity in their brains is often atypical and areas of their brain are often severely affected by this level of mistreatment. These young children will most likely form the long-lasting response of "freeze, flight, or fight" when they have experienced or are experiencing actions that are threatening and hurtful. The brain develops in a "use-dependent fashion," and children who experience chaos and trauma in their early environments are more likely to experience dysfunctional activation of the brain's stress response systems (Perry, 2006). In fact, Pollak, Cicchetti, Klorman, and Brumaghim (1997) found that maltreated children demonstrated more optimal cognitive processing related to fearful or angry stimuli as opposed to happy stimuli. Other researchers (Dozier, Manni, Gordon, Peloso, Gunnar, Stovall-McClough et al., 2006) have found irregular patterns of cortisol regulation in maltreated children.

Early chronic stress caused by maltreatment and its correlates contribute to sustained changes in affective systems (Pollak, Cicchetti, Klorman, and Brumaghim, 1997). This likely occurs because the body's major biological stress systems (related to the nervous system) are needed for survival and overwhelming stress on these systems, such as that which is predicted by child maltreatment, may lead to alterations of these systems and have permanent negative impact on development (DeBellis, Keshavan, Clark, Casey, Giedd et al., 1999; Perry, 2006).

The research reinforces what we know: responsive, consistent, nurturing adults are the first line of defense in protecting young children against stress and trauma. The young traumatized child's greatest resources for healing are caregivers who will share the story of trauma with the child and offer a protective relationship. Caring adults can and must offer every young child supportive, appropriate, intentional, safe and loving experiences daily to support optimal development.

The nature of maltreatment and foster care placement interrupts the possibility of positive interactions between caregivers and very young children that are critical for the creation of the stable, consistent, and nurturing relationships that are the building blocks for a child's social, emotional and cognitive development (Herrenkohl, Herrenkohl, & Egolf, 2003). Furthermore, recent research suggests that psychosocial stress experienced in the first two years of life may have a long lasting negative impact on children's later brain development, emotion regulation and social development.

We have good reason to be concerned about infants and young children in the child welfare system; evidence suggests that these children may suffer the greatest impact. Tiffany Field in *The Amazing Infant* writes, "With the development of increasingly sophisticated methods and measures, we can now say that the field of infancy is no longer in its infancy but in its childhood" (2007, p.1). Advances in the field are hopeful and promising as we strive to better understand the complexities of early development, trauma, abuse and neglect as well as design supportive systems and evidence-based interventions grounded in the research literature that promote optimal outcomes and ultimately protect and support the most vulnerable children and their families.

SITUATION ANALYSIS

Several researchers are exploring why, given similar conditions, some children experience long-term consequences of abuse and neglect while others emerge relatively unscathed (See Werner & Smith, 1989). The ability to cope, and even thrive, following a negative experience is sometimes referred to as "resilience." Resilience is characterized by positive adaptation despite exposure to considerable challenges, traumas and threats to development. Research has found that certain protective factors serve to ameliorate the adverse impact of risk factors (combinations of factors, such as poverty and substance abuse, predictive of negative outcomes). A number of protective factors may contribute to an abused or neglected child's resilience including intelligence, creativity, humor, and independence, as well as the desire to connect with and acceptance of peers and positive individual influences such as teachers and childcare providers. Other factors can include the child's social environment and the family's access to social supports.

Protective factors have a profound impact on children's 'resilience'— their ability to rebound from adverse experiences. It is now understood that resilience plays a central role in determining psychological outcomes for maltreated children.

To better understand the process of determining risk and protective factors of young children (birth to five) and families within the child welfare system, as well as determine where possible developmental screening might best fit, cases were randomly pulled from existing YFS caseloads and reviewed (*case mapping*) regarding service area involvement, steps taken within each service area, tools used for decision making, observations and case notes, and case decisions. Further, individual interviews with YFS caseworkers and supervisors, foster parents and biological parents working with YFS were completed to reflect current views and perspectives. A summary of the interviews and questions asked is presented in Appendix 1. Quotes from the interviews are noted below in sections marked "*Response from the Field*".

This synthesis is provided below and is organized along several key dimensions that affect or are affected by abuse/neglect, the degree of each child's resilience, system issues and the presence or absence of protective factors: Academic Readiness and Progress, Communication and Collaboration, Family and Environment, Systems of Support, Early Intervention and Infant Mental Health Services, and Child Welfare System Approaches.

Academic Readiness and Progress

Response from the Field

"I usually just ask our doctor about things if I don't think my kid is talking or walking soon enough." Foster parent of 2-year old child

"Our role is to identify issues and make referrals. We have a risk assessment tool and look at strengths and needs but it's hard to always know what to look for in such young children…especially when they're not talking." YFS Caseworker

"Trauma can affect the entire life of a child and contribute to that child's emotional, academic, physical and social health for the rest of their life if the appropriate interventions are not provided." YFS Blended Unit Social Worker, 4 1/2 years

***Practice Example* (Case Mapping)**

A 9-year old child was in conversation with a School Counselor regarding an incident at school and divulged information regarding a domestic violence incident in her home. Two other children (under the age of 5) are also in the home. The biological mother of all three children is pregnant and gave birth during the investigation phase.

The *Family Risk Assessment of Abuse and Neglect* completed by the investigative caseworker indicates a total neglect score of 11 and total abuse score of 3. The family's risk level was based on the highest score on one or more of three scales (Neglect Score, Abuse Score and Risk Level) – High Risk. Scores reflect indications of: two or more prior assigned neglect reports, primary caregiver lacks parenting skills, severe financial difficulty in household, and primary caregiver's motivation to improve parenting skills as motivated but unrealistic.

The *Family Assessment of Strengths and Needs* notes family strengths as: no/some substance abuse, minor problems (child characteristics) and adequate support network. Family needs are identified as: minor or moderate diagnosed mental health problems (biological mother), limited or ineffective communication/interpersonal skills, and unemployed. An evaluation is recommended for the 9-year-old child. Item S6, Child Characteristics, of the *Family Assessment of Strengths and Needs* is reflective of the 9-year-old child. (YFS caseworkers are to consider all children within the family; however, the child (as determined by the YFS caseworker) who presents himself/herself with the most challenges or areas of need is how the question is answered)

Interview documentation is recorded in the *Structured Documentation Tool Report*. The investigative caseworker completed a comprehensive interview and notations were made in the report for the 9-year-old child. The interview documentation for the two children under the age of five notes "Child is non-verbal" and checkmarks are placed next to: clean/well groomed, clothing adequate and appears healthy.

The interview documentation for the biological mother notes family strengths as "Seem to be bonded, close family…" Mother is diagnosed with "bipolar disorder, anger management issue and a learning disability." The mother receives services at CMC Randolph.

The case was transferred to permanency planning at which time the court ordered referrals to the Children's Developmental Service Agency for the two children under the age of three.

Risk Factor:
Child abuse and neglect have been shown, in some cases, to cause important regions of the brain to fail to form properly, resulting in impaired physical, mental, and emotional development *(Perry, 2002; Shore, 1997)*. In other cases, the stress of chronic abuse causes a "hyperarousal" response by certain areas of the brain, which may result in hyperactivity, sleep disturbances, and anxiety, as well as increased vulnerability to post-traumatic stress disorder, attention deficit/hyperactivity disorder, conduct disorder, and learning and memory difficulties *(Perry, 2001).*

Negative early experiences can impair children's mental health and effect their cognitive, behavioral, social-emotional development. *(Shonkoff, J., & Phillips, 2000).*

Young children with multiple risk factors are more likely to fare poorly in achieving benchmarks for early school success. *(United States Department of Education National Center for Educational Statistics, 2001)*

Child abuse and neglect have been shown to cause important regions of the brain to fail to form or grow properly, resulting in impaired development (De Bellis & Thomas, 2003). These alterations in brain maturation have long-term consequences for cognitive, language, and academic abilities (Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006). NSCAW found more than three-quarters of foster children between 1 and 2 years of age to be at medium to high risk for problems with brain development, as opposed to less than half of children in a control sample (ACF/OPRE, 2004a).

Protective Factor:
Training programs which focus on helping teachers to promote children's positive social and emotional competence are associated with children's increased social skills and a reduction in problem behaviors. *(Bierman, K. L.; Domitrovich, C. E.; Nix, R. L.; Gest, S. G.; Welsh, J. A.; Greenberg, M. T.; Blair, C.; Nelson, K. E.; Gill, S., 2008)*

Communication and Collaboration

Response from the Field
"I don't know…there isn't always much thought on good placement for kids…we are often short on placements but have tons of kids. There needs to be more attention to this. Social workers are good at describing behaviors but not necessarily enough time to give enough information. It would be great if there was a resource out there which could help us better identify the strengths, needs, personalities (what provides for a good match) and who has the right skills to work with particular kids." YFS Permanency Planning Social Worker, 7 years

"*I wish someone called me for a period of time…like each day…to check on us, see how we're doing together. When I get a new kid, I have to learn all kinds of things and I'm wondering who's gonna help me with this.*" Foster parent, 4-year-old child

"It would be helpful to have a checklist or something to help foster parents really see a kid…take the focus off what the foster parent is thinking and feeling and focus on what the child is experiencing." YFS Permanency Planning Social Worker, 7 years

Practice Example (Case Mapping)
Contact was made by the YFS Social Worker/Caseworker to a local community service agency, Child Development-Community Policing (CD-CP), involving a 2-year-old child. Information surrounding the case and the child's history was shared between the two professionals. A collaborative decision was made to make a referral to the local Children's Developmental Service Agency. The CD-CP Clinician attended the initial Child and Family Team meeting to support the case planning as well as the initial contact with the foster parent until an Infant Mental Health Specialist was identified and connected to the case.

Protective Factor:
Effective communication and collaborative relationships are essential to the educational well-being of children who experience foster care. Examples include: Accurate information sharing and collaboration between the school and social services. (*Lehnert, 2009; Smithgall, Gladden, Howard, Goerge, & Courtney, 2004; Smithgall , Gladden, Yang, & George 2005)*

Because young children's emotional well-being is tied so closely to the emotional status of their parents and non-family caregivers, the emotional and behavioral needs of infants, toddlers and preschoolers are best met through coordinated services that focus on their full environment and relationships. (*Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life, Working Paper 6, National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University, www.developingchild.net)*

Investigations of suspected child abuse or neglect should include a sophisticated assessment of the child's developmental status, including cognitive, linguistic, emotional and social competence via closer collaboration between child welfare services and early intervention programs. *(Excessive Stress Disrupts the Architecture of the Developing Brain, Working Paper 3, National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University, www.developingchild.net)*

Family and Environment

Response from the Field
"Some of these parents have such significant mental health needs and this certainly impacts care of their children. We need parenting classes that are effective. We send everyone but what does this mean? What's the benefit? We need to effectively identify and address the mental health needs of these parents." YFS Blended Unit Supervisor, 8 years

"*The needs of the child and family are basic at this age…they need a safe environment. But yet they are the most vulnerable to get their needs met – fed, clothed, bathed, supervised."* YFS Social Worker, 3 years

> **Risk Factor:**
> Parents and caregivers play an important role in supporting children's healthy development. Research shows that family risk factors, particularly maternal risk factors such as substance use, mental health conditions and domestic violence exposure, can impact parents' ability to support children's development, and may contribute to behavioral problems among young children as early as age 3. *(Whitaker, R. C.; Orzol, S. M.; Kahn, R. S., 2006)*

Systems of Support

Response from the Field
"If the kid is under three years, I refer them to Watkins. If older than three, CMS. You know, I can interview and have initial conversations with families…it doesn't hurt to have an evaluation but it's not always practical. It would be nice to have someone around to talk with. You try to talk with the pediatrician but they don't want to get involved…probably because they don't want to worry about having to testify to something." YFS Permanency Planning Social Worker, 5 years

"Right now my resources are magazines, MAPP curriculum, past case management experience and other foster parent's testimony." YFS Investigations Social Worker, 4 ½ years

Practice Example (Case Mapping)
A child was born at the Carolina Medical Center and the current permanency planning social worker was contacted and made aware of the news. A case is already open involving the biological mother and four children who are currently in the custody of Mecklenburg County DSS. The preceding allegations surrounded the biological mother's substance abuse history and failure to address the children's medical needs.

During the current investigation phase, a history of domestic violence is identified. The case notes indicate the mother did not receive prenatal care during her most recent pregnancy and that six domestic violence reports were

made during a 3 month time frame. One of the four children currently in custody is over the age of six and enrolled in Charlotte Mecklenburg Schools.

The four children have been in custody for over a year and the biological mother completed a portion of her case plan by attending parenting classes. Her screenings have been negative for drugs and alcohol for the past 3 months. The YFS investigative caseworker indicated it is too early to make a referral to the Children's Developmental Service Agency for the newborn; however, this will be "revisited in six months." Indicated in the report is a need for a referral to the North Carolina Child Life Program depending on the outcome of the investigation. Parent education is noted as the main intervention to support this family and ensure the safety of the newborn.

The *Structured Documentation Tool Report* indicates the caseworker completed a body inventory. Other notations include: "Child is non-verbal. Child is without marks and bruises. Child was observed to be held by his mother while she fed him a bottle of formula. Mother burped child and changed child's diaper and continued to hold the child while child slept in her arms."

Risk Factor:
Nearly 55 percent of family practitioners and pediatricians report that they did not use a standardized tool to screen for developmental delays during routine well-child visits for two-year olds. *(Sices, L.; Feudtner, C.; McLaughin, J.; Drotar, D.; Williams, M., 2003).*

Only four states use the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC:0-3R), a classification of mental health and related disorders in children birth to age 3, with Medicaid support. *(Stebbins, H.; Knitzer, J., 2007)*

Protective Factor:
Communities and states that use developmentally appropriate diagnostic classification tools like the DC-03R provide appropriate fiscal supports for early childhood social-emotional development related interventions. *(Knapp, P. E.; Ammen, S.; Arstein-Kerslake, C.; Poulsen, M. K.; Mastergeorge, A., 2007)*

American Academy of Pediatrics guidelines recommend that clinicians be aware of the unique health-related needs of children entering the child welfare system (*American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. Health care of young children in foster care. Pediatrics, 2002*)

Pediatric clinicians caring for high-risk populations will need to display vigilance in tracking the developmental and mental health of these children (*American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. Health care of young children in foster care. Pediatrics, 2002*)

Early Intervention and Infant Mental Health Services

Response from the Field

"I believe the parents should take the responsibility of understanding the developmental needs of their child. That's our responsibility of being a parent. Initially when I got to meet a new family, I talk to the caregiver about milestones the child has achieved at different points in the child's life. If the child is mobile, I like to see the child do things like crawl or walk. Depending on my simple assessment and information I gather from this visit, if I feel there are any slight or strong red flags, I will usually contact Watkins if they're three or under. I usually feel comfortable getting help from the expert." YFS Senior Social Worker, 2 years

"It's my responsibility as legal guardian, the one who has authorization over the case…I need to access the services. I interview family members to get developmental history information but I don't always know the right questions to ask. We need template forms so we can ask the right questions to get us the right information regarding development." YFS Permanency Planning Social Worker, 5 years

"When I have questions, I usually ask the doctor or my kid's daycare. I've gotten onto the internet before, too." Foster Parent, 3 year-old child

"I just wish the process of obtaining services was a little more consistent and streamline for parents. I would suggest that all non-school aged children (birth-five) would receive services through the same agency, versus going to Watkins and CMS. I would also suggest more innovative practices to work with those more transient populations who may not have transportation, telephone, or permanent address." YFS Blended Unit Social Worker, 4 1/2 years

"…more resources where kids go most – at a doctor's office. Reality is we're not in most people's home. Have a social worker in a doctor's office. If the kid comes into custody, foster parent could just bring child to the doctor's office." YFS Social Worker, 5 years

Risk Factor:

Professionals who are regularly involved in the lives of infants, toddlers and preschoolers often lack the knowledge and skills that would help them identify the early signs of mental health problems as well as fully understand the consequences of family difficulties and parent and mental health problems for young children's' development. (*Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life, Working Paper 6, National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University*, www.developingchild.net*)*

One-third of children ages 2 to 5 in child welfare need mental health services and related interventions. (Burns, B.; Phillips, S.; Wagner, H.; Barth, R.; Kolko, D.; Campbell, Y.; et al., 2004)

Research finds that among children in child welfare, younger children (birth to 5) experience higher rates of developmental delays and are less likely to receive developmental interventions. *(Zimmer, M. H.; Panko, L. M., 2006).*

Over half (53 percent) of children under age 2 who are involved with child welfare systems are at risk of a developmental delay or neurological impairment.

In most communities mental health services of young children and their families are often limited, of uneven quality, and difficult to access and there are few well-trained professionals with expertise in early childhood mental health. (*Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life, Working Paper 6, National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University, www.developingchild.net)*

Protective Factor:
Young children who experience debilitation anxiety and trauma as a result of personal abuse or neglect or who witness violence in their family or neighborhood, are amenable to early treatment. *(Excessive Stress Disrupts the Architecture of the Developing Brain, Working Paper 3, National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University, www.developingchild.net)*

Child Welfare System Approaches

Response from the Field
"I believe it's most important for children birth to five to have a safe environment and appropriate supervision." YFS Blended Unit Social Worker, 4 1/2 years

"One of the most important things I can do is ensure the social workers get the training they need and make regular staffings available to them. If they see things, I can help them with the process of what they need to do. I'm very big on policy…always go back to the manual to see what we can do and what we can't do. The manual gives us an umbrella to work under not prescriptive guidelines." YFS Blended Unit Supervisor, 8 years

"It's my responsibility to know exactly what I'm looking for. Also, upper management is responsible to make sure we're trained. Training is one thing but hands on experience is important. People need to shadow people doing it – watch them." YFS Social Worker, 5 years

"The Structured Documentation Tool is helpful. There are a series of questions to ask when we first meet the child. There are even questions for children who are nonverbal – How did they appear? Were they bonded to their parents? Kids will

even show us their rooms and that way we can see how clean and safe things are. The tool is there and available to use…some social workers will draw a correlation between all responses given and how it relates to social and emotional development…some don't…they just put 'child is nonverbal.'" YFS Blended Unit Supervisor, 8 years

Risk Factor:
Simply removing a child from a dangerous environment will not by itself undo the serious consequences or reverse the negative impacts of early fear learning. Science clearly shows that reducing fear responses requires active work and evidenced-based treatment. *(Persistent Fear and Anxiety Can Affect Young Children's Learning and Development, Working Paper 9, National Scientific Council on the Developing Child, Center of the Developing Child, Harvard University, www.developingchild.net)*

One study found that nearly one third of child welfare agencies had no policies in place that pertain to mental health or developmental assessments. *(Leslie, L. K.; Hurlburt, M. S.; Sigrid, J.; Landsverk, J.; Slymen, D. J.; Zhang, J., 2005)*

"Multiple placements are thought to have a pernicious impact on the development of attachment to primary caregivers, an early developmental milestone thought to be essential for the achievement of later developmental tasks." *(Lieberman, 1987; Provence, 1989)*

Protective Factor:
Recent research studies have shown that children's risks are becoming identified more systematically at the time of entry into foster care. (Leslie, Hulburt, Landsverk, Rolls, Wood & Kelleher, 2003)

ASSESSMENT OF PRACTICES ELSEWHERE

In an effort to benchmark our recommendations against some current practices, ZFive looked into the experiences of a few other states that have implemented developmental screening in child welfare settings, including:

- Pennsylvania's implementation of developmental screening for children with birth to three with a substantiated case of abuse or neglect as proscribed by the amendment to the Child Abuse Protection and Treatment Act in 2003. (Julie McCrae, University of Pittsburgh)

- Utah's screening and referral programs for children under three with a substantiated case of maltreatment (Patti Van Waggoner, Utah Department of Human Services)

- Houston's Children's Crisis Care Center Model (Christine Dobson, Child Trauma Academy) in which supervised masters or doctoral level clinicians outside of the CPS system administer screening tools designed to provide a "snapshot" of the child in the following domains: physical, family/social,

life events, cognitive/academic, developmental, and emotional/ behavioral.

- San Diego County's Polinsky Children's Center, an emergency shelter for children of all ages coming into custody. An assessment of the children's needs is conducted within 24 hours of admission; social and emotional development screening for children under 6 are completed by specialists outside the center. In a 2005 study, 70% of those with 'suspect' scores from the screening were found to have a significant developmental delay upon evaluation and 10% were found to have a 'mental health disturbance' The study acknowledges that the methods for uncovering mental health issues were not very sensitive. The study demonstrates the need to look at developmental needs of children who come into custody. (Journal of Developmental and Behavioral Pediatrics 26:177–185, 2005).

- Services to Enhance Early Development (SEED) aimed to create and implement case plans that were driven by the unique needs of each child, and to promote early permanent placement of children. SEED's multidisciplinary team met weekly and included child welfare workers, a public health nurse, and child development and mental health specialists. Each child in SEED was given a developmental/ mental health assessment at least annually, and clinicians provided mental health and parenting services such as parenting groups, home visits, and infant/parent and child psychotherapy. (Kathryn Orfirer and Diana Kronstadt Center for the Vulnerable Child Children's Hospital and Research Center, Oakland, California, Working Toward Relationship-Based Child-Welfare Practice: The Seed Model After Five Years, Zero to Three, April/May 2002).

From a brief review of the experiences at these sites, ZFive offers the following observations:

1. When child welfare workers are responsible for administering a screening tool for social/emotional or all developmental needs, difficulties emerge with respect to implementation due to a combination of:
    - Lack of follow-up to initial training of caseworkers
    - Time required for and logistical problems with screening on part of child welfare workers
    - Costs of purchasing valid and reliable tools
2. Training of caseworkers and supervisors on child development is important to their overall preparation and must be accompanied by ongoing consultation, coaching and support as well as supplemental training in order to integrate into practice what is learned.
3. Be sure that training ties to case planning. Role plays, case studies, and other forms of active learning will most likely produce better results than lectures.
4. Early Intervention workers, young child mental health providers and child welfare workers should develop a consistent message about the roles and purposes of each. Each has a distinct role but a common purpose. Cross-training between Early Intervention and child welfare

staff would be helpful so that each understands the other's role and focus of intervention.

5. Standardized screening tools bring reliability and sensitivity to understanding children's needs, but there is an ongoing expense to use them. It's important to have a well-coordinated purchase and distribution system in place before implementation.
6. The screening process and materials should be integrated into standard forms and procedures whenever possible so that they do not take on the appearance of being "extra".
7. Even young children for whom there is not a substantiated finding are likely to show delays. There is not necessarily a difference in developmental risk or status between children in the child welfare system who are substantiated and those referred but not substantiated. Both are at risk for developmental delays. (Barth et al., 2007)

RECOMMENDATIONS

After considering experiences elsewhere, highlights from the literature, and the local context, ZFive proposes the following recommendations, highlighted in Appendix 2:

Training

- Elevate the child development knowledge base of all components of child protective services including child protective service workers, supervisors and foster parents through initial and ongoing training in child development and the effects of trauma, abuse and neglect on children birth to five so that everyone has the same level of understanding. While some of this training should be provided in didactic sessions, the majority should come from the practical application of knowledge to actual case and family situations.
- Provide ongoing support and reinforcement, including consultation, coaching, and reflective case staffing to YFS staff of the material introduced in the training so that it becomes integrated into practice. This will be accomplished best by applying the core concepts learned in training to information gathered on specific families from case consultations and screenings.
- Develop and implement a set of guidelines and tools specific to child development that will become supplements to the process of the child and family risk assessment. Examples would include risk factor checklists and decision trees.
- Establish ongoing training and support approaches for foster parents. For example, the KITS Program (Kids in Transition to School) targets three elements which have been identified in the literature as most critical for school readiness: early literacy, self-regulation and social and emotional competence. The KITS program intervention consists of child playgroups, as well as support groups for foster parents.

Formal Screening

- Implement **formal screening in all areas of development** with a standardized instrument(s) for all children birth to five who have a substantiated finding of abuse, neglect or are in need of services. Because the research indicates that children without a substantiated finding are at as great a risk as those that are substantiated, we view this as a *minimal* recommendation, eventually expanding this to include all referred children.
    - This system should be designed to fit within the existing child and family risk assessment process. While this does not mean the screening would be completed by YFS staff, it does mean that it would be **integrated into the investigation process**.
    - Screening and assessment for young children should include a system for:
        - **collecting and identifying risk and protective factors** surrounding a young child and his/her family
        - **sharing information with the primary adults** in the children's lives, including biological parents, kin, non-relative caregivers, social workers, health care professionals and intervention services.
- Implement a **triage system** to provide follow-up and referral support for those children who show areas of need on developmental screens. Refer children needing further evaluation and/or intervention to the appropriate resources and agencies, including early intervention and infant mental health services.

Personnel

- Imbed an Infant Mental Health **(IMH) Specialist** (see Appendix 3) in **each YFS geo-district**. *This involves funding 3 new positions* beyond the position currently held by Kristin Tenney-Blackwell. At the present time, Kristin's position is a contracted role for about 30 hours a week. *We recommend expansion of the IMH Specialist role to a full-time 40 hours* a week in order to meet current needs and fulfill the supervisory responsibility for the Developmental Specialist.
- Delineate a position and role for a **Developmental Specialist** (see Appendix 4) imbedded within **each YFS geo-district** to provide screening and referral services. The Developmental Specialist would report to the IMH Specialist. *Ultimately, this involves funding for four new positions*.

Implementation

- Use the first new position to fund a Developmental Specialist to pair with Kristin Tenney-Blackwell, the Infant Mental Health Specialist in geo-district 1. This will allow for modeling and development of the basic dyad proposed in each geo-district.
- Follow a phased-in approach to implementation as new funding becomes available through enhancement funding and grant opportunities.

- Fund an **evaluation** component into the implementation to study both case process and outcomes that will inform how to expand the model. The following data represent a starting point for evaluation, some of which is captured currently by the IMH Specialist.
    - # children involved with YFS who are referred for screening
    - # trainings and consultations provided to:
        - YFS on birth to 5 issues
        - foster parents
        - early childhood educators
    - # YFS records with references to:
        - Child developmental information incorporated into case plans
        - Referrals for developmental, intervention and mental health services for parents or children
- Implement guidelines, training and tools specific to child development *in conjunction with and not in place of* the creation of new positions in geo-districts thus avoiding the substitution of these resources for the additional personnel themselves. Lessons learned from other sites indicate that tools and training do little to improve the situation in the absence of ongoing IMH experts to train, reinforce, consult, and coach.

Intervention and Treatment

- Assure that caseworkers and supervisors make referrals, as appropriate, to Children's Developmental Services at the Carlton Watkins Center, Charlotte-Mecklenburg Schools, MeckLink and the young child mental health provider community for determination of eligibility for early intervention, special education and mental health services.
- Explore continued linkages between YFS staff and the provider community to further the support base for workers, children and families. Create opportunities for joint learning that reinforces the connection between the two worlds.
- Consider researching service approaches such as Multidimensional Treatment Foster Care (MTFC) which has been designed to support preschool-aged children and foster parents.
- The following recommendations reflect possible future directions beyond YFS for which ZFive seeks support:
    - Continue development and maintenance of the ZFive provider list, decision tree and website to facilitate access to resources for outpatient and home-based parent-child interventions.
    - Mentor additional in-home, family visitation and licensed staff to build on the current base of developmentally appropriate skilled providers. Establish a training curriculum which is evidence-based and can be measured for specific outcomes.
    - Establish an endorsement process to promote and recognize the professional development and work experiences of infant, early childhood, family service, health and mental health professionals focusing on culturally sensitive, relationship-based infant and early childhood mental health.

CONCLUSION

The information contained in this report is designed to expand on the admirable work already being done within Mecklenburg County Department of Social Services, Youth and Family Services by extending the definition of child safety to include the social-emotional well being of young children. Child maltreatment is a community problem; no single agency, individual, or discipline has the entire and most necessary knowledge, skills, or resources to provide all necessary assistance needed by abused and neglected children and their families. Building upon the work already started through ZFive, with the support of numerous community agencies, the model presented herein provides another bridge for identifying children at developmental risk and linking them to a growing number of community-based developmental and mental health resources. What we have presented we hope will come to be viewed as a minimal community standard for supporting the work of YFS caseworkers by identifying those children at the most risk and providing them with developmentally sound interventions.

ZFive stands ready to undertake implementation planning such as recommending specific screening tools, training curricula, risk factor checklists and other elements of the model. We also acknowledge that there are several very important sectors of any system of support for the social and emotional health of children birth through five that were not within the scope of the current charge: pediatricians, family practitioners, pediatric specialists, judges, early childhood educators, and higher education faculty. ZFive has its sights set on this list of stakeholder groups for future collaborative work.

APPENDIX 1

Summary of Interviews and Questions to Gather Responses from the Field

Interview responses identified several areas as promising practices including the engagement of clients and families through strength-based practices, the benefits of quality training opportunities, community services, such as the local Children's Developmental Services Agency, working closely with supervision and utilization of community service providers in the case plan. Several barriers and challenges were also identified by YFS Supervisors and Social Workers when considering methods to support the development of young children (birth to five): lack of a larger pool of qualified foster parents, lack of resources to help identify developmental strengths and areas of need, the need for support from and collaboration with developmental and clinical experts as well as timeframe limitations due to the age of the child and caseload size.

Several of the interview participants, including foster parents and biological parents involved in and working with YFS, recognized that training programs are as good as their implementation. Some emphasized the need for clinical expertise. Highlighted was that it is important to help foster and biological parents emphasize and understand the effects of abuse, trauma and neglect as well as issues of grief over loss and separation and the child's expressions through behavior. Parenting classes were identified as a positive resource in the community; however, it was strongly indicated that "it depends on the parent," and "…some parents just do it because it is mandatory and they want to stay out of trouble and get their kids back."

Foster parents and biological parents identified the desire and need for resources and services which would support the value of shared experiences, communication, and ongoing, consistent support. They spoke about the desire to better understand their children and identify strategies to support behaviors. Foster parents and biological parents involved with the child welfare system are at times isolated in their solitary experience. Friends and family may not be available to provide desired levels of support and they are often unaware of others who may be experiencing a similar plight. Programs that encourage and offer and opportunity to share common experiences may help facilitate a process of change.

YFS Caseworkers Interview Questions

1. Tell me a little about your role in YFS as a caseworker.
2. Which service area do you work in?
3. How long have you been doing this type of work? At YFS? In what roles?
4. What do you feel is most important for young children (birth to five) in the child welfare system?
5. According to you, who should take responsibility for understanding the developmental needs of the young child entering the child welfare system?
6. What process do you use to determine whether or not a young child (birth to five) should receive a developmental screening or assessment?

7. What do you feel your role is in the process of developmental screening or assessment for young children in the child welfare system?
8. How do you assess for a child's individual strengths and characteristics (likes and dislikes, home and school routines, mental health needs and behavioral needs) prior to a placement? – PERMANENCY PLANNING CASEWORKERS ONLY
9. If you were to design a new service or resource for caseworkers to use to help support young children's development, how would it look and what would it include?
10. Other comments on our task to gauge readiness for implementing systemic change and training, specifically regarding developmental screening services and support for children under the age of six?

Optional

11. How does the agency prepare you specifically for children birth to five? (Specialized training? Formal discussions regarding this age group?)
12. What is your understanding of the effects of trauma on young children?

YFS Supervisors Interview Questions

1. Which service area do you work in?
2. How long have you been doing this type of work? At YFS? In what roles?
3. What do you feel is most important for young children (birth to five) in the child welfare system?
4. How might practice be improved to better support young children (birth to five)? Their families? Foster parents?
5. How do you support YFS caseworkers in practicing quality support and services for young children (birth to five), their families and foster parents?
6. How is a young child's development initially assessed? How are a young child's individual strengths, characteristics (likes and dislikes, home and school routines), mental health needs and behavioral health needs assessed?
7. What do you feel the YFS caseworker's role is in the process of developmental screening or assessment for young children in the child welfare system? (Prompt: How does your staff use decision-making tools to guide their practice? How does your staff use decision making to guide their assessments, decisions and practice?)
8. If you were to design a new service or resource for YFS caseworkers to use to help support young children's development, how would it look and what would it include?
9. According to you, who should take the responsibility for understanding the developmental needs of the young child entering the child welfare system?
10. Other comments on our task to gauge readiness for implementing systemic change and training, specifically regarding developmental screening services and support for children under the age of six?

Optional

11. What changes would you like to see made in the child welfare system with regarding to young children (birth to five)?
12. What do you think are some of the causes of placement disruptions for young children in out of home care and how might they be prevented?

Foster Parent Interview Questions

1. What do you find is most helpful to you in your role as a foster parent?
2. What could help you better understand the developmental needs of the young (birth to five) child or children in your care?
3. How does the YFS caseworker currently help you in better understanding the developmental needs of the young foster child(ren) in your care?
4. Where do you currently get parenting ideas/tips?
5. Can you think of a time you were unsure how to help your young foster child(ren) – what was it about and how did you feel?
6. How are you prepared before a child is placed into your home?
7. What types of information or documentation have you received that helped you care for a young child and maintain a stable placement?
8. What information do you get ahead of time regarding a child's needs (possible prompts: strengths, likes, dislikes, routines)?
9. In your experience, what contributes to successful reunification between a young child and his/her family?
10. Any other information you would like us to know? Additional comments?

Biological Parent Interview Questions

1. Please describe your relationship with the YFS caseworker. How often did you see and communicate with him/her?
2. What is your impression of the quality of the relationship between you and your YFS caseworker? Do you feel that it was helpful in supporting your young child to make positive change?
3. Were you referred for any services?
4. Are there things have gone well for you and your young child while involved in YFS? What made it go well?
5. When you want information about young children's learning and development, where do you go or whom do you ask?
6. When you want information about parenting strategies, where do you go or whom do you ask?
7. In your opinion, what barriers do you face in obtaining services to support your young child's development? Mental health needs? Support for challenging behaviors?
8. What could a service professional do to support you in your role as a parent?
9. What services and resources are important to you as a parent to help your young child(ren) to learn and develop well? Probes:
   · Early Learning services (such as child care, preschool, story times and reading programs, recreation classes, play groups)
   · Health services (such as health insurance enrollment, immunizations, well-child care, dental services, child development screenings and services)
   · Family support services (such as parent education classes or home visits; assistance enrolling in programs that assist with food, housing, or basic needs; mental health services and counseling, adult English as a Second Language or GED classes)
   · Other community resources (such as safe and appropriate parks and playgrounds; better transportation)
10. Any other information you would like to share? Additional comments?

APPENDIX 2

Summary of Recommended Model

Screening Model	Assumptions	Tool(s)	Resources	Training & Monitoring	Interventions
Developmental screening, including S-E screening, completed by Developmental Specialist on children with substantiated abuse/neglect or in need of services	Expertise in child development is outside the realm of CPS workers Developmental and mental health expertise can be effectively imbedded within the child welfare system Caseworkers scope of responsibility is too broad to screen effectively Parents are more likely to discuss development with professionals not directly affiliated with YFS	Adoption of a standardized tool (such as the ASQ and ASQ – SE) administered by someone with developmental background	Initial and ongoing supply of screening instruments and protocols that includes a funding plan to support initial and ongoing purchase of supplies Minimum of one Developmental Specialist per geo-district to handle screening and referral responsibilities in conjunction with at least one IMH Specialist to support CPS workers and inform CPS investigation and planning Consultation/supervision for developmental specialist	Initial training on scoring and use of the instrument, referral and resource options, integrating screening results into other aspects of CPS service delivery and other core competencies required of this position Initial and ongoing training of CPS workers on making referrals	Refer to EI and CMS related to concerns about development based on screening results Development of an early childhood continuum of relationship based and trauma focused interventions, including the expansion of the current Zfive provider list

APPENDIX 3

Infant Mental Health Specialist
Role Description

The primary purpose of this position is to provide support and technical assistance to child protective service workers who are charged with conducting investigations of abuse/neglect and those workers who subsequently work with families on whom cases have been substantiated involving young children birth to age five. The focus of the work with consumers is intended to be indirect in nature in that direct contact with children and families will be limited to assisting workers in formulating and developing treatment plans and outcomes that are developmentally appropriate and address the mental health needs of the young children involved.

Job Responsibilities

- Consultation – conduct case consultation and staffings with CPS workers in order to identify and address mental health issues and needs of affected children. Workers will be asked to articulate concerns about the child's emotional state and are asked to identify and describe risk factors within four major domains: insecure attachment, ineffective parenting, child characteristics that increase vulnerability, and multiple adversities in the family.

- Case Planning and Referral - assist caseworkers in developing appropriate case plans that address children's needs for attachment, security, safety and support consistent with System of Care principles. Gather and share information as appropriate with CPS workers on the effect of established conditions on young children's development. Assist with navigating complex or multi-risk families through the mental health and health care service system

- Training and Technical Assistance – identify, develop and provide training designed to enhance the knowledge of CPS workers in relation to young child development, social-emotional adjustment and maladaptation and healthy patterns of parent-child interaction. Provide training and technical assistance in small and large group formats. Identify and develop materials for use by CPS workers that assist in the identification of child and family needs.

- Observation and Screening – collaborate with CPS workers to complete child and caregiver-child focused observations and interviews as appropriate on cases prioritized as needing an additional level of evaluation. Assist in utilizing this information to plan additional evaluations, interventions or referrals to community agencies.

- Advocacy and Support – identify gaps and needs and advocate for resources and services related to mental health services that are not

available to children and families in the community. Conduct case specific advocacy as needed to bring attention and support to the needs of individual children and families. Provide testimony as appropriate to help the courts understand and resolve issues related to placement and treatment of young children and families.

Job Outcomes

- CPS staff will demonstrate an increased knowledge of early childhood development and the social-emotional needs of young children.
- CPS staff will report more confidence and competence in designing and implementing case plans with social-emotional goals.
- Families will be able to identify natural and informal supports and report improvement in their ability to support the development of their children.
- Case plans for children and families will show an increased incidence and attainment of social-emotional goals.

APPENDIX 4

Developmental Specialist
Recommended Role Description

The primary purpose of this position is to provide screening and referral services to children birth to age five and their families involved with Youth and Family Services on whom cases have been substantiated as abused/neglected or in need of services. The focus of the work with consumers is intended to identify those children most at risk for developmental delay and social-emotional mal-adaptation.

Job Responsibilities

- Screening – conduct screening with children and their families and staffings with CPS workers in order to identify and address developmental and mental health issues and needs of affected children. The screening specialist will identify concerns about the child's development in five domains: Cognitive, Communication, Motor, Self-Help and Social-Emotional development with particular regard to emotional state as affected by insecure attachment, ineffective parenting, child characteristics that increase vulnerability, and multiple adversities in the family.

- Case Planning and Referral - assist caseworkers and the IMH Specialist in developing appropriate case plans that address children's needs for attachment, security, safety and developmental support consistent with System of Care principles. Gather and share information as appropriate with CPS workers on the effect of environment, developmental delay and established conditions on young children's development. Make referrals to local early intervention agencies and assist with navigating complex or multi-risk families through the early intervention and health care service system. Provide follow-up as needed to link families to early intervention services.

- Training and Technical Assistance – identify, develop and provide training designed to enhance the knowledge of CPS workers in relation to young children's development. Provide training and technical assistance in individual case situations as well as in small and large group formats. Identify and develop materials for use by CPS workers that assist in the identification of child and family needs.

- Advocacy and Support – identify gaps and needs and advocate for resources and services related to mental health services that are not available to children and families in the community. Conduct case specific advocacy as needed to bring attention and support to the needs of individual children and families.

Job Outcomes

- Children birth to age five will receive developmental screenings with children and families linked to early intervention services as appropriate.
- CPS staff will demonstrate an increased knowledge of early childhood development.
- CPS staff will report more confidence and competence in designing and implementing case plans with developmental goals.
- Families will be able to identify natural and informal supports and report improvement in their ability to support the development of their children.
- Case plans for children and families will show an increased incidence and attainment of developmental goals.

SUGGESTED READING

Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life, Working Paper 6, National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University.

Excessive Stress Disrupts the Architecture of the Developing Brain, Working Paper 3, National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University.

Persistent Fear and Anxiety Can Affect Young Children's Learning and Development, Working Paper 9, National Scientific Council on the Developing Child, Center of the Developing Child, Harvard University.

The Science of Early Childhood Development, Closing the Gap Between What We Know and What We Do, National Scientific Council on the Developing Child, Center on the Developing Child, Harvard University.

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