

Practice Guide for Connecticut DCF Caseworkers serving Infants, Toddlers and Young Children and their Families

CENTER FOR THE STUDY
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A PROTECTIVE FACTORS FRAMEWORK

This practice guide was developed by the Center for the Study of Social Policy for the Connecticut Department of Children and Families. It was authored by Nilofer Ahsan and Sarah Morrison. Additional editing support was provided by Beth Maschinot and Kelsey Johnson.

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Introduction: Setting the Context

In October of 2011, the Department of Children and Families (DCF) was awarded the Early Childhood/Child Welfare grant from the Children's Bureau/Administration for Children and Families. As a result of this grant, DCF and our Early Childhood Partners have succeeded in:

- Expanding the existing DCF-Head Start Partnership
- Providing a shared Protective Factors/Strengthening Families cross training for over 300 DCF staff, early childhood educators and providers
- Developing the capacity of a cross-disciplinary group of 25 trainers in the state to train using the Strengthening Families protective factors framework
- Developing cross sector/interagency knowledge and capacity regarding infant mental health and the unique needs of infants/toddlers
- Creating opportunities for reflective supervision
- Increasing enrollment in quality Early Childhood Education Programs in Region 4

These efforts have significantly benefited DCF staff, Head Start and Early Head Start staff and providers, all of whom touch the lives of very young children and their families. Positive changes in practice methods, decision making strategies and overall approaches are reflected in the work of a wide array of childhood professionals, from DCF social workers, supervisors and managers to Head Start/Early Head Start providers, teachers and trainers. Our DCF-Head Start Partnership has grown significantly deeper and stronger as a result of this collaboration. We have improved our ability to work together to improve outcomes for children and families.

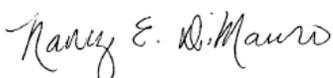
DCF is committed to continuing efforts to improve our work with very young children and their families and to expand training opportunities across the state.

We wish to thank our partners:

- CT Head Start State Collaboration Office, Grace Whitney
- CT Association of Infant Mental Health, Margaret Holmberg
- Ziegler Center/Yale University, Walter Gilliam
- Center for the Study of Social Policy, Nilofer Ahsan

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This practice guide could not have been possible without everyone's collaboration and input.



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Very Young Children in Child Welfare: The Need to Pay Close Attention

If you work with families with very young children, you probably already know that what happens to children at an early age can have a profound impact on their well-being later in life. Research on the developing brain clearly demonstrates that these early experiences are incredibly powerful. During the earliest years of life—from birth to age five or so—the brain is more easily impacted by outside experiences than at any other stage of life. The brain of a young child is shaped in incredibly important ways by these experiences. Positive experiences, such as loving attention, calm routines and sights, sounds and other sensory experiences that are varied but not over-stimulating, can directly impact the brain’s architecture.

However, because the brain is so sensitive during this early stage, extremely stressful or traumatic experiences can also have powerful repercussions. The traumatic experiences that bring children into our care (e.g., physical and sexual abuse or severe neglect) affect the basic foundation of the developing brain. Such experiences make it more difficult for a child to develop the cognitive, emotional and sensorimotor skills they will need to meet life’s challenges. Research suggests that the more harmful experiences a child is exposed to, the more likely the child is to have difficulty with social and emotional functioning, exhibit cognitive problems and fall behind in school.¹

This early stage in life is also unique because the well-being of a young child is particularly shaped by the relationship the child has with his or her primary caregiver. The quality of interactions between the caregiver and child shapes the child’s developing brain and creates the context through which learning occurs. Trauma in early childhood—particularly trauma that impacts the relationship between caregiver and child—can have a cascading effect on a child’s well-being. Not only can the brain be shaped by experiences of neglect and/or abuse at the hands of the caregiver, but these experiences also leave the child with the message that adults cannot be trusted. Research has found that children who have insecure relationships with their primary caregiver are more likely to struggle both academically and in developing healthy relationships with others. Children who develop insecure attachments to their caregiver are also at increased risk for mental health problems like depression and anxiety.²

The impact of these adverse experiences doesn’t end in childhood. The landmark “Adverse Childhood Experiences (ACE) Study” found that as the number of traumatic experiences in childhood increase, the risk for 17 serious problems later in life increases as well. These problems include alcohol and drug abuse, depression and STDs. Even chronic health conditions in adulthood (including heart disease, diabetes, cancer and lung disease) have been linked to the types of trauma experienced in families that protective services workers come into contact with on a daily basis.³

¹ Center on the Developing Child, Harvard University. In Brief- The Impact Of Early Adversity On Children’s Development.

² Jakobsen, I.S., Horwood, L.J., & Fergusson, D.M. (2012). *Childhood Anxiety/Withdrawal, Adolescent Parent-Child Attachment and Later Risk of Depression and Anxiety Disorder*. *Journal of Child and Family Studies*, 21(2).

³ Adverse Childhood Experiences (ACE) Study: Major Findings. (2013). *Centers for Disease Control and Prevention*.

Working with very young children can be especially challenging since they often have not yet developed the skills to tell you what has happened to them, what they are feeling or what they need. An important part of your role as a protective services worker is to learn to interpret children's expressions, body language, behavior and emotions so that you can make sure they get the help and support they need to thrive.

For all of these reasons, your engagement with families of very young children is crucial to children's well-being. This guide is intended to support you in this challenging work. The main message of this guide is that if you pay close attention to your work with very young children, you can make a lasting, positive impact on the families you serve.

This guide will focus on three specific aspects of child welfare practice in relation to families with infants, toddlers and preschoolers.

- Recognizing and responding to signs of trauma
- Assessing developmental progress and connecting families to developmental supports
- Building protective factors in families

The final section of the guide, *Windows of Opportunity*, looks at the components of existing child welfare practice to identify specific opportunities for incorporating these ideas into daily practice routines.

PART I: Recognizing and Responding to Signs of Trauma

This section of the guide gives a brief overview of how violent, threatening or neglectful situations can create toxic stress, and what you, as a protective service worker, can do to help lessen the damaging impact of trauma on both the child and the family.

Becoming Trauma-Informed

Throughout this guide, we will encourage you to employ a trauma-informed lens when engaging with the children and families in your care. A trauma-informed lens will help you to:

- Understand how traumatic experiences impact the child’s brain, behavior and development
- Be aware of signs of trauma, both in the children in your care and in their parents and caregivers
- Ensure that children and their caregivers are connected to resources and supports that can help them to address trauma
- Help caregivers and other adults in a child’s life understand how trauma may be impacting the child’s behavior and respond to the child’s behavior accordingly

Learn More: Visit the link below to view a video resource with more information on the effects of trauma on young children:

http://developingchild.harvard.edu/resources/multimedia/videos/theory_of_change/

How Trauma Impacts the Child

The brain of a young child grows and changes more rapidly than at any other time of life. While a newborn’s brain is only one-quarter the size of an adult’s, by age three the brain has more than tripled in size, and by age five it is 90 percent as large as a fully-developed, adult brain. This rapid development is greatly impacted by sensory stimulation from the child’s surrounding environment, as well as the child’s relationships within the environment. Healthy brain stimulation builds connections between neurons, while extreme stress can disrupt neuron development.

A newborn comes into the world with only one part of the brain well-developed. This area controls the physical processes we need to survive—respiration, circulation, sleep regulation, digestion, etc. The other two major parts of the brain, the cerebral cortex and the limbic system, are still very much “under construction” at the time of birth.

As the child grows, however, the cerebral cortex begins to develop, supporting the child’s increasing ability to think and process information. At this young age, normal development of this “thinking brain” allows the child to begin to

remember places, objects and people, and to begin to perceive similarities and differences. These skills set the stage for the later development of language and problem solving abilities. These thinking abilities constitute the functions that most people associate with general brain activity.

However, thinking abilities are not the brain's only role. Just as important to the healthy development of the child is the limbic system, or the "emotional brain." The "emotional brain" registers when we are happy, sad, frustrated or angry. Healthy development of the emotional brain allows us to gradually gain control over our emotional responses. This area of the brain is responsible for infants' growing ability to soothe themselves when they are upset, and, with the onset of toddlerhood, a child's beginning ability to delay gratification.

What do young children need to strengthen both the cognitive and emotional areas of the brain? Research has found three major sources of inputs necessary for healthy brain development. The first is adequate nutrition. The second is sensory stimulation—sights, sounds, tastes, smells and touch—that a child experiences when allowed to safely explore the world around them. The third, and perhaps the most important, is a consistent relationship with at least one caregiver who regularly responds to the child's needs and feelings. Over the course of a single day, a respectful, responsive caregiver will take hundreds of actions to encourage and soothe a child—even simple actions, like the back-and-forth of cooing and smiling with an infant, or holding the hand of the toddler who is taking his first steps, are incredibly important. A responsive caregiver also tries to protect the child from challenges and situations that may be overwhelming. And when the child faces a challenge that is too much for him or her to handle—for example, walking on rough pavement and falling—the caregiver will comfort the child and help him or her regain a feeling of security. All of these tiny exchanges contribute to the construction of stronger neural pathways in the child's brain, thereby helping the child develop resiliency.

But what if these positive experiences do not occur consistently? Or what if the child is subject to abuse? Neglectful or physically abusive experiences also have a negative effect on the development of neural pathways in the brain. When a child is physically or sexually abused or witnesses domestic violence, the child's brain goes on high alert. Stress hormones—cortisol and adrenaline—begin flooding the brain and body. If there is no one to comfort or soothe the child in these situations the stress hormones will continue to circulate through the brain, and can damage neural circuits. When these experiences happen multiple times, the actual structure of the child's brain may be permanently altered.⁴

Scientists call this sustained, overwhelming stress "toxic stress," because of the harm it does to the developing brain. Toxic stress results in strong, frequent and/or prolonged activation of the body's stress response system. Stressful events that are severe and uncontrollable, especially those that occur when a child lacks access to responsive adults, tend to provoke a toxic stress response.⁵ This toxic stress response harms both the cognitive and emotional centers of the brain. When this happens, the child's affect and behaviors become unbalanced.

In addition to direct effects on the brain and the nervous system, abuse and neglect can have a destructive impact on the child's sense of self-worth. If children don't get the responses they need from caregivers, they may begin to believe that they are incapable of eliciting care. And because all young children are egocentric—or unable to see the world from any perspective besides their own—they may be left with no understanding that the lack of care is not their fault. Instead, children in these situations may learn to view themselves as unworthy of being comforted and nurtured—or even of being kept safe. These feelings can lead to depression and anxiety in childhood, as well as later substance abuse and risky behaviors.⁶

⁴ Shonkoff, J.P., Boyce, W.T., & McEwen, B.S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. *Journal of the American Medical Association*, 301(21).

⁵ Life Course: Nurturing Early Growth and Development. (2013). *The Center for Leadership Education in Maternal and Child Public Health*.

⁶ Siegel, B.S., Dobbins, M.I., Earls, M.F., Garner, A.S., McGuinn, L., Pascoe, J., & Wood, D.L. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *The Journal of the American Academy of Pediatrics*, 129(1).

Your Role as a Caseworker

In your role as a protective services worker, one of the most important tasks you will have is *to assess whether or not a child is showing signs of trauma*, and if you observe these signs, *to access specialized help to address the child's trauma*. Appendices A1 and A2 provide lists of common signs of trauma in young children. These lists can be a useful tool for organizing your observations of the child, both as part of your initial assessment and throughout the life of the case.

Resources you can use: The Early Childhood Consultation Partnership© (ECCP) has developed a series of one page flyers called “Tips for Tots.” The Young Children in foster care series focuses on the child who is in foster care and addresses common issues that a young child between the ages of birth through five may experience while in their Foster Care setting. Each tip sheet provides education around developmental norms and recommended techniques to support the specialized social and emotional needs of these young children. A variety of practical strategies and additional resources for working with infants, toddlers and preschoolers in Foster Care is also provided. The strategies provided can be utilized by any DCF Social Worker or foster parent that is working with a child involved with the foster care system or who is at risk of being in Foster Care. Topics include: “Supporting Children with Incarcerated Parents,” “Building Attachment in Young Children,” “Welcoming a Foster Child into your Home,” “Trauma and Resiliency in Young Children,” “Supporting Young Children who Witness Domestic Violence,” “Supporting Young Children with Transitions,” and “Supporting Development in Young Children.” For more information about the Tips for Tots series or the Early Childhood Consultation Partnership© (ECCP) services please contact ECCP at (860) 704-6378 or visit ECCP’s website at: www.eccpct.com. ECCP is funded by the Department of Children and Families and is managed by Advanced Behavioral Health Inc.

In addition, the following links might be useful resources to help caregivers deepen their understanding of how to support a child that has experienced trauma:

- General guide for all parents on trauma:
<http://actagainstviolence.apa.org/materials/publications/act/trauma.pdf>
- Guide written for adoptive parents on providing care to a child that has experienced trauma:
http://www.fosteringperspectives.org/fp_v10n1/Kennedy&Bennett.pdf

Recently, there has been a surge in the development of new and promising treatments for combatting the harmful effects of trauma on very young children. Research shows that the sooner the child receives treatment after exposure to traumatic experiences, the less likely the trauma is to cause problems in development.⁷ In Connecticut, the Early Childhood Consultation Partnership or ECCP, is one resource that is available to provide immediate early childhood mental health consultation support. ECCP, an evidenced-based best practice early childhood mental health program, is offered statewide at no cost to families or early care and education providers. As a caseworker, you can make referrals to ECCP and/or use the ECCP’s published informational resources to inform parents, foster parents and other caregivers about how to support a child who is dealing with trauma.

Another resource for trauma-informed care is the CT Association for Infant Mental Health, an affiliate of the World Association for Infant Mental Health which sponsors a variety of training opportunities for staff specifically focused on the development of infants and toddlers in the context of their caregiving relationship. The *CT-AIMH offers the CT-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health*[®]

⁷ Terr, L.C. (2013). Treating Childhood Trauma. *Child and Adolescent Psychiatric Clinics of North America*, 22(1).

for those working in this field. Currently, CT-AIMH is partnering with DCF and its early childhood community partners, including Early Head Start, to provide cross-sector training and reflective supervision in each of the DCF regions. These programs help to increase staff knowledge and skills related to working with infants and families who have experienced trauma and loss. The multi-sector nature of these activities also results in closer working relationships, better aligned practices and a more trauma sensitive service system for families. Additional information on CT-AIMH training can be found at: <http://www.ct-aimh.org>.

A more extensive list of trauma resources is provided in [Appendix A3](#). As a caseworker, you can use these resources to inform caregivers about the effects of trauma. When caregivers understand how trauma impacts their children, they become more likely to positively engage in the child's healing process.

In addition to assessing signs of trauma and accessing further professional support for the child, protective service workers are also in a position to *help reduce the risk of future trauma for the child*. For children who remain in the care of their family, workers can help the family become more resilient in the face of stressful situations, including the stress of interacting with the child welfare system. We will address this aspect of your role in Part III of this Guide.

What to Look For

Recognizing trauma in very young children can often be challenging. Young babies obviously lack the language skills to tell you what they are feeling. Even older infants and toddlers are just beginning to recognize and talk about their own emotions. With very young children, it is sometimes only possible to recognize trauma through analyzing behavioral clues. However, even this can be extremely difficult as different children can express trauma in very different ways. Some may express trauma through externalization—crying and throwing visible tantrums. Others may show signs of internalizing—becoming withdrawn or less responsive. However, as mentioned previously, some common signs of childhood trauma have been identified and are listed in Appendices A1 and A2.

Questions to Ask

Because young children often do not have the verbal skills to express themselves, it is important to engage caregivers in helping to understand whether trauma has occurred and, if it has, what methods to use to best minimize the impact of trauma. Case workers and caregivers should ask themselves the following questions if they suspect trauma has occurred:

- Has the child's behavior changed in noticeable ways? What do these changes look like?
- Are there particular times of day or types of interaction which seem to be more challenging for the child?
- When the child is upset are there objects or actions that help to soothe them?
- Who does the child turn to for comfort?

PART II: Assessing Developmental Progress and Connecting Young Children to Developmental Supports

As we have seen, the period of early childhood—from birth to age 5 or so—is the most intense period of brain development in a person’s life. This growth and maturation of the brain facilitates children’s development of physical, cognitive and emotional skills. These skills, in turn, contribute to the brain’s unique architecture by further strengthening neural connections in the child’s brain. Children who have been traumatized or require DCF involvement often lag behind other children in meeting age-appropriate developmental standards.

Trauma often affects the developmental task that is the foundation of all other skill development: the ability to connect with at least one caregiver. From an extremely early age, babies are constantly learning to interact with the people around them, first cooing in response to a caregiver, and, a bit later, smiling. The coos and smiles that an infant relies on to connect with caregivers are later followed by a toddler’s hugs and need for reassurance. Though a child’s behavior changes with age, the need to have at least one adult the child can rely on for safety and security remains constant throughout childhood.

These early attachment relationships can have a major influence on how a person relates to others across his or her lifespan. Early attachment also sets the stage for other physical, cognitive and emotional skills. Young child often needs at least one dependable person in order to practice a variety of tasks (walking, talking, eating, hopping, climbing, learning about feelings, etc.). Moreover, secure early attachments impact many other areas of children’s development, such as comfort with exploring their environment or forming relationships with other children and adults, both of which are important building blocks for more advanced developmental tasks. For all of these reasons, trauma that disrupts a child’s ability to form early nurturing relationships can have a major impact throughout his or her life.

Learning More About the Child’s Developmental Progress

Every encounter with a young child and his or her caregivers is an opportunity to observe the child’s development and to engage parents or other caregivers in conversations that can inform your assessment. In your role as a protective services worker, you are asked *to monitor the developmental progress of the child*, using information from your own observations, as well as information you collect from parents, early childhood teachers and other involved adults. You are also in the position to *access the resources that will help the child reach developmental goals*. Over the course of the case, you should carefully monitor the child’s developmental progress, making referrals or case plan adjustments as necessary.

While your primary goal throughout this process is to identify developmental problems that need to be addressed, casework meetings also provide an important opportunity to share developmental information with caregivers and to

give them the support they need to help their child take the next steps in development. There are two main questions to address with the information you are collecting:

- Are the child’s physical, cognitive and emotional skills age-appropriate?
- Does the child show any indications of developmental delays?

In order to help you answer these questions, we have outlined many resources and strategies in the next section. These include: guidance for caregivers, ways to connect parents to developmental supports and tips for communicating with early childhood partners. Additional resources have been provided in the Appendices, including:

- Developmental checklists, which can be used either by the casework or in conjunction with the caregiver to identify possible signs that a child needs additional developmental support ([Appendices B1, B2 and B3](#))
- Questions to explore with caregivers and other key informants to better understand the child’s developmental needs ([Appendices C1 and C2](#))
- A glossary of developmental screens currently used in Connecticut ([Appendix D1](#))

Learning from Caregivers and Other Key Informants about the Child’s Developmental Status

In order to create a complete picture of a child’s development (and to plan support and services accordingly), it is important to collect as much background information as possible. Ideally, information should be collected from parents, legal guardians and/or informal primary caregivers, as well as from teachers, child care providers, doctors and other agency service providers. [Appendix C](#) includes a set of simple questions that build off those already in the Purposeful Visitation Practice Guide to help you learn more about the child’s development. In addition to collecting information about the child, creating a conversation around these questions can also serve as a useful way to engage caregivers as partners in encouraging the child’s development.

Reviewing Information from Existing Assessment Tools

It is helpful to read and review copies of any existing developmental assessments of the child that might have been completed. [Appendix D1](#) provides a brief description of some of the commonly used assessment tools in the State of Connecticut. Additionally, [Appendix G](#) provides an overview of the *Bright Futures* guidelines for regular pediatric preventative care screenings and visits. This useful resource can help you to determine what pediatric assessments might have been completed recently.

Using Developmental Checklists

Although every child develops at a different pace, developmental checklists can be a helpful aid in determining if the child’s development falls within the average range expected for his or her age. These checklists direct attention to physical activity, social-emotional interactions and verbal and non-verbal indications of intellectual development. It is important to remember that there are no absolute “deadlines” for children to meet in achieving these skills as every child’s developmental trajectory is unique. Similarly, short observatory periods may not always reflect a child’s typical behavior—especially if the observations take place shortly after a traumatic event. As such, it is useful to compare your observations with others who have more regular opportunities to observe the child. This might include the parent(s), other caregivers, the family’s pediatrician or even close family friends. You can be more thorough in your assessment by collecting information from a variety of sources and by utilizing multiple assessment tools.

Keeping all of these considerations in mind, however, checklists can be helpful in providing general guidelines when assessing whether a child could benefit from additional supports. The following developmental checklists have been provided in [Appendix B](#):

- [Appendix B1](#): Developmental Milestones for Infants(0-18 months)
- [Appendix B2](#): Developmental Milestones for Toddlers (18-36 months)[Appendix B3](#): Developmental Milestones for Pre-Schoolers (3-6 years)
- [Appendix B3](#): Developmental Milestones for Pre-Schoolers (3-6 years)

Are you prepared?

Actions you can take to build your capacity to serve.

- I have completed training in the use of developmental and behavioral screening and assessment tools for infants, toddlers, and preschoolers.
- I collaborate with community healthcare providers to ensure that developmental and behavioral screening and assessment tools for infants, toddlers and preschoolers are trauma-informed.
- I am knowledgeable regarding the developmental and behavioral screening and assessment tools for infants, toddlers and preschoolers being used by partnering agencies, and I coordinate with those agencies to address identified needs.
- I know where to find information and further training on developmental and behavioral screening and assessment tools for infants, toddlers and preschoolers.
- I use an Agency Agreement and Release of Information to obtain health, developmental, and behavioral screening and assessment information regarding infants, toddlers and preschoolers.

Ensuring That an Ages and Stages Questionnaire (ASQ) is Administered

The Ages and Stages Questionnaire (ASQ) is a screening tool for young children under the age of five and a half. It is the goal of the DCF to ensure that every young child (ages 0-3) with a substantiated case of child abuse and/or neglect receives an ASQ. DCF is partnering with the 211 info line in Connecticut to make sure this happens. As the case worker, you may have a role to play in this process. Here are the protocols:

- If the child is in out-of-home care the ASQ will be administered at the Multidisciplinary Evaluation and submitted to the 211 Child Development Infoline
- If the child is accepted for in-home services it is the role of the DCF Ongoing Social Worker to help the caregiver connect to 211 for filling out the ASQ
- For all substantiated cases that are not accepted for in-home services the intake worker is responsible for helping the caregiver connect to 211 in order to fill out the ASQ

Once the connection to 211 has been made and the ASQ has been completed, the Child Development Infoline will take responsibility for scoring the results, sharing the information with parents and connecting families to developmental resources as needed. If developmental concerns are identified, the family will be referred directly to Birth to Three services by their Child Development Infoline case manager.

Your Role as a Caseworker

As a caseworker you may need to help parents understand the importance and value of the ASQ and/or help them connect with 211 to complete the ASQ. Doing so may entail sitting with the caregiver to help make the 211 call or assisting the caregiver in locating an online version of ASQ. For more information on the ASQ, refer to [Appendix D2](#). Once the ASQ is completed, you should make sure to follow-up with the parents to:

- Learn more about the results
- Address any questions or concerns they might have
- Talk about how the child’s developmental needs can be incorporated into the case plan
- Discuss how to engage early childhood partners in supporting the child’s needs

Connect the Family to Services to Support the Child’s Development

After assessing a child’s developmental progress, you may need to help the family access developmental supports for the child. Services to support the child’s development are defined in this guide as all services that can help support the child and caregivers in successfully navigating through childhood. These services include early learning opportunities like quality child care, Head Start and pre-school. They also include family support services, such as home visiting programs (including *ChildFirst*), family resource centers, parenting education classes and programs for fathers. Finally, these support services include early development programs, such as parent-child programs, playgroups or early childhood mental health services, as well as services and supports that are specifically designed for families with young children—for example homeless shelters serving families.

Research tells us that children who are involved in child welfare systems tend to do less well than their peers on early developmental indicators and on school readiness measurements. Consequently, even if no immediate developmental issues are apparent, it may still be important to connect the family with developmental supports like high quality child care, early learning or family support services. In addition to the direct impact on the child’s development, such resources can help families to meet other important goals by:

- Alleviating pressure during a time of stress
- Addressing family isolation by connecting the family to social networks (for example, social networks that often form between parents in early childhood programs)
- Increasing the number of caring adults who can help with monitoring the child’s wellbeing

[Appendix E](#) includes a Community Landscape Worksheet designed to keep track of early childhood resources available in your area. By filling in the worksheet with contact information for providers in your community, you can make sure that you are prepared to connect families with support services. You can also dial 1-800-505-7000 to access the Child Development Info Line and find out the current contacts for your region.

When making referrals to developmental supports, you should always adhere to the following standards of care:

- **Timeliness:** When children are young, developmental changes happen rapidly. Because development is sequential—one step builds on the next—it’s important to address developmental issues as quickly as possible. Not doing so may mean that other aspects of the child’s development will be compromised.
- **Quality:** Child welfare involvement creates a unique opportunity to connect families to quality developmental

supports. The quality of a child's early childhood setting can have a tremendous impact on his or her development. Unfortunately, many children are in less than ideal settings and may lack regular access to developmentally appropriate stimulation, enrichment activities, healthy foods or connections with community supports. Child welfare engagement provides an opportunity to review and enhance the quality of the child's care with an eye toward their long-term well-being.

- ▶ **Continuity:** While it is important to connect children to quality care, it is also important to understand that the continuity of the child's emotional attachment is a very important part of their developmental well-being. During child welfare engagement, many children will experience separation from key caregivers. Even if the child does remain in the home, the stress of child welfare engagement may disrupt existing attachment relationships with the primary caregiver and important others. Consequently, it is important to review existing child care arrangements in order to decide:
 - ▶ When the child is significantly attached to the caregiver and siblings or other children in the home, will the value of placing them in a higher quality setting outweigh the potential damage the new placement could have on the child's sense of well-being?
 - ▶ Is there an optimal timing for any change in placement?
 - ▶ If a change in child care placement is deemed advisable, how will you structure the child's opportunity to say good bye to their existing caregiver, sibling(s), family and friends?
- ▶ **Parent Engagement:** Parents and caregivers need to be involved in all decisions about creating a service plan to support their child's development. Engaging them in this way provides a unique opportunity to educate them about what their child needs developmentally. It also encourages them to be partners in ensuring that their children get what they need and in creating a home environment that better supports the child's developmental trajectory. This is also an opportunity to engage the parent in a dialogue about the supports they need for their parenting, and how developmental supports for their child can simultaneously serve as resources for parents as well.

ACYF Information Memorandum

In 2011, a Joint memorandum from ACYF, the Children's Bureau and the Office of Head Start was released titled "**Child Welfare and Head Start Partnerships: Partnering with Families Involved in Head Start and Early Head Start Programs.**"

This memorandum was written to reinforce the commitment to supporting child welfare partnerships with Head Start and Early Head Start agencies. These partnerships are key in the effort to improve young children's access to and continuity of high quality, comprehensive early care and education services.

An emphasis on continuous quality care experiences is especially important for infants and young children who are at greatest risk for abuse and neglect as they make up a vulnerable population that need special attention.

The memorandum contains a list of examples of specific actions that may be incorporated into a formal agreement between Child Welfare agencies and Head Start/Early Head Start agencies.

For more information please visit: http://archive.acf.hhs.gov/programs/cb/laws_policies/policy/im/2011/im1101.htm

The Special Relationship with Head Start

In 1999, representatives of DCF and Head Start at the federal, state and local levels began a pilot effort to create better working relationships between Connecticut's DCF and Head Start. Out of this early partnership a protocol for DCF-Head Start partnerships was established, and is still in use across the state. This partnership with Head Start is crucial, as the program provides comprehensive education, health care and social services to low-income children birth to five and their families. Early Head Start serves approximately 1,000 infants, toddlers and pregnant women in Connecticut through center-based child care, family child care and home-based care/home visiting. Meanwhile, Head Start serves approximately 6,000 children ages three to five in both part-day and full-day center-based preschools in nearly every community across the state.

The Connecticut Part C Memorandum of Understanding

In recognizing the importance of providing Part C services to young children who have experienced abuse and neglect, the Connecticut Department of Children and Families and the Connecticut Department of Developmental Services have developed a Memorandum of Understanding, which outlines the priorities, roles, responsibilities and processes needed to ensure that young children served by DCF are assessed for and receive Part C services as needed.

In addition to promoting healthy cognitive and social-emotional development, Head Start and Early Head Start programs include health, nutrition, disability and family engagement services.

Head Start and the child welfare system also partner at the federal level. (See *ACYF Information Memorandum, above.*) Head Start programs receive funding directly from the federal government. Services are free to families who meet federal poverty income guidelines. In addition, all children in foster care are categorically eligible for Head Start services, regardless of the family's income level. In fact, children receiving any child welfare services are prioritized for enrollment.

DCF's goal is to have all foster children enrolled in Early Head Start, Head Start or another quality early childhood setting. Given that children involved with protective services are, as a group, at the greatest risk of school failure, our goal is to

ensure that all children who receive child welfare services attend the highest quality early childhood programs available.

Since 2005, DCF and Head Start staff from across the state have met quarterly around a core set of collaborative activities to better support DCF's young children and families. Many area offices have MOUs or service agreements with the Head Start programs in their community specifically outlining how they will work together. In recent years, collaborative partnerships with DCF Area Office Teams have included ECCP, Supportive Housing for Families, Foster Care, Child FIRST, DRS Providers and a range of additional early childhood partners in local communities. Designated DCF and Head Start staff co-lead activities in each local community.

Referrals to Head Start: Your Role as a Caseworker

- **Discuss with parents.** A referral to Head Start should be discussed with any parent that is income eligible. Even if the child is enrolled in another early learning program, the family may want to consider moving the child to Head Start to take advantage of the wide range of ancillary services and supports available to families participating in Head Start.
- **Make the referral.** Specific referral protocols vary between regions within the state. Each DCF Area Office has developed a referral process to meet the unique needs in their community. To learn more about the referral protocol within your region, check with your Area Office's Lead Staff for the DCF-Head Start Partnership, or use the link to the Head Start Program Locator below to find and contact the Head Start program in the community you are engaging with: <http://eclkc.ohs.acf.hhs.gov/hslc>.
- **Use partnership with Head Start to learn more about the child's development.** Head Start programs are required to complete a developmental screening of each child within 45 days of enrollment and a health screening within 90 days. These screenings can serve as important resources for you as you continue to monitor the child's developmental status. More information on Head Start developmental screenings can be found in [Appendix F](#).

Connecting Families to Part C Services

Studies show that half of all children birth to three who have experienced abuse and/or neglect have significant delays in communication or cognitive development, and a quarter have delays in motor development.⁸ Part C services are

⁸ Blatt, S.D., Saletsky, R.D., Meguid, V., Church, C.C., O'Hara, M.T., Haller-Peck, S.M., & Anderson, J.M. (1997). A comprehensive, multidisciplinary approach to providing health care for children in out-of-home-care. *Child Welfare*, 76(2).

designed to support children who have developmental delays or conditions that might cause a developmental delay. Nationally, there is a special interest in ensuring that children connected to child welfare systems are also connected to Part C services.

Based on the Part C Memorandum of Understanding, case workers should make a referral for assessment for Part C eligibility for any child in their caseload who is age three or below and, (a) has a substantiated case of abuse and/or neglect and are suspected of having a developmental delay, or, (b) is affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.

Service plans vary to meet the unique needs of every child. Below is a partial list of services that may be available to a child who is eligible for Part C:

- Audiology services
- Assistive technology
- Counseling/psychological assessments
- Family training, counseling and home visits
- Medical evaluations (for diagnostic purposes only)
- Nursing care
- Nutritional assistance
- Occupational therapy
- Physical therapy
- Service coordination
- Social work services
- Speech/language therapy
- Transportation services

Ongoing Communication with Early Childhood Partners

Once early childhood partners are engaged in supporting the child and the family, it will be important to establish and maintain ongoing communication. This continued communication serves two major purposes:

1. Keeping early childhood partners up to date on changes in case status helps them be more effective in supporting the child. For example, if early childhood partners are aware that the child will be undergoing a placement change, that knowledge can help them to interpret and respond to behavioral or emotional changes the child might exhibit.
2. Early childhood partners can also be excellent sources of information about the child and the child's behavior. This information can help to evaluate the child's overall status, understand the dynamics between parent/caregiver and child, and stay attuned to behavior changes.

Are you prepared?

Actions you can take to build your capacity to do the work:

- Get to know your local Birth to Three provider to learn more about the services they provide and their protocols
- If you have questions about Part C talk with your local Birth to Three provider—it is important that you understand these services so you can help link families to them

Obtaining Consent To Share Information

Parental consent will be needed in order to facilitate regular sharing of information between protective services workers and the child's early childhood providers. [Appendix H](#) includes the DCF consent to share information form. In encouraging parents to provide their consent, the following strategies may be helpful:

- Let parents know that the goal of information sharing is to ensure that DCF and the early childhood partner can best work together to make sure that their child is healthy, cared for and on track with developmental milestones. Inform the parents that signing the consent form will allow you to best ensure that their child receives the care he or she deserves.
- Let the parent know what information will NOT be shared. Parents may feel anxious that you will be sharing details of their case with the early childhood partner. Explain that the intent is to share only information that will help the early childhood partner to best respond to your child's unique needs
- Be prepared to discuss with the parent the specific information that will be shared, as well as what information will remain confidential. If possible respect parental requests to keep certain information private. Details of the case that are not directly related to the child care providers' role with the child should not be shared.
- When information is shared with early childhood partners, inform parents; and, whenever possible, provide them with documentation of that information sharing.

Obtaining consent also provides an opportunity to talk with and educate parents about the importance of the early childhood provider as a resource for information about their child and their child's development. By engaging parents in the information sharing process you can:

- Educate them on their child's developmental progress
- Model how to engage with early childhood partners in order to learn about and support the child's developmental needs
- Teach parents how to effectively work with early childhood partners, for instance, by helping parents formulate questions and interpret answers
- Help parents understand what type of issues are red flags in their child's development, and how to go about addressing those issues.

PART III: Supporting Parents and Caregivers in Their Parenting Role

The nurturing support young children receive from their primary caregivers can serve as the foundation for their well-being and ongoing development. When caregivers become involved in the child welfare system, it is usually because their ability to serve as a strong foundation for their child is compromised.

Oftentimes this is related to parents' own experiences of past or ongoing trauma. However, because nurturing support from a primary caregiver is still the best foundation for a young child's well-being and ongoing development, the state of Connecticut has adopted a framework for child welfare practice called Strengthening Families (SF). Using the SF approach, parents become partners in building a stronger platform for their child's well-being. There are five protective factors at the heart of the SF framework. Research has shown that each of these factors contribute to caregivers' capacity to provide the nurturing and support that children need. The five protective factors at the heart of the Strengthening Families framework are:

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete support in times of need
- Social and emotional competence of children

The presence of these five protective factors has been shown to enhance parental capacity, reduce incidence of child abuse and neglect and create conditions for optimal development throughout childhood.

Strengthening Families™ is an evidence-informed approach to increasing family stability, enhancing child development, and reducing child abuse and neglect. The approach focuses on building five protective factors:

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete support in times of need
- Social and emotional competence of children

More than thirty states currently use Strengthening Families as a framework for child and family services. A growing number of states, including Connecticut are also using Strengthening Families as a framework for child welfare practice.

The Center for the Study of Social Policy (CSSP), which coordinates the national Strengthening Families agenda, has defined three core foci of Strengthening Families' approach to child welfare:

- Building protective factors for caregivers
- Providing supports for developmental needs of children in care
- Engaging parents as decision-makers

For more information, visit www.strengtheningfamilies.net.

In this section, we will focus on strategies to build protective factors for caregivers to enhance their ability to provide nurturing care for infants, toddlers and young children in the child welfare system. The term "caregivers" is often used interchangeably with the term "parents." This reflects the need for caseworkers to employ a protective factors approach in supporting all of the caregivers that are part of the family's life. In this sense, "caregivers" refers not only to birth parents, but may also include the family's extended network, foster or adoptive parents, or kinship providers.

Parental Resilience

Understanding this Protective Factor

Resilience is the process of managing stress and functioning effectively, even when faced with challenges, adversity and trauma. Parental resilience as defined in the Strengthening Families framework has two components:

Resilience Related to General Life Stress

- calling forth the inner strength to proactively meet personal challenges, manage adversities and heal from the effects of trauma or stress
- becoming more self-confident and self-efficacious
- believing that one can make and achieve goals
- solving general life problems
- building trusting relationships; feeling respected and appreciated
- maintaining a positive outlook on life in general
- managing anger, anxiety, sadness, loneliness and other negative feelings
- seeking help for addressing personal issues as needed

Resilience Related to General Parenting Stress

- proactively meeting challenges
- not allowing stressors to keep one from providing nurturing attention to one's child(ren)
- solving parenting problems
- having a positive attitude about one's parenting role and responsibilities
- seeking help for one's child(ren) when needed

Numerous researchers have concluded that the way parents respond to stressors is much more important than the stressor itself in determining outcomes for both themselves and their children. Parents are resilient when they are able to call forth their inner strength to proactively meet challenges (both personal challenges and those related to their child), manage adversities, heal the effects of trauma and function successfully as a family unit. By effectively managing stressors, parents can decrease their stress levels, providing them with the ability to be more nurturing and attentive to their child. This in turn enables the child to form a secure emotional attachment with the caregiver. Receiving nurturing attention and developing a secure emotional attachment with parents fosters the further development of resilience in children, thereby allowing them to better handle life stressors later on.

It is important to remember, however, that many parents who come into contact with the child welfare system grew up in environments of toxic stress, and because of this, their capacity for resilience may have been compromised. As

STAYING TUNED TO EACH FAMILY'S NEEDS

Each family comes with its individual needs and experiences which will shape the support that they need from DCF as they build their skills to care for their young children. Certain types of parents face more significant challenges and will need added focus and special support to effectively address trauma, meet their child's developmental needs and build their protective factors. For example:

- **Adolescent parents** are simultaneously going to need supports as parents and as developing adolescents who are making their own developmental transitions.
- **Parents with children with special needs or developmental delays** are going to need extra support in understanding their child's development when many of the normal markers and experiences may not apply.
- When **parents themselves have special needs or developmental delays** the standard resources which we can provide to support and help parents with young children build their capacity may not be appropriate or useful tools.
- When parents are concurrently dealing with other high need issues (domestic violence, substance abuse, mental health issues, incarceration of themselves or partner) these issues can interfere with their ability to parent effectively and depress their protective factors. Effectively supporting these parents requires balancing concurrent work to address these issues and building their protective factors to both support their parenting and their efforts to address the other complex issues in their lives.

Are you prepared?

Actions you can take to build your capacity to do the work:

The beliefs, behaviors, parenting orientation and values that are central to a family's culture may be influenced by race, ethnicity, gender, sexual orientation, language, religion/spirituality, economic circumstances, and geographic location among other sources. Understanding the dynamics of the family within the context of their culture is essential in informing individualized services based on their unique strengths and needs. This requires an open mind and the willingness to listen to families and their views.

- Developing your skills in this area requires:
- Engaging in self-assessment and self-awareness
- Understanding your own culture and how it influences you and how you see others
- Acknowledging cultural differences
- Acquiring cultural knowledge and skills
- Asking effective questions to help you understand the family's history, background and experiences and how these influence them
- Viewing behavior within a cultural context

children, they themselves may have experienced strong, frequent and prolonged adversity without the buffering protection of nurturing adult support. As a result, these parents may display symptoms of depression, anxiety or other clinical disorders that inhibit their ability to respond consistently, warmly and sensitively to their own child's needs. Parents can be helped to manage clinical symptoms and reactions to their own histories of poor attachments and trauma. In this way, they become stronger and more able to protect their own children from adversity, and to provide the more nurturing care necessary for secure emotional attachment and healthy development in their children. Remember that your Regional Resource Group is available for consultation if you feel that the caregiver you are working with is showing signs of stress, depression or mental health issues.

Your Role as a Caseworker

Engagement with the child welfare system is necessarily emotional and difficult for parents and can cause self-doubt that fundamentally undermines resilience. As a caseworker part of your role is to make the child welfare experience as constructive as possible by:

- Projecting a positive and strengths-based approach to the family
- Supporting the family as key decision-makers throughout the case planning process
- Making self-care a part of the case plan
- Encouraging the parent to explore their own past experiences of trauma and address how those experiences impact them in the present
- Normalizing the fact that parenting is stressful and helping the parent plan proactively about how to respond to stressful parenting situations
- Validating and supporting good decisions

Questions to Ask

- What helps you cope with everyday life?
- Where do you draw your strength?
- How does this help you in parenting?
- What are your dreams for yourself and family?
- What kind of worries and frustrations do you deal with during the day? How do you solve them?
- How are you able to meet your children's needs when you are stressed?
- How does your spouse or partner support you? When you are under stress, what is most helpful?
- What do you do to take care of yourself when you are stressed?

What to Look for

- Problem solving skills
- Ability to cope with stress
- Self-care strategies
- Help-seeking behavior
- Receiving mental health or substance abuse services if needed
- Does not allow stress to impact parenting

Social Connections

Understanding this Protective Factor

Constructive, supportive social connections help buffer parents against stressors and support nurturing parenting behaviors that promote secure attachments in young children. What matters is not the quantity of connections a parent has, but rather the quality of those connections. More specifically, it is important that parents have social connections that provide:

- **Emotional support** (e.g., affirming parenting skills or being empathic and nonjudgmental)
- **Informational support** (e.g., providing parenting guidance or recommending pediatric care)
- **Instrumental support** (e.g., providing transportation, child care, financial assistance or links to jobs)
- **Spiritual support** (e.g., providing hope and encouragement)

Several research studies have demonstrated that—for both mothers and fathers—high levels of emotional, informational, instrumental or spiritual support is associated with positive parental mood; positive perceptions of and responsiveness to one's children; parental satisfaction, well-being and sense of competence; and lower levels of anger, anxiety and depression. Conversely, inadequate, conflicting or dissatisfying social connections can be the source of parental stress. At the extreme end of the continuum of poor social connections issues such as social isolation (i.e., the lack of available and quality relationships) and loneliness (i.e., feelings of disconnectedness from others) arise. Social isolation is a risk factor consistently associated with disengaged parenting, maternal depression and increased likelihood of child maltreatment. Similarly, loneliness may be a major stressor that inhibits parents' ability to provide

consistent, nurturing, responsive care to their children. Many families connected with child welfare experience specific barriers to developing positive social connections. Such barriers might include poor relational histories stemming back to trauma in early childhood or specific experiences, such as domestic violence, which tend to promote isolation. These families may require not only opportunities to engage, but also specific coaching and support for entering into positive relationships.

Your Role as a Caseworker

As the family's caseworker you can help them to think critically about their social network and how to utilize it more effectively, as well as the skills and tools they need to expand it. Be sure to take the time to understand the family's existing social network and which parts of that network provide (or could provide) the quality connections a family needs. The DCF Practice Guide on Assessment provides information on conducting both eco-maps and genograms with families. In addition, the following strategies can help you engage the families in developing social connections:

- Model good relational behavior and use the case management process as an opportunity to help the caregiver develop stronger relational skills
- When engaging the family's broader network in teaming or other support be sensitive to the quality of existing relationships and help the family identify supporters in their network who will contribute positively
- Encourage the caregiver to expand or deepen their social network as part of the case plan
- If there are specific issues that serve as barriers for the family in developing healthy social connections such as anxiety or depression, encourage the family to address these

Questions to Ask

Everyone needs someone they feel connected to—someone who supports them, cares about them, provides them with help in times of need. It's important to work with parents to assess whether they have someone in their life who can offer them this positive support. It may be helpful for parents to consider the following questions:

- Do you have friends or family members that help you out once in a while?
- Are you a member of any groups or organizations?
- Who can you call for advice or just to talk? How often do you see them?
- What kind of social support do you need?
- Do you find it easy or challenging to make friends? If it is challenging, what specific things represent a barrier for you?
- What helps you feel connected?

What to Look for

- Does the parent have a supportive relationships with one or more persons (friends, family, neighbors, community, faith-based organizations, etc.)?
- Can the parent turn to their social network for help in times of need (for instance, when they need help with transportation, child care or other resources)?
- Is the parent willing and able to accept assistance from others?
- Does the parent have positive relationships with other parents of same-age kids?
- Does the parent have skills for establishing and maintaining social relationships?
- Does the parent provide reciprocal social support to peers?

Knowledge of Parenting and Child Development

Understanding this Protective Factor

Children’s developing brains need proper nutrition, regularly scheduled periods of sleep, physical activity and a variety of stimulating experiences. This development also depends highly on the availability of emotionally attuned parents and other primary caregivers—individuals who recognize and respond to the child, interacting with him or her in an affectionate, sensitive and nurturing manner. An understanding of parenting strategies and child development helps parents understand what to expect and how to provide what children need during each developmental phase. Understanding the mounting evidence about the nature and importance of early brain development enables both parents and those who work with children to know what young children need most in order to thrive: nurturing, responsive, reliable and trusting relationships; regular, predictable and consistent routines; interactive language experiences; a physically and emotionally safe environment; and opportunities to explore and to learn by doing. Ideally families should seek, acquire and use accurate and age/stage-related information about parenting. They should know about parental behaviors that lead to early secure attachments, as well as the importance of being attuned and emotionally available to their child.

It is important to recognize that the ways parents treat their children is often a reflection of the way they themselves were parented. Many families who come into contact with child welfare services have their own childhood experience of abuse and neglect. Acquiring new knowledge about parenting and child development enables parents to critically evaluate the impact of their own childhood experiences on their current parenting practices, and to consider that there may be more effective ways of guiding and responding to their children.

Your Role as a Caseworker

As the family’s caseworker you play an active role in helping parents connect with the information and tools they need to develop their knowledge of parenting and child development. Each and every contact you have with the family provides an important opportunity to link them to parenting resources, provide parenting information and model and validate effective caregiving. Specific strategies you should use include:

- Connect parents to parenting education classes or resources as part of case planning
- Model appropriate expectations for the child and engage the parents in dialogue when their expectations are not in line with the child’s developmental phase
- Underline the importance of nurturing care to help the parent in valuing the importance of their own role
- Provide “just in time” parenting education—information a parent needs at the time when parenting issues arise (please see [Appendix B](#) for information about common issues that come up during particular phases of early childhood development)
- Help the caregiver identify a series of trusted informants that they can turn to when they need parenting information

Questions to Ask

- How do you learn about parenting skills?
- How do you learn about your child’s development?
- What has helped you learn about yourself as a parent?
- What kinds of things make your child happy, sad, frustrated or angry and what do they do when they feel this way?

- How do you respond to these behaviors?
- How does your child respond?
- Are there things that worry you about your infant/toddler/preschooler?
- Have other expressed concern about your children?
- How do you encourage your child to communicate, explore surroundings, try new things and be more independent?

What to Look for

- Do parents understand and encourage healthy development and are they able to respond and manage their child(ren)'s behavior?
- Do they understand and demonstrate age-appropriate parenting skills in expectations, discipline, communication, protection and supervision of their infant/toddler/preschooler/child?
- Are parents concerned about their child's behavior? Does the child respond positively to the parents' approaches?
- Do the parents understand and value their parenting role?
- Do the parents have a reliable source for parenting information when issues come up?
- Do the parents know how to encourage social emotional development and apply a range of disciplinary strategies that are age appropriate? Are parents involved in their infant/toddler/preschooler/child's early learning? Are parents aware of the importance of quality early childhood education?
- Do the parents understand the child's specific needs (especially if the child has special developmental or behavioral needs)?

Concrete Support in Times of Need

Understanding this Protective Factor

Assisting parents with identifying, finding and receiving concrete support in times of need helps to ensure they and their family receive the basic necessities everyone deserves in order to grow (e.g., healthy food, a safe environment), as well as specialized medical, mental health, social, educational or legal services. When parents seek help, it should be provided in a manner that does not increase stress. Services should be coordinated, respectful, caring and strengths-based.

Providing a referral linkage to a service provider is often not enough to ensure the provision of concrete support. For some parents, asking for help is not an easy thing to do. It may be embarrassing because it can feel like an admission of incompetence—it can feel like asking for help implies that they don't know how to solve their own problems or take care of their family. Other parents may not seek help because they don't know where to go for help, or the services needed have a stigma associated with them, such as mental health clinics and domestic violence or homeless shelters. Thus, parents need experiences that enable them to understand their rights in accessing services, gain knowledge of relevant services and learn how to navigate through service systems.

Your Role as a Caseworker

As the family's caseworker your role is not just to provide referrals to needed services, but to identify what barriers the families may have to accessing those services and to help them overcome those barriers. This help may entail:

- Encouraging help seeking behavior
- Working with the family to understand their past experience with service systems and any stigma they attach to certain services
- Helping the family to navigate complex systems by explaining eligibility requirements, filling out forms or making a warm handoff to an individual who can help them negotiate getting access to the services they need
- Helping the caregiver understand their role as an advocate for themselves and their child

Questions to Ask

- What do you need to _____ (stay in your house, keep your job, pay your heating bill etc.)?
- What have you done to handle the problem? Has this worked?
- Are there community groups or local services that you have worked with in the past? What has been your experience accessing their services?
- Are there specific barriers that have made it difficult for you to access services in the past?
- How does dealing with these issues impact the way you parent?

What to Look for

- Is the caregiver open to accessing and utilizing services?
- Has the caregiver had positive experiences with services in the past?
- Does the caregiver have specific barriers (literacy, lack of transportation, etc.) that will make it difficult to access services?
- Are there personal behavioral traits—punctuality, willingness to share personal information, etc.—which the caregiver could address to more effectively utilize services?
- Does the caregiver try to buffer the child from the stress caused by the family's concrete needs?

Social and Emotional Competence of Children

Understanding this Protective Factor

A growing body of research has demonstrated the strong link between young children's social-emotional competence and their cognitive development, language skills, mental health and school success. The dimensions of social-emotional competence in early childhood include:

- Self-esteem – good feelings about oneself
- Self-confidence – being open to new challenges and willing to explore new environments
- Self-efficacy – believing that one is capable of performing an action
- Self-regulation/self-control – following rules, controlling impulses, acting appropriately based on the context
- Personal agency – planning and carrying out purposeful actions
- Executive functioning – staying focused on a task and avoiding distractions
- Patience – learning to wait
- Persistence – willingness to try again when first attempts are not successful
- Conflict resolution – resolving disagreements in a peaceful way
- Communication skills – understanding and expressing a range of positive and negative emotions
- Empathy – understanding and responding to the emotions and rights of others
- Social skills – making friends and getting along with others
- Morality – learning a sense of right and wrong

These dimensions of social-emotional competence do not evolve naturally. The course of social-emotional development—whether healthy or unhealthy—depends on the quality of nurturing attachment and stimulation that a child receives. Numerous research studies show that a relationship with a consistent, caring and attuned adult who actively promotes the development of these dimensions is essential for healthy social-emotional outcomes in young children.

As children develop they become more capable in recognizing their own emotions as well as those of others. This key development of their social-emotional competence allows them to first understand others' perspectives and to then use their emerging cognitive skills to think about appropriate versus inappropriate ways of responding. Conversely, research shows children who do not have caretakers who actively promote social-emotional competence may lack secure attachments, have limited language and cognitive skills and/or have a difficult time interacting effectively with their peers. The good news is that a great deal of evidence suggests that early and appropriate interventions focused specifically on social-emotional development can help to mitigate the effects of negative experiences, thereby improving cognitive and social-emotional outcomes.

Learn More: The Center for the Social Emotional Foundations of Early Learning has resources for parents and other caregivers that help explain the importance of social-emotional development and provide tools to help build and support a child's social-emotional skills. You can access this information at:

<http://csefel.vanderbilt.edu/>

Your Role as a Caseworker

- Increase caregivers' awareness of the importance of early relationships and of their role in nurturing their child's social-emotional development
- Provide concrete tips and resources for the caregiver to help their skills
- Stay attuned to trauma and how it impacts the child's relationships with significant adults and, as they grow, with peers
- Connect the family to resources that can help support the child's social-emotional development—these might be as simple as classes like Second Step, or books and games that help children to name or recognize their emotions, but can also include more intensive interventions, such as mental health counseling
- Provide families with support in dealing with children's attachment issues and/or challenging behaviors

Questions to Ask

- How is the emotional relationship between you and your child?
- How do you express love and affection to your child?
- How do you help your child express his or her emotions?
- In what situations are your infant/toddler/preschooler/child's emotions hard for you to deal with?

What to Look for

- Does the caregiver create an environment in which children feel safe to express their emotions?
- Is the caregiver emotionally responsive to the child?
- Does the caregiver model empathy?
- Does the caregiver set clear expectations and limits (e.g., "People in our family don't hurt each other")?
- Does the caregiver separate emotions from actions (e.g., "It's okay to be angry, but we don't hit someone when we are angry")?
- Does the caregiver encourage and reinforce social skills such as greeting others and taking turns?
- Does the caregiver create opportunities for children to solve problems? (e.g., "What do you think you should do if another child calls you a bad name?")?

PART IV: Windows of Opportunity in Every Day Practice

Every encounter we have with infants, toddlers, preschoolers, children, families and caregivers gives us the opportunity to explore and understand children’s developmental progress, strengthen caregiving capacity and link families to early childhood services. The DCF Family Engagement Practice Guide suggests that case workers or managers can “*Look, Listen, Engage and Support. You can help promote the healthy development of infants and young children.*” The previous sections of this guide provided an overview of how case workers can do just that by:

- Recognizing and responding to signs of trauma
- Assessing developmental progress and connecting to developmental supports
- Building protective factors in families

This section asks case workers and supervisors to consider the opportunities they have in their everyday practice to apply the strategies discussed in the earlier sections of the guide.

A Consistent Lens—Strategies to Use in all Interactions with Families

- **Project a positive and strengths-based approach to the family.** Start where the family is; seek to understand the family’s situation by asking questions and acknowledging responses in a respectful manner; “catch the caregivers doing something right,” and reinforce their efforts, thereby validating and supporting good decisions; normalize the fact that parenting is stressful; identify situations or stressors where the family may need additional support and help plan ways to proactively respond in these situations.
- **Deepen your understanding of family and child strengths.** Address parenting challenges and how they’ve been handled successfully; look over daily routines, parenting views and patterns of family and social interaction that have been successful for the family; seek to understand the positive qualities of the family’s existing social network and status of current connection to child care/early childhood education; appreciate cultural norms; understand any trauma history and identify the strengths used in overcoming that trauma.
- **Monitor and educate parents about children’s developmental progress, needs, environment and social-emotional well-being.** Check in with the parent or caregiver to see if they have any concerns about the child’s development; update caregivers and parents about what you have learned from early childhood partners, both about their child and services available to them within the community.

- **Provide “just in time” parenting education.** Provide concrete tips and resources for the caregiver to help develop and improve their skills; model and provide information on appropriate expectations for the child; engage the parent in dialogue when expectations are not in line with the child’s developmental phase; provide caregivers with support and information regarding available resources to deal with children’s challenging behaviors; emphasize the importance of nurturing care; help the parent value the importance of their own role.
- **Connect the family to resources.** Provide families with the early childhood and parenting resources available in the community; help the family understand eligibility requirements for potential services; connect the family with advocates who can help them negotiate access to the resources and services, as needed.
- **Help caregivers identify trusted friends, family members and professionals who they can turn to for support.** Be sensitive to the dynamics of the family’s broader network and help the family identify who can contribute positively to developing their parenting capacity; model good relational behavior by being interested in the caregiver’s well-being, self-care and interests other than child rearing.
- **Emphasize the importance of caregiver self-care.** Become attuned to caregiver; address trauma the caregiver may have experienced and its effect on their functioning; provide the caregiver with resources and strategies to care for themselves.

The figure on the following page lists routine practice activities and requirements that can be beneficial. Some activities relate to encounters we have with parents and/or children that provide opportunities to recognize and address trauma, assess developmental progress and offer supports and strengthen caregiver protective factors. Other activities provide opportunities to “check-in” on a family’s progress and strategies we can use to hold ourselves accountable for achieving results with families and children.

Family Assessment Response and Intake

Family Assessment Response (FAR) cases represent a unique opportunity to establish a supportive relationship with families. Connecticut’s FAR process already integrates many aspects of the approach embodied in this guide and there are many opportunities to integrate these ideas further. It is important to consistently integrate strengths-based, protective factors approaches with the implementation of FAR. The steps below outline ways in which this incorporation can be carried out:

Respond to Signs of Trauma

- **Address the possible trauma caused by child welfare engagement.** Give the family an opportunity to talk through the presenting situation that led to the involvement with DCF. Even though it may be determined that the child(ren) is safe, it is likely traumatic for the entire family to receive a DCF report. Allowing the parent to talk about the situation and their own feelings can help to relieve stress.
- **Help parents help their children to heal.** Help the family explore whether the alleged incident might have caused trauma to the child. It is important to talk about this with the parent in a non-judgmental way that keeps them focused on the important role they can play in helping promote their child’s well-being.
- **Note who the child turns to.** Research demonstrates that children are much better able to bounce back from a traumatic event when they have a caring adult in their lives who they trust and feel comfortable with. Regardless

Windows of Opportunity to Support Young Child Development

EVERY DAY CASE WORK

Family Assessment
Response

Investigations

Planning

Case Work Visits

Facilitating Visitation-
“Parenting Time”

Considered Removal
Child and Family
Team Meeting

Permanency Child
and Family Teaming

Medical
Appointments

Case Closing

DESIRED RESULTS

Trauma

- Signs of trauma are identified and responded to
- Children and caregiver(s) are connected to therapeutic supports
- Caregiver is supported in addressing trauma and helping the child heal

Early Childhood Development

- Developmental issues are identified and services are put in place
- Infants/toddlers/preschoolers are connected to age-appropriate quality early child care, education and developmental supports
- Caregivers, early childhood partners and DCF staff work together to support the child’s developmental needs

Protective Factors

- Caregivers are supported in building protective factors as a pathway to becoming confident and informed, thereby enhancing their ability to provide nurturing care to the child

of the outcome of the investigation, it is likely that the investigation itself will be traumatic for the child and family. As an investigator, noting what an infant communicates with facial expressions and positioning, or where the child automatically turns for comfort and support, can provide valuable information, both to the investigation itself and in implementing further steps at the close of the investigation. If a case is opened, the assigned on-going case manager can use such information in case planning with the family. If the investigation determines the triggering report is unsubstantiated, closing out the investigation could result in service referrals for the child and family that specifically include the person to whom the child is attached.

- ▶ **Attempt to reduce the stress parents and children may feel as the subjects of a report of maltreatment.** While gathering parental perspectives on the allegations that triggered a child maltreatment investigation, be mindful of the stress the parents and child are experiencing and how escalating parental stress can further affect the child. Approaching the parents in a respectful, composed manner can help reduce the tensions provoked by the investigation, both for the parent and child. Providing a non-judgmental environment that allows the parents to talk about the situation and their own feelings can help to relieve stress and also provide useful information for investigative conclusions.
- ▶ **Help the parents understand how their own behaviors can cause emotional stress and traumatic experiences for their child.** Even well-intentioned parents and family members may not realize the impacts their adult interactions can have on a child. For example, reports of child maltreatment may stem from disagreements and distrust between separated or divorcing parents, or extended family feuds. In such situations, making a “hotline” report may be a tool one adult uses to hurt another adult or to build a case for full child custody. While the report of maltreatment may be unsubstantiated in such situations, help parents and family members to understand how the investigations are not just nuisances to adults—they are also traumatic to children who must be examined and questioned every time a serious concern is raised.

Support the Child’s Development

- ▶ **Use the FAR assessment process to deepen your knowledge of the child’s developmental trajectory.** Both parents and collateral contacts have a wealth of information about the child’s developmental progress. The questions listed in Appendices [C1](#) and [C2](#) can help you learn more. A strong understanding of the child’s developmental progress can provide a good platform for connecting with the parent, potentially allowing you to develop ways to collaborate and support the child together.
- ▶ **Connect families to developmental supports.** Because FAR cases are voluntary, they can provide a good opportunity to connect families with other services in the community. These services can help support the child’s early development. It is extremely important to ensure access to developmental supports and opportunities as part of the individualized family case plan.
- ▶ **Keep an eye out for telltale signs that might indicate developmental delays.** Although the investigation timeframe and scope of inquiry is not designed to fully assess a child’s developmental health, children who have obvious developmental delays need to be connected to appropriate services as early and as quickly as possible. During the investigation, be prepared to offer the family referrals to services that will address the identified delays. The investigation does not need to be complete before you start the referral process. Even if the report of maltreatment is unsubstantiated, or no signs suggest developmental delays, you should still be prepared to provide parents and caregivers with community resources that help keep children developmentally healthy. Should the report of maltreatment be substantiated and a child welfare case opened, more detailed information on the child’s developmental status will be collected during the subsequent case planning process. For families already involved with community providers such as Head Start, you should work with the parents to engage providers as family partners in supporting any developmental needs the child may have.

Support and Strengthen Parental Protective Factors

- ▶ **Use the FAR assessment as a platform for building a protective factors approach with families.** The FAR assessment and service plan process is a strong platform for building a protective factors approach to work with families. The initial FAR dialogue used to engage parents establishes protective factors as the focus of all on-going dialogues with families.
- ▶ **Build relationships with providers that can support families in building protective factors.** Even in situations where there is a concern that maltreatment may have occurred and the response is a formal investigation to determine the facts of the allegation and assess a child's safety and risk of harm, it is still incredibly important to engage families. Although the investigator's primary responsibility is to investigate substantiated child maltreatment, child protective investigations still do provide opportunities to approach caregivers in a way that helps to reduce stress, as opposed to allowing it to spiral to greater levels, potentially causing more harm to the child. As in the FAR, the investigation of child maltreatment is an opportunity to impart and obtain information that benefits young child development, no matter the outcome of the final investigative conclusion.
- ▶ **Use the opportunity to educate.** Help the caregiver to see the situation from the baby's or young child's perspective. What about the situation could be harmful to the child's well-being? What long-term impacts could the situation have on the child's development? On the relationship between the caregiver and the child? Exploring the answers to these questions may help the caregiver to more fully engage in promoting their child's behavior and well-being.
- ▶ **Talk with parents about what they can do to prevent a subsequent report to DCF.** If the report of maltreatment is unsubstantiated, it is still important to help parents take a long-term approach to their child's well-being. Help the parents understand that a report of alleged child maltreatment that leads to an investigation is triggered by a concern for the well-being of the young child. Explore with them how the concern came about and what steps they could take to protect their children and nurture their child moving forward. Help them identify friends or neighbors they trust who might be able to help them to take advantage of community resources designed to help them with their children.
- ▶ **Ask about the parent's own sense of well-being.** Asking the parent about what they are struggling with, either in parenting or in other parts of their life, can bring into focus how taking care of oneself can be an important pathway for taking care of one's child. For new parents, balancing the new responsibilities of parenting can be especially challenging. Does the child have a special need that is creating stress? While adapting to new needs and experiences, caring for oneself can be difficult, so it is important to help parents develop self-care strategies.

Case Worker Visits

Depending on the investigative findings, the child will either remain with his/her parents or be removed from the home and placed with substitute caregivers. If a child welfare case is opened, case workers will routinely visit with children, their caregivers and possibly other family members. These case worker visits provide opportunities to take proactive steps, such as:

Respond to Signs of Trauma

- ▶ **Observe the infant's behavior.** As discussed in Section I, even though very young children may not be able to explicitly tell you when they are frightened or sad, they often exhibit many behavioral cues that can help you to gauge their sense of well-being. Pay careful attention to these signs and non-verbal cues.

- **Educate the caregiver about the infant/toddler/preschooler’s experience.** It is important that the caregiver knows what the child has experienced. They should be made aware of signs or behaviors to look out for as they care for the child. If the child has been placed with a substitute caregiver, this information should be shared in a way that helps them be prepared to respond appropriately to the child, while not making them biased toward the child’s birth family. Caregivers should also be fully aware of and engaged with the clinical services to which the child is referred. During every visit, caregivers can be helped to more fully understand the child’s behaviors, as well as their own role in the child’s healing and healthy development. It is also important to discuss with caregivers their own self-care, so as to ensure that they are emotionally ready to cope with possible challenges the child may presents. Taking care of a child who has been traumatized can be challenging. Caregivers may need additional support to understand that many challenging behaviors are likely a reflection of the trauma the child has experienced, not a rejection of the caregiver. You may also consider offering them a referral to an ECCP consultant, as appropriate.
- **Observe how the infant/toddler/preschooler is interacting with his/her caregiver.** Do the caregiver and child respond appropriately to one another’s behavior – laughing/cooing and playing in response to the other’s smile and joy? Does the caregiver show praise for accomplishments? Does the caregiver provide comfort when the child seems anxious or distressed? These interactions are key to the child’s healing. Explore how the child and caregiver spend time together. What do they do for fun? What do they do during quiet times? If there are others adults or children in the home, observe how the child interacts with them and how the caregiver supports or directs those interactions.
- **If the child begins to exhibit behaviors related to trauma, link the child and caregiver to therapeutic assessments.** A child who has been removed from his/her birth family and placed with substitute caregivers may not immediately demonstrate any concerning behaviors. There may be a “honeymoon” period for both the child and the caregiver. However, frequent meaningful visits and regular communication should provide you with sufficient observations to identify “out of the ordinary” behaviors and to discuss them with the caregivers. Such behaviors should be monitored and may require further therapeutic assessment and response. Be prepared to connect the child and caregiver to the appropriate resources.

Support the Child’s Development

- **Prepare for the visit by referring to the appropriate developmental guidance and reflecting on what you have observed in previous visits.** This will help you make notes about what to look for, how to interact with the child and questions to ask the caregiver about the child’s daily routine. It will also prepare you to check up on anticipated and/or achieved developmental milestones. Use the information obtained about the child from service providers – clinicians and early care and education providers – to further prioritize what needs to be accomplished during a visit.

Support and Strengthen Parental and Caregiver Protective Factors

- **Get to know the caregiver.** Develop an understanding of what is going on in the caregivers’ lives, any potential sources of stress and how they are managing to cope with challenges. Respond with empathy to the life stresses they may be experiencing – job frustrations, financial issues, family dynamics, etc. Explore what they are doing to take care of themselves. Acknowledge that your visit itself may be a stressor and alleviate this stress by fully explaining the purpose and goals of your visit. For instance, talk with them about the developmental checklist and how you are using it to guide your interactions with the child. Discuss with them the changes you see from visit to visit so that you can include them in your assessment and understand their perspective. Always respect them as an expert about this child.

Considered Removal Child and Family Team Meeting (CR-CFTM)

Although the possibility for a child's removal can create a tense and stressful environment for meeting with a family, these meetings can still serve as opportunities to recognize and strengthen protective factors within the family, as well as opportunities to connect young children to the developmental services they need. Within these meetings, case workers and facilitators have an opportunity to:

Respond to Signs of Trauma

- **Make possible trauma to the infant/toddler/preschooler a subject of the conversation.** The primary focus of the meeting may be the decision of whether or not to remove the child. In making this decision, it is important to consider what level of trauma the child could experience due to a removal. This evaluation of the potential for trauma is an important component of the decision making process. What has the child witnessed or been exposed to that is of concern? How will removal potentially deteriorate the child's experience? If the decision is to allow the child to remain at home with a safety plan in place, what needs to be a part of that safety plan to minimize further traumatizing experience and promote protective factors?

Support the Child's Development

- **Consult with others to receive feedback about your assessment of the child's development.** Speaking with others who are close with the child provides an opportunity to discuss necessary steps to promote the child's healthy development. Whether the child remains at home or is removed, his/her developmental needs will always require attention.

Support and Strengthen Parental and Caregiver Protective Factors

- **Encourage parents to bring their circle of support to the table.** Parents and caregivers can be encouraged to think about including not only their immediate circle of family and friends, but also other significant caregivers in the child's life, e.g., child care providers, teachers, the family's pastor, neighbors— people who are already helping them to rear their children or have a role in their child's life. However, it is also important to be sensitive to the dynamics of the family's broader network and help the family identify who can contribute positively to developing their parenting capacity while keeping their child(ren) safe.
- **Help caregivers think about what they want to share about their child.** In preparing for the meeting, parents can be helped to understand they are their child's voice at the meeting. They should be encouraged to share information about their child and about how they successfully interact with their child.

Planning with the Caregiver

In keeping with DCF stated principles of case planning, meetings with the caregivers to assess progress provide opportunities to respond to trauma, build caregiver protective factor capacity and ensure young children are receiving the developmental support they need. For example, case planning is an opportunity for the case worker to:

Respond to Signs of Trauma

- ▶ **Work with caregivers to explore available service options.** Connecticut has developed a wealth of service resources designed to help families address childhood trauma. For example, ChildFirst, a home-based service, is designed to decrease the incidence of serious emotional disturbance. [Appendix A3](#) includes a series of resources for young children who have experienced trauma. In discussing service options with families, it is important to note that not all services match the severity/type of trauma experience or the identified needs of the child and family. Therefore, the assessment information about the degree of trauma the child has experienced should be shared with the family in order to guide decision making when identifying appropriate service(s) to include in the case plan.
- ▶ **Accurately document assessments, diagnoses and/or manifestations of the child's trauma within the plan itself.** The case plan is part of the child's official record. Therefore, any emotional/behavioral diagnoses should be recorded in the plan. Be as specific as possible when describing the behaviors the child is exhibiting and, when possible, tie them to an assessment, assessment plan or diagnoses. Accuracy and currency help to make the plan an accountability mechanism for guiding and assessing services designed to help the child heal. Vague descriptions about behaviors that are not sufficiently grounded in accurate and culturally sensitive assessments can lead to inaccurately labeling a child, which can exacerbate the trauma a child experiences.

Support the Child's Development

- ▶ **Include steps in the plan that link children and parents to early childhood services.** Earlier, we discussed how Head Start can serve as a significant resource for families of young children (see p. 17-18). In addition to Head Start, other early childhood services should also be explored as possibilities. Ensure that both caregivers and parents understand which early childhood services are being initiated and have the opportunity to connect with providers.
- ▶ **Accurately document assessments, diagnoses and/or manifestations of child's developmental progress in the plan itself.** Again, as noted above, the case plan is part of the child's official record and it bears repeating that developmental assessments and progress should be recorded and updated as appropriate with the same specificity required of therapeutic assessments and treatments.
- ▶ **Closely collaborate with both birth parents and substitute caregivers to define how the parent-child connection will be supported.** The following segment – *parenting time: facilitating visitation between parents and children* – provides guidance on how to best arrange visits in a way that promotes and maintains healthy child-parent connections. Planning for these visits should be reflected in the case plan so that expectations for all parties are clearly defined. Be especially sure to discuss and document scheduling specifics, location and transportation supports to avoid confusion over logistics.
- ▶ **Explore with both parents and substitute caregivers the roles extended family members and friends can continue to play in the child's life.** Strong social support will foster the child's healthy development. Not only should parental connections be maintained as a source of social support, but the child should also have access to the wider circle of connections among family members and the community. Again, the specifics of scheduling and expectations for maintaining these connections should be spelled out in the case plan.

Support and Strengthen Parental and Caregiver Protective Factors

- ▶ **Show parents how their voices are reflected in the plan.** To effectively engage parents, they need to feel like their opinions are valid and that their voice has been heard. It is important, therefore, for case plans to include the parents' own words and choices. Any disagreements should be addressed at family team meetings so that parents can be supported by their social connections throughout the planning process.

- ▶ **Start with the assumption that parents want of the best for their child.** Begin by asking parents what they want for their child and family. What do they envision as a perfect future for their family? Ask them who they turn to for help with child rearing. Find out what support and information they receive and what resources they would like to receive. Ask them what changes they would like to make to become the best parents they can be and find out what they would like to learn in order to better meet those personal goals. Explain how various classes and services can help them strengthen their parenting skills. Provide them with information to share with their peers and address any inaccurate information they may have received from others.
- ▶ **Teach caregivers appropriate ways to respond to stress.** Explore the causes of any challenges the parents are experiencing. Determine what self-care strategies they are employing in dealing with these challenges and build on their successful strategies as you continue to plan together.
- ▶ **Encourage the parent to expand or deepen their social network.** Start by understanding who is part of the parent's current network. Address any resistance or discomfort they may experience when reaching out to members of their network. Brainstorm how their social network could be improved. Explore with them the strengths of their network and get their ideas on how it could be expanded or strengthened. Find out what each social connection could contribute to the family's healing. Also discuss what kinds of activities and organizations they may have thought about engaging with in the past. If they have considered new approaches to strengthening their social network, find out why they did not follow up on those approaches. If they were unsure about how to go about getting involved or deciding how to best reach out to others, help them create a plan for getting started. Incorporate the results of these conversations within case planning for the family.
- ▶ **Connect the family to resources that can help support the child's social-emotional development.** Planning together is an opportunity to help caregivers navigate the various resources and systems that are available to the family. All too often, however, engaging with these systems turns out to be complicated or confusing. Planning with the parent and assisting with referrals can lead to effective linkages with other resources and systems. This step is important to discuss with parents even if the child has been removed from the parents' home because the parent should continue to be involved with services that support their child. They should continue to be part of the decision making about their child, regardless of caregiving circumstances.
- ▶ **Connect parents to services and resources that provide first-hand knowledge of child development.** Traditional services like parenting classes should always be considered, but other alternative methods are worth exploring, as well. Ask the parent what resources they think would be the most helpful and, based on that information, provide them with specific referrals that are tailored to meet their goals. This could entail setting up regular meetings between parents and Head Start or child care providers – perhaps once a week or so – for some personal discussions and information exchanges. Thinking “outside the box” when generating potential solutions can provide opportunities for more effective and individualized plans.
- ▶ **Supply concrete resources or help parents to navigate public and private community resources.** Parents may need more than a referral to obtain government benefits or to understand the requirements of the local food bank. Understand what the concrete needs of the family may be and be prepared to accompany the parents to referral source to help them apply and obtain the tangible resources they need. Additional advocacy by the case worker may be necessary and provided as appropriate. Case workers should make every effort to remain informed and connected with community resources through participating in the DCF-Head Start Partnership or other community networking activities.

Parenting Time: Facilitating Parental Visitations

Children, especially very young children, need frequent and consistent contact with their parents.⁹ Connecticut's family visitation policy states that **“Because physical proximity with the caregiver is central to the attachment process, an infant should ideally spend time with parents on a daily basis, and a toddler should see the parents every 2-3 days.”** This regular visitation schedule provides a unique opportunity to monitor the child and their needs, engage with the parent in ways that build their capacity and support the bond between the child and parent. When planning for visits, however, it is important to be sensitive to both the parent's needs and the child's needs. Remember that these visits are taking place during a particular part of the child's developmental cycle. As such, be sure to consider how the visits can be planned in a way that supports the child's unique developmental needs. For example, the parent of a one-year old may need the chance to help the child develop fine motor skills, while the parent of a preschooler may prefer opportunities to engage his or her child in reading books or playing games.

Developmentally appropriate parent-child contact:

- Is individualized for each family, according to their needs;
- Aims for daily contact;
- Occurs in locations and times that work for birth parents, foster parents, and the infants and toddlers;
- Addresses parenting practice and relationship building;
- Focuses on parent involvement in normal family activities, such as doctor's appointments and birthday celebrations; and
- Limits those involved in supervising visits to one or two people who develop ongoing relationships with the child and caregivers.

From: *A Call to Action on Behalf of Maltreated Infants and Toddlers*. American Humane Association; Center for the Study of Social Policy; Children's Defense Fund; and ZERO TO THREE, 2011. P. 14

Respond to Signs of Trauma

- **Build sensitivity to the emotional impact of visits.** Visits can remind the child that they are missing their parent or open up old anxieties. Regardless of the cause, children may be fussier or exhibit other signs of emotional impact either prior to, during or after a visit with a parent. The parent and substitute caregiver should be reminded that this is normal. Developing a plan for how each visitation session will end, including what language will be used with the child, may help ease some of the anxiety around separation between visits.
- **Build familiarity into the visit structure.** Work with the parents to learn more about their and the child's regular routines. Create opportunities to “anchor” the visit with key activities from daily life that help the child feel reconnected. Whether this entails the parents reading the child's favorite book to them, or singing the song they always sing with the child, bringing these routines into the visit helps establish a sense of normalcy for the child.
- **Observe and respond to the child's cues.** It is important for all adults involved in the visitation to be sensitive and responsive to the child's verbal and non-verbal cues. This can be difficult at times, particularly when what the child seems to need and want doesn't coincide with the adult's needs. For example, it can be hard for a mother that has been anxious to see her baby to deal with the fact that the child is fussy or does not want to be held during a visit. Being a careful observer and helping to mediate when these tensions arise is important.

Support the Child's Development

- **Observe and flag developmental needs of the child that should be addressed.** Use visitation as an opportunity to observe the child and check in with the substitute caregiver about any emerging developmental

⁹ Smariga, M. (2007). *Visitation with Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know*. ZERO TO THREE Policy Center: Practice & Policy Brief.

issues. Asking for the parent's observations about the child is also important because it engages the parent in the assessment process and can provide teaching opportunities.

- ▶ **Build relationships between parents and early childhood partners.** When appropriate and desired by the parent, invite their early childhood partners to participate in visits. This might be a mental health consultant if the child is showing signs of trauma, a developmental specialist if the child is experiencing delays or an early care and education provider who can offer information on the child's progress in early learning. Care should be taken, however, to ensure that these individuals do not interfere with the parent and child's ability to interact and spend quality time together during the visit.
- ▶ **Broaden the parent's experience of developmentally appropriate settings.** Creatively choosing visitation settings can provide an opportunity for the parent to interact with their child in ways that expand their understanding of supporting their child's development. Holding a visitation session at a children's museum, a local park or the library can provide not only an opportunity for the parent and child to have a fun outing, but also a way for the parent to learn about new resources and strategies for engaging with their child. In some instances, early care and education providers may be included in organizing visits that offer a family friendly setting.
- ▶ **Educate parents on their child's developmental progress.** Speak with early childhood partners and caregivers ahead of time to identify developmental issues and to plan materials and activities that can demonstrate the learning skills the infant/toddler/preschooler/child is currently focused on. These might be red flags or new developmental achievements. Brief the parent prior to the visit on what to look for in their child's behavior. This is especially important with young children, for whom developmental changes are happening rapidly.
- ▶ **Build an alliance between the parent, the substitute caregiver and you, the case worker.** Ideally, visits become an opportunity for you, the parent and the substitute caregiver to collaborate in planning how best to support the child's developmental progress. Time should be reserved on a regular basis to discuss where the child is developmentally, what they need, how the current plan or services may need to be changed or modified and how you can work together to best support the child moving forward.

Support and Strengthen Parental and Caregiver Protective Factors

- ▶ **Treat parents as the experts.** Planning for visitation presents another opportunity to identify and build parental protective factors. As you coordinate the visit with parents, take the time to learn from them about what will make their child feel safe and supported. Validate their expertise about their own child while also helping them to think strategically about what their child needs to thrive. All of these methods serve as good techniques for helping parents to build their parenting skills.
- ▶ **Help parents practice the tough stuff.** Pay close attention to what aspects of parenting seem stressful for the parent. Address these issues by providing parents with resources, tips and strategies that can be used during the next meeting. You can help them to analyze prior visits, identifying opportunities when they could have utilized new or different skills. You should also debrief with them after every visit, making sure to emphasize and praise the effective parenting practices that you observed.
- ▶ **Allow the parent to engage others.** Ask the parent if there are other people in their network who they would like to invite to participate in visits.

Permanency Child and Family Teaming

Permanency Child and Family Teaming is a case management process designed to focus practice on activities leading to permanency. Permanency teaming informs and enhances assessment, service planning, service delivery and case closing. It is also an excellent opportunity to help strengthen and build caregiver protective factors and track children's developmental progress. Permanency teaming can help workers to:

Respond to Signs of Trauma

- **Explore how the lack of permanency can be unsettling for the infant/toddler/preschooler/child.** A child who has been removed from home and only allowed to see family members within certain structured settings – times, location and duration – may experience some attachment issues. Since early childhood is a particularly sensitive period for the development of the child's mental model of attachment, it is important to address attachment problems as soon as possible. Keep in mind that attachment issues may eventually affect successful reunification or other permanency options. Be sure to consider the possibility of such issues and discuss what needs to be in place to achieve successful permanency for a child. For example, if the plan is to reunify the child with his/her parents, identify what therapeutic services may need to be put into place both before and after reunification.

Support the Child's Development

- **Ask parents if early childhood partners can be invited.** Children placed in out of home care and who have been linked to early childhood care resources should be represented at permanency child and family team meetings by those who see them on a daily basis – particularly teachers and caregivers from early childhood settings. These individuals bring valuable knowledge about what the child needs from a permanent family and can share this knowledge with family members in a useful way.
- **Identify how the child's connections to family and community can be preserved.** Many permanency options can be constructed in ways that allow children to stay connected to both the family and to any substitute caregivers they may have become attached to. These opportunities should be discussed in light of their importance to the child's healthy development.

Support and Strengthen Parental and Caregiver Protective Factors

- **Explore barriers to developing healthy social connections.** Use the meeting as an opportunity to discuss how the parents could be assisted in developing healthy connections for themselves and their children. For example, unresolved family dynamics may be impeding the parents from having a healthy, supportive relationship with their own immediate and extended family. Discussing the importance of resolving those familial issues may lead to the identification of additional actions to help the child achieve permanency. Help parents determine who within their support network really can contribute positively to helping them and their child.
- **Model good relational behavior.** As the facilitator, help parents develop stronger relational skills by demonstrating effective interactions with others. Encourage the parents to interact with others by giving them the freedom to ask as many questions as they want and to respond to the information that is shared.
- **Provide parents with information about their child.** Use this opportunity to review the child's physical

and emotional progress and discuss how the parent perceives the child's progress. Help the parent understand how to use information about their child's development to identify the child's needs.

- ▶ **Make protective factors part of the conversation.** This teaming provides an important platform to think about what will happen after the case closes, and the protective factors can serve as a strength-based framework for that process. Helping caregivers to think about their on-going plan to support and build their own protective factors should be a major part of the conversation.

The Child's Medical Appointments

Children's medical appointments are an opportunity to obtain a professional assessment of the child's developmental progress and to determine whether additional services or supports need to be put in place. Parents and current caregivers should be asked to attend and participate in the appointment as an opportunity for them to share insights about their child and to learn about the child's needs. Such participation supports and validates the importance of their role in nurturing their infant/toddler/ children. It is also an opportunity to:

Respond to Signs of Trauma

- ▶ **Identify professionals who understand the trauma experiences of infants, toddlers and preschoolers involved in child welfare.** Visits to the doctor can be stressful for many people, children and adults alike. They can be particularly tense for children immediately after they have been removed from their birth parents and are entering placement. It is important to refer children to medical professionals who have an understanding of the challenges children in foster care face. Not every medical professional has this knowledge, so be careful to choose physicians who are trauma-informed.
- ▶ **Ensure the medical professional is made aware of child's history.** Physicians and nurses who see the child for the first time or on a regular basis need to know what the child has experienced in order to effectively respond. Once they have addressed basic physical health needs, they can also attend to and promote psychosocial recovery. For instance, they can help reframe the child's behaviors in a way that promotes deeper parental understanding and appropriate caretaker responses

Support the Child's Development

- ▶ **Regular health care visits for young children should include a developmental assessment.** The Early Prevention Screening Diagnosis and Treatment (EPSDT) requirements dictate early and regular assessments of children's developmental progress and physical health. Use these assessments to better support the child and be aware of what you should look for when you visit with the child or observe the child's interaction with caregivers. You can learn more about the EPSDT schedule for Connecticut here: <http://www.ctvoices.org/sites/default/files/files/cov07epsdtref.pdf>
- ▶ **Discuss your observations with health professionals.** Share what you are observing in your interactions with the child and ask for guidance as to what more you could be doing to support healthy development. You should also relay information you receive from caregivers or child care staff who cannot accompany you and the child to the visit. Be sure to bring up their questions and observations and report back to them after the visit.

Support and Strengthen Parental Protective Factors

- ▶ **Encourage parents/caregivers to prepare for the medical appointment.** Before the appointment, suggest that parents write down questions they have about the child's behavior and health. If they cannot think of any questions on their own, help them to generate some by going over your own observations or by referencing this guide. Try to help the parent/caregiver have at least one or two questions ready for the physician.
- ▶ **Model effective interactions with health professionals.** Caregivers can be intimidated by professionals in any discipline and may hesitate to ask questions or advocate for themselves or their child. By encouraging them to engage with health professionals, you can help them recognize that they can and should be asking questions, seeking clarifications and obtaining information that will help them support their child's well-being.

Case Closure

Closing a case creates a new “beginning” for the family. Case closure, therefore, is an opportunity to reflect with the caregiver and family about what has been accomplished and how their achievements can be sustained. In preparation for case closure, it is essential to reflect with the family on how they can independently:

Respond to Signs of Trauma

- ▶ **Reflect on the healing that has occurred.** As you review the presenting problem that brought the family to the attention of DCF and required a case to be opened, it is important to remind yourself and the parent of the trauma and stresses the child experienced, and how healing occurred for the whole family. Acknowledge that this may have been a difficult process and celebrate what has been accomplished in the face of adversity. Ask the parents to reflect on what they have learned and on their improved ability to respond positively to their child's needs. Review strategies they can continue to use to protect their child from any further trauma.
- ▶ **Ensure that therapeutic services will continue if necessary.** While acknowledging progress, also recognize that the parents and child may need services to continue the healing process as the child grows. Work with the family to ensure that they have the ability to access any necessary services. For example, you may need to help them to apply for Medicaid benefits or transfer their case to another service provider who can help them continue to move forward.

Support the Child's Development

- ▶ **Assess how well the parent can now support the child's social and emotional development.** Consider how effectively the parent has created an environment in which the child feels safe to express his or her emotions. What expectations do parents have of the child? Are those expectations realistic? Observe interactions between the caregivers and the child to determine that the quality and types of caregiver response will support the child's continued development.
- ▶ **Ensure that early childhood linkages established while the case was open will be continued.** As with ensuring continued access to any necessary therapeutic care, it is important for the child to remain connected to all early childhood support she/he received while separated from the family. Ideally, the child should

continue to have access to the provider they had while in care. However, this arrangement may not be realistic for the parents to maintain because of distance between their home and the provider. If that is the case, work with the parents to explore potential transportation options or to ensure they find another appropriate match for the child. If it is necessary for them to find the child an alternate provider, help them to find quality care and to plan a smooth transition for their child.

- ▶ **Ensure parents can address any special needs the child may have.** In some situations, the child will require special services— such as speech therapy or specialized medical care. In these situations, be sure to review with the parents what services will be needed and how they best meet those needs. Again, assist the parents with assessing service providers and completing applications for services and financial aid.

Support and Strengthen Parental and Caregiver Protective Factors

- ▶ **Reflect on the parents' accomplishments and personal growth.** This is a good time to review how the parent has improved his or her problem solving abilities, coping skills and parenting abilities. Discuss how they acquired these new abilities and what they can continue to do to maintain their progress. Explore how they will use what they have learned about themselves, their family and their child to handle challenging situations in the future.
- ▶ **Allow parents to express and discuss feelings of concern.** Acknowledge that they may still be working on strengthening some skills. Discuss their options for confronting any difficulties they may face. These options include seeking help from DCF as well as from their supportive network. Emphasize the self-care strategies they have put into place and the importance of maintaining those strategies.
- ▶ **Review their children's developmental progress.** Discuss how the child has grown and changed. Explore the developmental milestones the child has already reached, as well as the anticipated developmental changes the child will experience as he or she grows. Go over possible ways for parents to address these changes and answer any questions the parents may have about their child's future development.
- ▶ **Help the parent understand eligibility requirements for available services.** As noted, parents may need help navigating various social service systems. Helping parents understand social service eligibility requirements can be helpful. It is also important to make a warm handoff to other providers who can help them negotiate access to services they may need.

QUESTIONS TO ASK WHEN CONSIDERING CLOSING A CASE	INDICATORS OF CHANGE AS FRAMED BY PROTECTIVE FACTORS
<p>Has client functioning acceptably improved?</p>	<p><u>Strengthened Parental Resilience</u></p> <ul style="list-style-type: none"> • Improved problem solving skills • Better able to cope with stress/does not allow stress to impact parenting • Self-care strategies in place
	<p><u>Early Childhood Development</u></p> <ul style="list-style-type: none"> • Caregivers are emotionally responsive to the infant/toddler/preschooler/child(ren) • Caregivers have created an environment in which the child(ren) demonstrate a sense of safety to express emotions • Caregivers separate emotions from actions • Caregivers provoke age-appropriate social-emotional responses and encourage/reinforce social skills • Caregivers create opportunities for child(ren) to explore and solve problems
<p>How has parents' willingness and ability to reach out to others in times of need changed?</p>	<p><u>Strengthened Parental Resilience</u></p> <ul style="list-style-type: none"> • Help-seeking behavior improved • Receiving mental health or substance abuse services as needed
	<p><u>Enhanced Social Connections</u></p> <ul style="list-style-type: none"> • Caregivers have supportive relationships • Caregivers have a network they can turn to for help • Caregivers have relationship building skills
	<p><u>Concrete Support</u></p> <ul style="list-style-type: none"> • Caregiver is open to accessing and using services
<p>Do parents have realistic expectations for their child(ren)?</p>	<p><u>Knowledge of Parenting and Child Development</u></p> <ul style="list-style-type: none"> • Caregivers are more confident in their parenting skills • Caregivers have a new appreciation for their nurturing role • Caregivers have developed a balance for parenting and self-care • Caregivers better understand/encourage healthy development • Caregivers better understand/employ age-appropriate responses to child(ren)'s behaviors • Child(ren) responds more positively to the caregiver's approach • Caregivers are effectively linked to early childhood resources • Caregivers are involved in their child(ren)'s early childhood activities • Caregivers understand their child(ren)'s special needs and how best to meet those needs
	<p><u>Children's Social and Emotional Development</u></p> <ul style="list-style-type: none"> • Caregivers set clear and age appropriate expectations/limits • Caregivers have created an environment in which the child(ren) can safely express his or her emotions • Caregivers are emotionally responsive to the child(ren)

Opportunities to Share Family and Child Progress with Other Key Parties

Supervisory conferences and Administrative Case Reviews are two routine mechanisms that can be used during the life of a case to share information and gain insights from other involved parties.

Hold regular supervisory conferences. As DCF moves to a new and expanded definition of supervision, there are multiple opportunities for the ideas covered in this guide to be reinforced within the four broad goals of the supervisory process:

1. Ensure the quality of service provided to families.
 - Strive to gain a deeper understanding of the family's history and trauma experiences so as to better support the case work decisions and ensure that the needs of young children are attended to.
 - Assess how well services are matched to the individual/family strengths and needs.
 - Encourage case workers to seek additional support and information from early childhood partners.
2. Ensure that administrative tasks, such as documentation and case plans, are completed accurately and in a timely manner.
 - Coach case workers to effectively use tools available to them. For example, before documenting case plans, they can review genograms or eco-maps to obtain a more accurate understanding of the family's network and dynamics.
3. Provide support to staff in their roles as they face work-related challenges.
 - Make sure case workers develop self-care plans that can be implemented into their routines.
4. Help all staff to grow and develop their skills.
 - Model and coach the behaviors case workers should use with families, including a positive, strength-based approach.

Validate and support good decisions. Central to implementation is the expanded definition of supervision. This expanded definition calls for a collaborative implementation process that includes case consultation through Administrative Case Reviews. Administrative Case Reviews are a chance to reflect on the effectiveness of services and providers. In determining the effectiveness of placement plans and services, case workers should review:

- The child's trauma experience and how families and children have been connected to services and resources to address trauma experiences. This includes an evaluation of whether optimal healing has occurred or not.
- Developmental concerns that might have contributed to the placement and how they have been addressed. It is important to note whether child development has been enhanced and how services/resources could be improved.
- Family and service provider efforts to strengthen family's protective factors and the implications for continued placement and permanency.

Appendices

APPENDIX A1: Signs and Symptoms of Trauma—Ages 0 to 2

A child may have experienced trauma if he or she exhibits any of the following signs and symptoms:

- Acts withdrawn
- Demands attention through both positive and negative behaviors
- Demonstrates poor verbal skills
- Displays excessive temper tantrums
- Exhibits aggressive behaviors
- Exhibits memory problems
- Exhibits regressive behaviors
- Experiences nightmares or sleep difficulties
- Fears adults who remind them of the traumatic event
- Has a poor appetite, low weight and/or digestive problems
- Has poor sleep habits
- Screams or cries excessively
- Shows irritability, sadness, anxiety and fear in facial expressions, tone or body language
- Startles easily

APPENDIX A2: Signs and Symptoms of Trauma—Ages 2 to 6

A child may have experienced trauma if he or she exhibits any of the following signs and symptoms:

- Acts out in social situations
- Acts withdrawn
- Demands attention through both positive and negative behaviors
- Displays excessive temper
- Is anxious and fearful and avoidant
- Is unable to trust others or make friends
- Is verbally abusive
- Believes he or she is to blame for the traumatic experience
- Develops learning disabilities
- Exhibits aggressive behaviors
- Experiences nightmares or sleep difficulties
- Experiences stomachaches and headaches
- Fears adults who remind him or her of the traumatic event
- Fears being separated from parent/caregiver
- Has difficulties focusing or learning in school
- Has poor sleep habits
- Imitates the abusive/traumatic event
- Lacks self-confidence
- Shows irritability, sadness and anxiety
- Shows poor skill development
- Startles easily
- Wets the bed or self after being toilet trained or exhibit other regressive behaviors¹⁰

¹⁰ Source: National Child Traumatic Stress Network: <http://www.nctsn.org/trauma-types/early-childhood-trauma/Symptoms-and-Behaviors-Associated-with-Exposure-to-Trauma>

APPENDIX A3: Additional Resources on Trauma and Young Children

Connecticut Specific Resources

CT Association for Infant Mental Health: Sponsors training opportunities for staff specifically focused on the development of infants and toddlers in the context of their caregiving relationship.

<http://www.ct-aimh.org>

The Early Childhood Consultation Partnership (ECCP) is a mental health consultation program, designed to meet the social/emotional needs of children birth to five by offering support, education, and consultation to those who care for them. The Early Childhood Consultation Partnership© (ECCP): Provides resources including the “Tips for Tots”, a series of one-page flyers with information, recommendations, strategies and resources for working with infants, toddlers and preschoolers in foster care.

www.eccpct.com

Other National Resources

In addition, the following links are helpful resources for caregivers who want to support children who have experienced trauma:

- A guide for foster and adoptive parents on parenting a child that has experienced trauma: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FamilyHandout.pdf>
- Guide written for adoptive parents on providing care to a child that has experience trauma: http://www.fosteringperspectives.org/fp_v10n1/Kennedy&Bennett.pdf
- [The National Child Traumatic Stress Network](#). Includes a wealth of resources including a trauma training for child welfare workers.
- [Best Practice Tutorial Series](#) on the Center for Early Childhood Mental Health Consultations’ [website](#)
- [Identifying Seriously Traumatized Children: Tips for Parents and Educators](#) from the National Association of School Psychologists (pdf available [here](#))
- American Psychological Association: [Resilience Guide for Parents and Teachers](#)
- The NYU Child Study Center’s [Children’s Resilience in the Face of Trauma](#)
- US Department of Health and Human Services Administration for Children and Families, Child Welfare Information Gateway: [Resiliency in Children and Youth](#)

APPENDIX B1: Developmental Milestones for Infants (0-18 months)

Physical

0-3 MONTHS

- Demonstrates sucking, grasping reflexes
- Lifts head when held at shoulder
- Moves arm actively
- Is able to follow objects and to focus

3-6 MONTHS

- Rolls over
- Holds head up when held in sitting position
- Reaches for objects
- Lifts up knees, crawling motions

6-9 MONTHS

- Sits unaided, spends more time in upright position
- Learns to crawl
- Climbs stairs
- Develops eye-hand coordination

9-18 MONTHS

- Achieves mobility, has strong urge to climb, crawl
- Stands and walks
- Learns to walk on his or her own
- Learns to grasp with thumb and finger
- Feeds self
- Transfers small objects from one hand to another

Social-Emotional

- Wants to have needs met
- Develops a sense of security
- Smiles spontaneously and responsively
- Likes movement, to be held and rocked
- Laughs aloud
- Socializes with anyone, but knows mother or primary caregiver
- Responds to tickling
- Prefers primary caregiver
- May cry when strangers approach
- Consistently anxious
- Extends attachments for primary caregivers to the world
- Demonstrates object permanence; knows parents exist and will return
- Tests limits

Intellectual/Cognitive

- Vocalized sounds (coos)
- Smiles and expresses pleasure
- Recognizes primary caregiver
- Uses both hands to grasp objects
- Has extensive visual interests
- Puts everything in mouth
- Solves simple problems, e.g., will move obstacles aside to reach objects
- Transfers objects from hand to hand
- Responds to changes in environment and can repeat action that caused it
- Begins to respond selectively to words
- Demonstrates intentional behavior, initiates actions
- Realizes objects exist when out of sight and will look for them (object permanence)
- Is interested and understands words
- Says words like “mama,” “dada”

Act Early: Contact the Child's Pediatrician If:

By 2 months the child...

- Doesn't respond to loud sounds
- Doesn't watch things as they move
- Doesn't bring hands to his mouth
- Can't hold head up while on stomach and pushing up

By 4 months the child...

- Doesn't watch things as they move
- Doesn't smile at people
- Can't hold head steady
- Doesn't coo or make sounds
- Doesn't bring things to mouth
- Doesn't push down with legs when feet are placed on a hard surface
- Has trouble moving one or both eyes in all directions

By 6 months the child...

- Doesn't try to get things that are in reach
- Shows no affection for caregivers
- Doesn't respond to sounds
- Has difficulty getting things to mouth
- Doesn't make vowel sounds ("ah", "eh", "oh," etc.)
- Doesn't roll over in either direction
- Doesn't laugh or make squealing sounds
- Seems very stiff, with tight muscles
- Seems very floppy, like a rag doll

By 9 months the child...

- Doesn't bear weight on legs with support
- Doesn't sit with help
- Doesn't babble ("mama", "baba", "dada," etc.)
- Doesn't play any games involving back-and-forth play
- Doesn't respond to own name
- Doesn't seem to recognize familiar people
- Doesn't look where you point
- Doesn't transfer toys from one hand to the other

By 12 months the child...

- Doesn't crawl
- Can't stand when supported
- Doesn't search for things that he or she sees you hide
- Doesn't say single words like "mama" or "dada"
- Doesn't learn gestures like waving or shaking head
- Doesn't point to things
- Loses previously achieved skill sets/abilities

By 18 months the child...

- Doesn't point to show things to others
- Can't walk
- Doesn't know what familiar things are for
- Doesn't copy others
- Doesn't gain new words
- Doesn't have at least 6 words
- Doesn't notice or mind when a caregiver leaves or returns
- Loses previously achieved skill sets/abilities

APPENDIX B2: Developmental Milestones for Toddlers (18-36 months)

Physical

- Enjoys physical activities such as running, kicking, climbing, jumping, etc.
- Beginnings of bladder and bowel control develop towards latter part of this stage
- Increasingly able to manipulate small objects with hands

Social-Emotional

- Becomes aware of limits; says “no” often
- Begins establishing a positive, distinct sense of self through continuous exploration of the world
- Continuing to develop communication skills and experiencing the responsiveness of others
- Needs to exhibit autonomy and achieve some simple tasks for him/herself
- Making simple choices such as what to eat, what to wear and what activity to do

Intellectual/Cognitive

- Has a limited vocabulary of 500-3,000 words and is able to form three to four word sentences
- Has a basic grasp of prepositions (in, on, off, out, away, etc.)
- Most toddlers can count, but they do so from memory, without a true understanding of what the numbers represent
- Cognitively, children in this age range are very egocentric and concrete in their thinking and believe that adults know everything. This means that they look at everything from their own perspective.
- They assume that everyone else sees, acts and feels the same way they do, and believe that adults already know everything. This results in their feeling that they don’t need to explain an event in detail.
- Toddlers are able to relate their experiences, in detail, when specifically and appropriately questioned
- Learning to use memory and acquiring the basics of self-control

Source: National Resource Center for Permanency and Family Connections
Hunter College School of Social Work • 129 E. 79th Street • New York, NY 10021 • Tel. 212/452-7053 • Fax. 212/452-7051 • www.nrcfcppp.org

Act Early: Contact the Child’s Pediatrician If:

By 2 years the child...

- Doesn’t use 2-word phrases (for example, “drink milk”)
- Doesn’t know what to do with common things, like a brush, phone, fork, spoon, etc.
- Doesn’t copy actions and words
- Doesn’t follow simple instructions
- Doesn’t walk steadily
- Loses previously achieved skill sets/abilities

Source: The Centers for Disease Control and Prevention: “Learn the Signs. Act Early. Milestones 2 years – NCBDD.” Published online at: <http://www.cdc.gov/ncbddd/actearly/milestones/milestones-2yr.html>

APPENDIX B3: Developmental Milestones for Pre-Schoolers (3-6 years)

Physical

- Is able to dress and undress
- Has refined coordination and is learning many new skills
- Is very active and likes to do things like climb, hop, skip and do stunts

Social-Emotional

- Develops capacity to share and take turns
- Plays cooperatively with peers
- Is developing some independence and self-reliance
- Is developing ethnic and gender identities
- Learning to distinguish between reality and fantasy
- Learning to make connections and distinctions between feelings, thoughts and actions

Intellectual/Cognitive

- With pre-schoolers, their ability to understand language usually develops ahead of their speech
- By age 6, their vocabulary will have increased to between 8,000 and 14,000 words but it is important to remember that children in this age group often repeat words without fully understanding their meaning
- They have learned the use of most prepositions (up/down, ahead/behind, etc.) and some basic possessive pronouns (mine, his, ours, etc.) and have started to master adjectives
- Pre-school children continue to be egocentric and concrete in their thinking. They are still unable to see things from another's perspective, and they reason based on specifics that they can visualize and that have importance to them (i.e. "Mom and Dad" instead of "family").
- When questioned, they can generally express who, what, where and sometimes how, but not when or how many.
- They are also able to provide a fair amount of detail about a situation.
- It is important to keep in mind that children in this age range continue to have trouble with the concepts of sequence and time. As a result, they may seem inconsistent when telling a story simply because they hardly ever follow a beginning-middle-end approach

Act Early: Contact the Child's Pediatrician If:

By 3 years the child...

- Falls down a lot or has trouble with stairs
- Drools or has very unclear speech
- Can't work simple toys (such as peg boards, simple puzzles, turning handles, etc.)
- Doesn't speak in sentences
- Doesn't understand simple instructions
- Doesn't play pretend or make-believe
- Doesn't want to play with other children or with toys
- Doesn't make eye contact
- Loses previously achieved skill sets/abilities

By 4 years the child...

- Can't jump in place
- Has trouble scribbling
- Shows no interest in interactive games or make-believe
- Ignores other children or doesn't respond to people outside the family
- Resists dressing, sleeping and using the toilet
- Can't retell a favorite story
- Doesn't follow 3-part commands
- Doesn't understand "same" and "different"
- Doesn't use "me" and "you" correctly
- Speaks unclearly
- Loses previously achieved skill sets/abilities

By 5 years the child...

- Doesn't show a wide range of emotions
- Shows extreme behavior (unusually fearful, aggressive, shy or sad)
- Unusually withdrawn and not active
- Is easily distracted, has trouble focusing on one activity for more than 5 minutes
- Doesn't respond to people, or responds only superficially
- Can't tell what's real and what's make-believe
- Doesn't play a variety of games and activities
- Can't give first and last name
- Doesn't use plurals or past tense properly
- Doesn't talk about daily activities or experiences
- Doesn't draw pictures
- Can't brush teeth, wash and dry hands or get undressed without help
- Loses previously achieved skill sets/abilities

Source: The Centers for Disease Control and Prevention: "Learn the Signs. Act Early. Milestones 2 years – NCBDD." Published online at: <http://www.cdc.gov/ncbddd/actearly/milestones/index.html>

APPENDIX C1: Questions to Explore with Caregivers to Better Understand the Child’s Developmental Needs

From the DCF Purposeful Visitation Practice Guide:

- What is child’s daily routine? Is the child in any early childhood program to promote his/her development and learning?
- How does this child seek comfort?
- Is the child easy to soothe?
- How does this child show warmth and affection?
- What does he/she do when content/happy? How does the child show that he/she is upset, hurt, sad, afraid, etc.?
- Who does baby seek comfort from? Does the child show a preference to a particular adult or child?
- Who takes the child to medical appointments?
- Discuss medical appointments, any medical concerns, weight gain, etc.; Ensure that the parents know how to care for any special medical needs their child has.
- Discuss temperament—does the baby cry a lot? Does the toddler tantrum a lot?

Supplemental Questions for Parents/Caregivers:

- Is there anything about your child’s behavior that surprises you?
- Is there anything about your child’s behavior that frustrates you?
- Is there anything that your child has done that has made you want to ask questions about why he/she is doing that?
- Is there anything about your child’s development that worries you or makes it hard for you to parent?
- For preschoolers: Does your child play with other children his/her age?
- Do you notice things that your child can’t do that other children their age can do?
- What does your child do in the day time?
 - Enrolled in Early Head Start/Head Start program?
 - Enrolled in a child care or preschool program – either a child care center or licensed family child care home?
 - In an informal child care setting (with a friend, relative, neighbor or other informal provider)?
 - At home with the parent?
- Is your child receiving any other services to support their development?
- What would help your child thrive?
- For parents of infants: How has becoming a parent been for you?

APPENDIX C2: Questions for Other Key Informants to Better Understand the Child's Developmental Needs

Supplemental Questions for the Child's Child Care Provider:

- Do you have any concerns about how your child is growing? Learning?
- Do you notice things that this baby/young child can't do that other children their age can do?
- Was the child given a developmental screening in your program? If so when? Did this screening suggest any signs of developmental delays?
- Is there any other information about this child that would help others understand how to best support the child's development?
- What supports would help this child be successful in your program?
- Do you have concerns about this child's attachment relationship?

Supplemental Questions for the Pediatrician:

- When was the child's most recent developmental or behavioral screening? Were any concerns noted at that time?
- Overall, has the child's development been on track?
- Is there anything that is important for me to know about this child?

APPENDIX D: Connecticut's Commonly Used Screening Tools

Screening tools currently used by Head Start and Early Head Start programs in Connecticut:

- ▶ **Ages & Stages Questionnaire (ASQ):** A questionnaire used as a screener to monitor development in children from 1 month to 5 ½ years old.
- ▶ **Ages & Stages Questionnaire – Social Emotional (ASQ-SE):** A companion tool to the ASQ, the ASQ-SE is a questionnaire used to screen for appropriate social and emotional development in infants and young children.
- ▶ **Battelle:** A battery of tests which is designed to assess key developmental milestones in children from birth to age 8. The test administrator observes the child's ability to follow directions, interact and perform selected tasks. Information and observations from parents are used to supplement areas that cannot be assessed during test sessions. The child's performance is scored based on standardized criteria using a simple three point scoring system.
- ▶ **Brigance Early Childhood Developmental Inventory:** Tracks a child's progress toward an early learning standard. Plans for developmentally appropriate, individualized instruction are easily developed using this information. The inventory provides teachers with a flexible, valid and reliable ongoing assessment of school-readiness skills.
- ▶ **Developmental Indicators for the Assessment of Learning (DIAL)-3:** A tool for screening preschool and kindergarten children. It tests for five early childhood areas: motor skills, language skills, concept skills, self-help development skills and social development skills. The unique use of a station format allows for the screening of many children quickly and efficiently.
- ▶ **Early Screening Inventory-Revised (ESI-R™):** Provides a brief developmental screening instrument designed to be administered to children from 3.5 to 5.11 years of age. This screening is used to identify those students who may benefit from special education services. Research has shown the ESI-R to be highly reliable and valid.
- ▶ **Learning Accomplishment Profile - Diagnostic Edition (LAP-D):** Provides a systematic method for observing children functioning in the 30-72 month age-range. The purpose of this assessment is to assist teachers, clinicians and parents in determining individual skill development in four major developmental domains: gross motor skills, fine motor skills, cognitive skills and language skills. The results of the LAP-D help to develop a complete picture of a child's developmental progress so that individualized, developmentally appropriate activities can be planned and implemented. This assessment is designed for children with both typical and atypical development.
- ▶ **Devereux Early Childhood Assessment (DECA) – I, T and P:** An assessment of whether preschool children aged two to five possess protective factors. It evaluates the effectiveness of individual child and program-wide interventions and provides developmentally appropriate strategies to foster resilience. This assessment can also effectively screen for emotional and behavioral concerns.
- ▶ **Gesell Screen (GES):** A screening instrument that assists parents, educators and other professionals in quickly determining a child's Performance Level Rating. This rating labels development as Age Appropriate, Emerging or Concerning. Four domains of development are tested: cognitive skills, language skills, motor skills and social/emotional/adaptive skills. The GES can be reliably administered by persons with varying levels of experience in less than 20 minutes. GES scores are used to flag children who may benefit from further diagnostic evaluation.
- ▶ **Temperament & Atypical Behavior Scales (TABS):** TABS is specifically designed to identify temperament and self-regulation problems that can indicate a child's risk for developmental delay, as early as possible. Since it is a norm-referenced assessment tool, infants and young children who are at risk, or who have delays or disabilities, can qualify for essential early-intervention and behavioral support services they might not otherwise receive. This tool is appropriate for children ages 11 to 71 months.

Assessment tools currently used by Head Start and Early Head Start programs in Connecticut:

- **Brigance** (See above)
- **Creative Curriculum:** The Creative Curriculum for Infants, Toddlers, and Two's helps teachers understand developmentally appropriate classroom practices. It also facilitates the creation of daily routines and experiences that respond to children's strengths, interests and needs. The Creative Curriculum for Preschool is comprised of "The Foundation," five research-based volumes that provide the knowledge base of the curriculum, and "Daily Resources," which offer step-by-step guidance in the form of teaching guides. It also contains additional daily teaching tools. The Creative Curriculum for Preschool is fully aligned with the Head Start Child Development and Early Learning Framework and state early learning standards. The Creative Curriculum for Preschool enables children to develop confidence, creativity and lifelong critical thinking skills.
- **Teaching Strategies GOLD:** An observational system for assessing children from birth through kindergarten. It helps teachers observe children in the context of everyday experiences, which is an effective way to get to know them well and find out what they know and can do.
- **Parents as Teachers (PAT) Developmental Milestones:** PAT is a national home visiting models that supports a parent's role in promoting children's school readiness and healthy development. PAT home visitors provide health, hearing, vision and developmental screenings for eligible children through the use of approved screening tools and methods.
- **Connecticut Preschool Assessment Framework:** A curriculum-embedded tool for assessing 3- and 4-year old children in their preschool classrooms. This tool sets out comprehensive performance standards or learning outcomes. These curriculum and assessment frameworks enable teachers to plan and implement curriculums that address specific learning standards, and to observe and assess children's progress in achieving these standards.
- **Work Sampling:** This easy-to-use tool helps you collect information on the child's work and compare it to grade-specific guidelines. It allows you to identify what children are learning, what they are beginning to master and what they still need to work on. It also helps you use your observations and simplify the process of recording and interpreting the child's behaviors. Work Sampling also informs curriculum and instruction planning.

For more detailed information on commonly used screening tools please visit:
<http://www.nectac.org/~pdfs/pubs/screening.pdf>

APPENDIX D2: The Ages and Stages Questionnaire – 3rd Edition At-A-Glance

Purpose	Used as a screener to monitor development in children from 1 month to 5 ½ years old
Age range covered	1–66 months
Intervals	21 questionnaires and scoring sheets at 2, 4, 6, 8, 9, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54 and 60 months of age
Areas screened	Communication, gross motor, fine motor, problem solving and personal-social skills
Who completes it	Parents/caregivers complete questionnaires; professionals, paraprofessionals or clerical staff score them
Time	Each questionnaire takes 10–15 minutes to complete and just 1-3 minutes to score
Validity and reliability	Excellent—validity is .82 to .88, test-retest reliability is .91 and inter-rater reliability is .92
Languages	Questionnaires are available in English, Spanish and French
Other features	Cost-effective, reproducible, can be used alone or in conjunction with ASQ:SE
Online options	Online management with ASQ Pro for single-site programs, ASQ Enterprise for multi-site programs, ASQ Hub to link the two and ASQ Family Access for online questionnaire completion

APPENDIX E: Community Landscape Worksheet

	Providers	Contact Information	Connection Made
DCF			<input type="radio"/> Yes <input type="radio"/> Not Yet
Foster Care			<input type="radio"/> Yes <input type="radio"/> Not Yet
Head Start/Early Head Start(s)			<input type="radio"/> Yes <input type="radio"/> Not Yet
ECCp			<input type="radio"/> Yes <input type="radio"/> Not Yet
Supportive Housing for Families			<input type="radio"/> Yes <input type="radio"/> Not Yet
Child FIRST			<input type="radio"/> Yes <input type="radio"/> Not Yet
Child Care(s)			<input type="radio"/> Yes <input type="radio"/> Not Yet
DRS Provider			<input type="radio"/> Yes <input type="radio"/> Not Yet
Birth to Three Provider(s)			<input type="radio"/> Yes <input type="radio"/> Not Yet
Family Resource Center(s)			<input type="radio"/> Yes <input type="radio"/> Not Yet
Discovery/Early Childhood Council			<input type="radio"/> Yes <input type="radio"/> Not Yet
Family Homeless Shelter(s)			<input type="radio"/> Yes <input type="radio"/> Not Yet
Domestic Violence Provider/Shelter			<input type="radio"/> Yes <input type="radio"/> Not Yet
Family Based Recovery			<input type="radio"/> Yes <input type="radio"/> Not Yet
Fatherhood Programs & Services			<input type="radio"/> Yes <input type="radio"/> Not Yet
			<input type="radio"/> Yes <input type="radio"/> Not Yet
			<input type="radio"/> Yes <input type="radio"/> Not Yet
			<input type="radio"/> Yes <input type="radio"/> Not Yet

APPENDIX F: CT DCF-Head Start Protocol for Working Together (1999)

Section I – Identifying and Reporting Child Abuse and Neglect

- Head Start initiates calls to DCF Hotline
- DCF assists Head Start to establish reporting protocols
- DCF assists Head Start in training on child abuse and neglect

Section II – Communication on Open DCF Investigations

- Head Start provides information to DCF
- DCF provides feedback to Head Start on their reports to DCF
- DCF provides feedback to Head Start on reports alleging Abuse/neglect by a Head Start staff member

Section III – Treatment Planning and Case Management

- Head Start and DCF work together to plan on-going services
- Head Start assists families in making self-referrals for voluntary services with DCF

Section IV – Placement of Children

- Head Start assists DCF in identifying and locating relatives for Head Start children facing out-of-home placement
- Head Start and DCF will coordinate services to assist children placed outside of their communities

Section V – DCF Referrals to Head Start

- DCF caseworkers and foster parents initiate referrals to Head Start
- DCF assists Head Start in determining appropriate service options for DCF-involved families

Section VI – Agency Planning

- DCF assists Head Start in finding eligible families and assists Head Start in recruitment and enrollment
- DCF assists Head Start in planning efforts
- Head Start assists DCF in planning efforts
- Head Start assists DCF in identifying and recruiting relative and foster and adoptive homes

APPENDIX G1: Bright Futures Recommended Schedule for Pediatric Preventative Health Visits and Screenings – Infancy¹¹

Recommended Medical Screening — Infancy

UNIVERSAL	ACTION	NB	1W	1M	2M	4M	6M	9M	
Metabolic and hemoglobinopathy	Done according to state law	•	•	•	•				
Development	Structured developmental screen							•	
Oral health	Administer OH risk assessment						•	•	
Hearing	All NB before discharge; if not by discharge, in 1st month; verify documentation of screening results and appropriate rescreening by 2M		•	•	•	•			
SELECTIVE	RISK ASSESSMENT (RA)	ACTION IF RA +	NB	1W	1M	2M	4M	6M	9M
Blood pressure	Children with specific risk conditions or change in risk	Blood pressure	•	•	•	•	•	•	•
Vision	Prematurity with risk conditions, abnormal fundoscopic exam, parental concern (all visits); abnormal eye alignment (4M and 6M); abnormal cover/uncover test (9M)	Ophthalmology referral	•	•	•	•	•	•	•
Hearing	+ on risk screening questions	Referral for diagnostic audiologic assessment					•	•	•
Anemia	Preterm/LBW; not on iron-fortified formula	Hemoglobin or hematocrit					•		
Lead	+ on risk screening questions	Lead screen						•	•
Tuberculosis	+ on risk screening questions	Tuberculin skin test			•			•	

OH – oral health; NB – newborn; LBW – low birth weight

¹¹ Hagan, JF, Shaw JS, Duncan P, eds. 2008. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*, Third Edition. Pocket Guide. Elk Grove Village, IL: American Academy of Pediatrics. Pgs. 58 and 59

APPENDIX G2: Bright Futures Recommended Schedule for Pediatric Preventative Health Visits and Screenings – Early Childhood

Recommended Medical Screening — Early Childhood

UNIVERSAL	ACTION		12M	15M	18M	2Y	2½Y	3Y
Development	Structured developmental screen				•		•	
Autism	Autism Specific Screen				•	•		
Vision	Objective measure with age-appropriate visual acuity measurement (using HOTV; tumbling E tests; Snellen letters; Snellen numbers; or Picture tests, such as Allen figures or LEA symbols)							•
Hearing	Audiometry							
Anemia	Hematocrit or hemoglobin		•					
Lead*	Lead screen		•			•		
SELECTIVE	RISK ASSESSMENT (RA)	ACTION IF RA +	12M	15M	18M	2Y	2½Y	3Y
Oral health	No dental home	Referral to dental home; if not available, oral health risk assessment (12M, 18M, 2Y, 2½Y). Referral to dental home (3Y).	•		•	•	•	•
	Primary water source is deficient in fluoride	Oral fluoride supplementation	•		•	•	•	•
Blood pressure†	Specific risk conditions or change in risk	Blood pressure	•	•	•	•	•	
Vision	Parental concern or abnormal fundoscopic exam or cover/uncover test	Ophthalmology referral	•	•	•	•	•	
Hearing	+ on risk screening questions	Referral for diagnostic audiologic assessment	•	•	•	•	•	•
Anemia	+ on risk screening questions	Hematocrit or hemoglobin			•	•		•
Lead‡	+ on risk screening questions	Lead screen	•			•		
Lead	No previous screen or change in risk	Lead screen			•			
	No previous screen and + on risk screening questions or change in risk	Lead screen						•
Tuberculosis	+ on risk screening questions	Tuberculin skin test	•		•	•		•
Dyslipidemia	+ on risk screening questions; not previously screened with normal results (4Y)	Fasting lipid profile				•		

*Universal lead screen = high prevalence area or on Medicaid; †Beginning at age 3, blood pressure becomes part of the physical examination; ‡Selective lead screen = low prevalence area and not on Medicaid

APPENDIX H: Consent to Share Information

DCF-2131 (T) AUTHORIZATION FOR THE RELEASE OF INFORMATION TO THE DEPARTMENT OF CHILDREN AND FAMILIES

Revised 3/2012



I _____, authorize

(Name of person granting permission)

(Name and address of person, institution or organization in possession of records)

to disclose to the Department of Children and Families (DCF) and

_____ information/records pertaining to:

(Name, address and telephone number of DCF staff receiving the information)

(Name and DOB of person who is the subject of the record)

Type of information/records to be released (check all that apply):

Psychiatric Psychological Medical Education Medication

Psycho-therapy notes (*NOTE: a request for psycho-therapy notes cannot be combined with a request for any other records.*)

Other (specify) _____

I specifically authorize the release of the following sensitive information from my record (**initial all that apply**):

____ Substance abuse (alcohol/drug)

____ Sexually transmitted diseases

____ Confidential HIV/AIDS-related information

____ Genetic testing

The purpose of this authorization/disclosure is to provide information to DCF for use in case planning, judicial proceedings related to child protection, development/implementation of an educational program or any other purpose for which this information can be lawfully used.

The nature and extent of the information to be disclosed is the entire record unless otherwise specified below:

This authorization, if not revoked, will expire on _____ or in one year, whichever occurs first.

I understand that refusal to sign this authorization form will not affect my right to obtain present and future services from DCF, except where disclosure of the records requested is necessary for services. I also understand that I may revoke this authorization by notifying DCF in writing. A revocation of this authorization will not apply to any records disclosed before the authorization is revoked. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by federal law.

(Signature of person giving permission or authorized representative)

Date

Check if this form has been signed by a person other than the subject of the record:

parent/guardian attorney guardian ad litem other (**explain**) _____

NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV/AIDS records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit the recipient of the records from making any further disclosure without specific written consent of the person to whom the record pertains. A general authorization for the release of this information is **NOT** sufficient for this purpose.

APPENDIX I: Resources on Children’s Social and Emotional Competence

Zero to Three:

- ▶ [Tips and tools for supporting your child’s social and emotional development](#)
- ▶ Contains a lot of helpful resources for promoting social and emotional development like podcasts, tip -sheets, scholarly articles and info sheets, including:
 - ▶ [Tips for Promoting Social-Emotional Development](#) - Discusses how parents can support their child’s social-emotional development through everyday interactions.
 - Information about social-emotional development at three different ages:
 - [Birth to 12 months](#)
 - [12 to 24 months](#)
 - [24 to 36 months](#)
 - These age-based handouts focus on how children begin learning self-control—the ability to manage their emotions and stick to the limits that are set.
 - [Birth to 12 months](#)
 - [12 to 24 months](#)
 - [24 to 36 months](#)

Center on the Social and Emotional Foundations for Early Learning

- ▶ [Resources: Family Tools](#), which include several training modules, such as:
 - [Infant/Toddler Training Modules](#)
 - [Pre-School Training Modules](#)
 - [PreSchool Parent Training Modules](#)
 - [Infant/Toddler Parent Training Modules](#)

American Academy of Pediatrics

- ▶ [Tips to Promote Social-Emotional Health Among Young Children](#)

www.AbilityPath.org

- ▶ [How to Support Your Child’s Social-Emotional Development](#)
- ▶ Contains an overview of some ways to support a child’s social-emotional development

Center for Early Childhood Mental Health Consultation

- ▶ Georgetown University Center for Child and Human Development
- ▶ [Tutorial 6 · Recognizing and Supporting the Social and Emotional Health of Young Children Birth to Age Five](#)
- ▶ Contains a detailed understanding of the behaviors related to social and emotional health in infants and young children, as well as strategies that adults can use to support these behaviors within every day routines in the home and within early care and education settings.

Syracuse University

- ▶ Mid-State Central Early Childhood Direction Center Bulletin Summer 2009
- ▶ [Understanding Social and Emotional Development in Young Children](#)
- ▶ Provides information about social and emotional development and answers key questions.

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