

# Addressing the Mental Health Needs of Young Children in the Child Welfare System

*What Every Policymaker Should Know*

Janice L. Cooper | Patti Banghart | Yumiko Aratani

September 2010



The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

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This issue brief explores what we currently know about the prevalence of young children (ages birth to 5) in the child welfare system, how the occurrence of maltreatment or neglect affects their development, and the services currently offered versus needed for these young children. It is based on the "Strengthening Early Childhood Mental Health Supports in Child Welfare Systems" emerging issues roundtable convened by NCCP in New York City in June 2009. The meeting brought together child welfare research, policy, and practice experts and family leaders to discuss the mental health needs of young children and suggest new directions (See Appendix for list of participants). We also present our analyses based on the National Child Abuse and Neglect Data System (NCANDS) Child File, 2006. NCANDS is a voluntary national data collection and analysis system established as a result of the requirements of the Child Abuse and Prevention Treatment Act (CAPTA).

### AUTHORS

Janice L. Cooper, PhD, is interim director at NCCP and assistant clinical professor, Health Policy and Management at Columbia University Mailman School of Public Health. Dr. Cooper directs *Unclaimed Children Revisited*, a series of policy and impact analyses of mental health services for children, adolescents, and their families. From 2005 to 2010, she led NCCP's health and mental health team.

Patti Banghart, MS, is a research associate at NCCP who conducts research on early care and education, child welfare, and children's mental health. She is part of NCCP's children's mental health and early childhood research teams.

Yumiko Aratani, PhD, is senior research associate at the National Center for Children in Poverty. Her research has focused on the role of housing in stratification processes, parental assets and children's well-being

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### Introduction: Why Focus on Mental Health in the Child Welfare System?

The early years of life present a unique opportunity to lay the foundation for healthy development. It is a time of great growth and of vulnerability. Research on early childhood has underscored the impact of the first five years of a child's life on his/her social-emotional development. Negative early experiences can impair children's mental health and affect their cognitive, behavioral, and social-emotional development.<sup>1</sup> Developmental research has shown that consistent, responsive, and nurturing early relationships foster emotional well-being in young children, as well as create the foundation for the behavioral, social, and cognitive development essential for school readiness.<sup>2</sup> Parents are one of the primary influences on a child's healthy development. Given parents' central role, it is not surprising that children's experience of abuse and neglect especially in early childhood can pose major risks to their development.

Children younger than three years of age are the most likely of all children to be involved with child welfare services,<sup>3</sup> and young children who have been maltreated are subsequently at risk for experiencing developmental delays. Maltreatment in children younger than 3 years of age has been found to be associated with concurrent gross and fine motor delays,<sup>4</sup> failure to thrive,<sup>5</sup> heightened arousal to negative emotions,<sup>6</sup> speech and language delays,<sup>7</sup> and hypervigilance.<sup>8</sup>

Age of the first episode of maltreatment is associated with mental health problems in adulthood. For example, maltreatment at age 2 to 5 has been linked with anti-social personality disorder by age 29. Younger ages of onset (birth to 2) were associated with depression and other internalizing disorders by age 40.<sup>9</sup>

Research on preschoolers exposed to family violence showed increased rates of disturbances in self-regulation and in emotional, social, and cognitive functioning.<sup>10</sup>

Placement out of the child's home also increased the risk for mental health problems for young children. Infants who experience maltreatment and placement in foster care faced the greatest risk for emotional and behavioral problems. Infants in foster care had longer placements, higher rates of reentry into foster care (experiencing recurrent maltreatment and disruption of family bonds), and high rates of behavioral problems, developmental delays, and health problems.<sup>11</sup>

Child welfare agencies have historically focused on children's safety and placement options but have been ill equipped to address children's developmental needs and to access necessary and comprehensive referrals for early intervention services. Since 2000, the Federal Government has assessed states on their "substantial conformity" with federal requirements

designed to promote positive outcomes in the areas of safety, permanency and well-being for children in the child welfare system. The process results in a state Child and Family Services Review (CFSR) report and a Program Improvement Plan.<sup>12</sup>

In an analysis of 2002 Child and Family Services Reviews (CFSRs) reports and Program Improvement Plans (PIPs) from 32 states, investigators indicated that 97 percent of those states did not meet the standard in providing adequate services to meet the “physical and mental well-being” of the children under their care.<sup>13</sup> Only two states rated mental health for the children they served as a strength of their system.<sup>14</sup> The most common challenges included lack of service capacity and poor quality (11 states); lack of standardization in use and types of health, mental health, and developmental assessments (six states); inability to appropriately match children with needed services (15 states); poor family involvement (15 states); and the absence of appropriate placement options for children (nine states).<sup>15</sup> In general, states performed poorly when it came to mental health compared to other indicators of child well-being. Only one state in the review indicated they had a developmental assessment appropriate for very young children.<sup>16</sup>

Changes to federal policy through the Child Abuse and Prevention Treatment Act (CAPTA) in 2003 required child welfare agencies to have provisions in place to identify and refer young children to early intervention services.<sup>17</sup> The role of child welfare workers to address children’s mental health was therefore greatly expanded under such legislation. How have child welfare workers addressed this new role? How is the mental health and development of young children in the child welfare system being addressed?

This issue brief explores what we currently know about the prevalence of young children (ages birth to 5) in the child welfare system, how the occurrence of maltreatment or neglect affects their development, and the services currently offered versus needed for these young children. It is based on the “Strengthening Early Childhood Mental Health Supports in Child Welfare Systems” emerging issues roundtable convened by NCCP in New York City in June 2009. The meeting brought together child welfare research, policy, and practice experts and

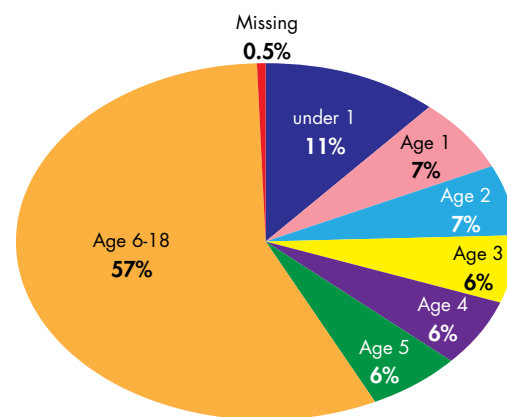
family leaders to discuss the mental health needs of young children and suggest new directions for policy and practice. (See Appendix for list of participants.) We also present our analyses based on the National Child Abuse and Neglect Data System (NCANDS) Child File, 2006. NCANDS is a voluntary national data collection and analysis system established as a result of the requirements of the CAPTA.

### Why Focus on Young Children (Birth to Age 5)?

Research shows that the younger the child, the more likely he or she is to experience involvement with the child welfare system. Children younger than three years of age are the most likely of all children to become involved with Child Welfare Services,<sup>18</sup> and they have the highest rate of victimization of maltreatment among all age groups. Nearly 32 percent (31.9 percent) of all victims of maltreatment were children age birth to 3, and 12 percent of those children were under a year old. Boys under the age of 1 had the highest rate of victimization at 22.2 per 1,000 children. In general, victimization rates decrease with age.<sup>19</sup> Likewise, the number of children with substantiated cases of abuse or neglect is high: 794,000 (10.6/1000).<sup>20</sup> There were 510,000 children in out-of-home care and 33 percent of children in out-of-home care were age 5 or younger in 2006.<sup>21</sup>

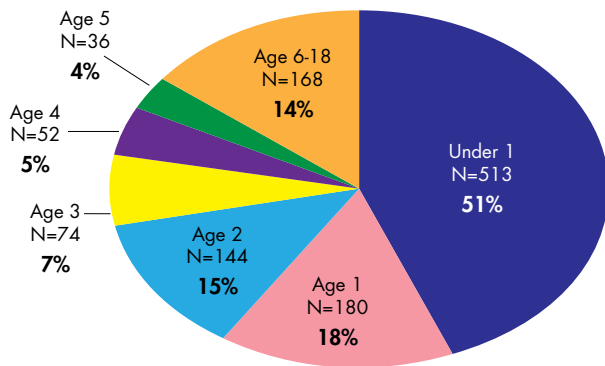
- ◆ Nationally, there were an estimated 1,760 child fatality victims; and three-quarters (75.7 percent) of child fatality victims were younger than 4 years old. Infant boys (under one year of age) had the highest fatality rate of 18.85 per 100,000 boys of the same age.<sup>22</sup>

Graph 1: Proportion of victimized children by age group



Data source: Based on NCCP analysis on NCANDS Child File, 2006\*

**Graph 2: Proportion of children by age group who died as a result of maltreatment**



Data source: Based on NCCP analysis on NCANDS Child File, 2006\*

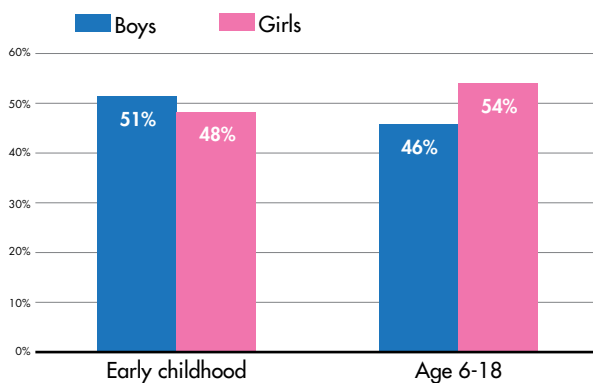
- ◆ There were more fatality victims in 2007, compared with 1,168 in 2006 (see Graph 2).
- ◆ More than 85 percent of children who died as a result of maltreatment are under age 6 (see Graph 2).
- ◆ Moreover, 21 percent of all children in foster care entered prior to their first birthday. Forty-five percent of all infant placements occurred within 30 days of the child's birth.<sup>23</sup>

### Characteristics of Young Children in the Child Welfare Systems

#### Young boys are more likely than young girls to be abused.

- ◆ Boys under the age of one had the highest rate of victimization at 22.2 per 1,000 children.<sup>24</sup> Among young children, boys are more likely to be victimized than girls, while girls increase the risk of victimization after age 6 (Graph 3).

**Graph 3: Gender of victimized children by age group (%)**



Data source: Based on NCCP analysis on NCANDS Child File, 2006\*

### Box 1: What defines child abuse and neglect?

Child abuse and neglect are defined by federal and state laws. The Federal Child Abuse Prevention and Treatment Act (CAPTA) provides minimum standards that States must incorporate in their statutory definitions of child abuse and neglect. The CAPTA definition of "child abuse and neglect," at a minimum, refers to:

- "Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

Nearly all States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands provide civil definitions of child abuse and neglect in statute (MA defines it in regulation). States recognize different types of abuse in their definition of abuse and neglect including: physical abuse, neglect, sexual abuse, and emotional abuse.

- Physical abuse: generally defined as "any nonaccidental physical injury to the child" and can include striking, kicking, burning, or biting the child, or any action that results in a physical impairment of the child.
- Neglect: frequently defined as the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision such that the child's health, safety, and well-being are threatened with harm. Neglect also includes: the failure to educate a child as required by law in twenty-four states and U.S. territories; failure to provide special medical treatment is defined as medical neglect in seven states and withholding of medical treatment or nutrition from disabled infants with life-threatening conditions is considered medical neglect in four states.
- Sexual abuse: all states include sexual abuse in their definitions of child abuse.
- Emotional abuse: nearly all states include emotional maltreatment in their definition of abuse and neglect. Thirty-two states provide specific definitions of emotional abuse to a child.
- Victimized child is defined as a child for whose incident of abuse or neglect was determined to be accurate as a result of an investigation or assessment or there is significant evidence to suspect maltreatment.
- Substantiated cases are defined as cases where state law or state policy supported or found the allegation of maltreatment or risk of maltreatment to be accurate as a result of their investigation. This is considered to be the highest level of finding by a State Agency.

Source: U.S. Department of Health and Human Resources. Administration for Children and Families. Child Welfare Information Gateway [http://www.childwelfare.gov/systemwide/laws\\_policies/statutes/define.cfm](http://www.childwelfare.gov/systemwide/laws_policies/statutes/define.cfm). Also see endnote 19.

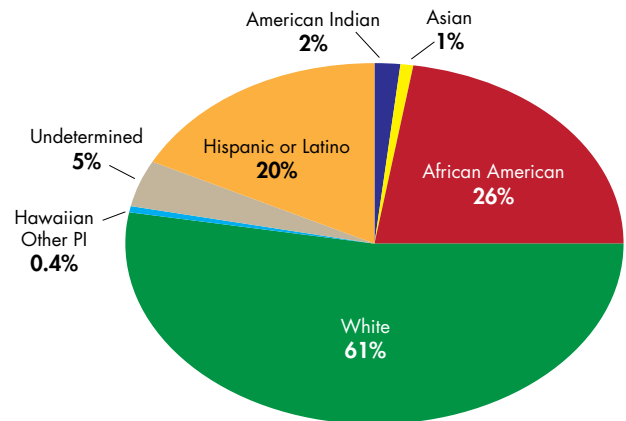
**Young children of color have high rates of victimization and substantiated abuse/neglect.**

- ◆ African-American children, American Indian/Alaska Native children, and children of multiple races had the highest rates of victimization at 16.7, 14.2, and 14.0 per 1,000 children of the same race or ethnicity, respectively.<sup>25</sup>
- ◆ Among young children (under age 6) who were reported to be victimized in 2006, African-American children were over-represented (26 percent) compared to their representation among the total child population (14 percent). American Indian children are also over-represented (two percent) compared to their representation in the total population (one percent) (see Graph 4).
- ◆ Among young children involved in child welfare investigations, overall over one-third of children are found to be victimized. This rate varies only slightly across racial/ethnic groups (see Graph 5).
- ◆ Young African-American children have disproportionately higher rates of referrals and substantiation and removal from their parent's home than other racial and ethnic counterparts.<sup>26</sup>
- ◆ Young African-American children are three times more likely to be placed in foster care than young white children.<sup>27</sup>

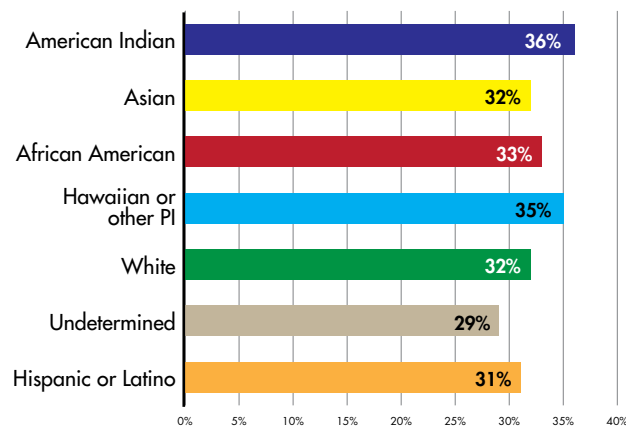
**Children who are abused or neglected are more likely to have medical or developmental conditions.**

- ◆ Children with chronic medical or developmental conditions experience an even higher level of involvement with child welfare, including an increased likelihood of removal from parental care and a prolonged stay in foster care, compared to their peers.<sup>28</sup>
- ◆ Over 8,000 young children who are victimized have some medical conditions. There are also about 700 to 1000 victimized children with reported disabilities, however because of a large amount of missing data, it is difficult to reliably report prevalence information (Based on NCCP's analysis on National Child Abuse and Neglect Data System (NCANDS) Child File).

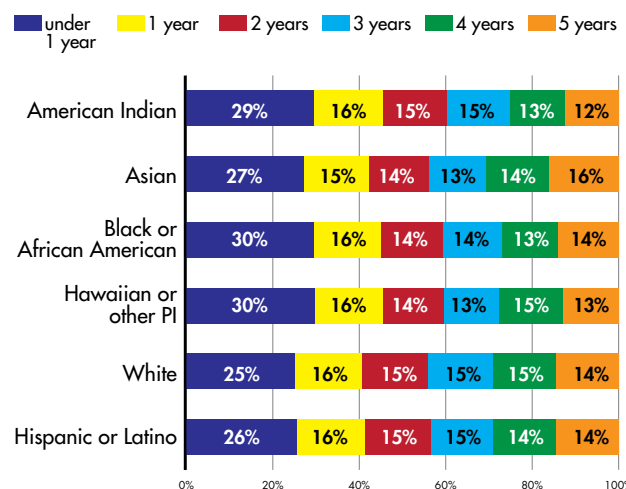
**Graph 4: Racial and ethnic composition of victimized young children**



**Graph 5: Proportion of those victimized among investigated cases by race/ethnicity**

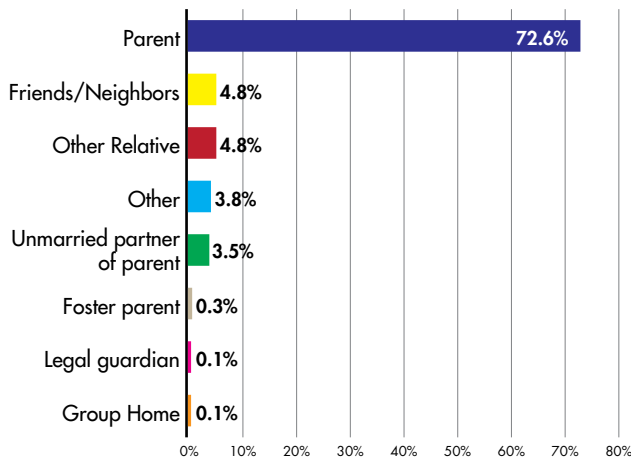


**Graph 6: Age distributions of children who are victimized by race/ethnicity**



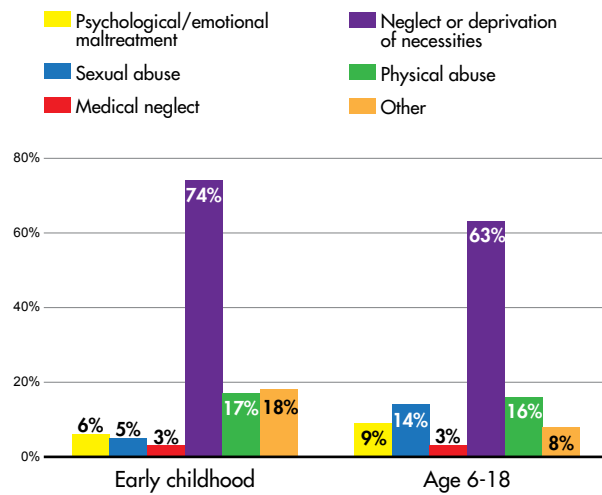
Data source: Based on NCCP analysis on NCANDS Child File, 2006\*

**Graph 7: Type of perpetrator's relationship to victimized children**



Data source: Based on NCCP analysis on NCANDS Child File, 2006\*

**Graph 8: Type of maltreatment by age group (%)**



Data source: Based on NCCP analysis on NCANDS Child File, 2006\*

**Young children are most often abused by their parent or parents.**

- ◆ Among young children, more than three-quarters of them are abused by their parent or parents (see Graph 7).

**Caretakers of children who are victimized tend to abuse alcohol and drugs, be exposed to domestic violence, and receive public assistance.**

- ◆ Analysis of the NCANDS Child File 2006 shows that the most frequently reported conditions that caretakers of children faced were domestic violence followed by receiving public assistance, drug use, inadequate housing and financial problems. However, it should be noted that there is a lot of missing information in this data.

**List A: Top five conditions that caretakers of children who are victimized face**

- Domestic Violence
- Public Assistance
- Drug Abuse
- Inadequate Housing
- Financial Problems

Data source: NCCP's analysis on NCANDS Child File in 2006

**What Type of Maltreatment Do Young Children in Child Welfare Face?**

Maltreatment constitutes several forms of neglect and abuse. These range from physical neglect (including medical neglect, abandonment, failure to provide sustenance and security for a child), to emotional and educational neglect. Abuse falls into three major categories, physical, sexual and emotional/psychological.

- ◆ Young children are most likely to experience neglect or deprivation of necessities (75 percent), followed by physical abuse (17 percent), psychological/emotional maltreatment (six percent), sexual abuse (five percent) and medical neglect (three percent) (see Graph 8).
- ◆ Children removed from their home because of neglect are more likely to be younger when they enter the child welfare system (under 5 years old) and experience less favorable permanency outcomes.<sup>29</sup>

**Research shows that child maltreatment may begin in utero with prenatal exposure to substances. Other risks include neglect and abuse/neglect leading to death in a small proportion of cases. While uncommon, child fatalities in child welfare are more likely to occur with young children.**

- ◆ Nearly 80 percent of children in foster care have prenatal exposure to substances. Forty percent of children in foster care are born at low birth weight or prematurely.<sup>30</sup>
- ◆ Of those victims who were medically neglected, 20.4 percent were younger than 1 year old.<sup>31</sup>

Factors that predict risks for infant maltreatment include the following:<sup>32</sup>

- ◆ smoking during pregnancy;
- ◆ infant having two or more siblings;
- ◆ medicaid enrollee;
- ◆ unmarried;
- ◆ infant low-birth weight;
- ◆ less than high school education;
- ◆ teen mother;
- ◆ short spacing (under 15 months) between pregnancy;
- ◆ poor pre-natal care; and
- ◆ adverse outcomes in prior pregnancy.

### *What Are the Mental Health Needs of Children Age Birth to 5 and Their Families in the Child Welfare System?*

Research shows a high prevalence of mental health disorders and developmental delays among children and youth in the child welfare system. Young children appear to have the greatest unmet needs.

- ◆ As many as 80 percent of all youths involved with child welfare agencies have emotional or behavioral disorders, developmental delays, or other indications of needing mental health intervention.<sup>33</sup> A significant proportion of these children (32 to 42 percent) are under age 6.<sup>34</sup> The prevalence of behavioral health problems experienced by young children (2 to 5 years old) in child welfare ranged from 32 percent to 42 percent.<sup>35</sup> Among young children (2 to 5 years old) in child welfare, 32 percent had an identified mental health need yet less than seven percent of these children received services to meet those needs.<sup>36</sup>
- ◆ Young children in child welfare were less likely than any other age group to access needed services (7 percent versus 16 percent and 26 percent respectively for other age groups).<sup>37</sup>

- ◆ Only young children who had experienced child sexual abuse were more likely to access mental health treatment (nearly four times more likely than their peers without such abuse).<sup>38</sup>
- ◆ For preschoolers in child welfare who did access mental health services, 40 percent entered the mental health service system without a diagnosis or with identified needs related to family stress and were identified as having problems with adjustment.<sup>39</sup>
- ◆ The number of children already in foster care under the age of 3 with established disabilities and developmental delays is almost 10 times the rate of children in the general population.<sup>40</sup>
- ◆ Seventy-five percent of children entering foster care between 12 and 36 months of age with no formal diagnosis were at medium to high risk for neuro-developmental problems.<sup>41</sup>
- ◆ Fifty-five percent of children under the age of 3 with substantiated cases of maltreatment are subject to at least five risk factors associated with poorer developmental outcomes.<sup>42</sup>
- ◆ Thirteen to 62 percent of young children entering foster care have developmental delays, which is four to five times the rate found among all other children.<sup>43</sup>
- ◆ Infants who are maltreated often experience insecure attachment and have parents who had insecure attachment relationships with their own caregiver.<sup>44</sup>
- ◆ A study of the profile of young children (4 to 6 year olds) in child welfare who used mental health services suggests that young service users were more likely to be male, in out-of-home placements, white, have a caregiver with high education, and experience multiple risks.<sup>45</sup>
- ◆ Young children in one study who accessed mental health services experienced variation in receipt of services by gender and race. Young boys were almost twice as likely to receive mental health services as girls and Black boys were less than one-third as likely to receive mental health services.<sup>46</sup>

**In addition, parents of young children have high mental health needs that may also impact their children's well-being.**

- ◆ According to the National Survey of Child and Adolescent Well-Being, 15 percent of investigated caregivers had a serious mental health problem.<sup>47</sup>



- ◆ Maltreatment by a caregiver in childhood has been associated with involvement in the child welfare system later as a parent.<sup>48</sup>
- ◆ One study in a large metropolitan area indicated that an estimated 20 percent of parents who come into contact with the child welfare system had a mental health diagnosis.<sup>49</sup>
- ◆ Within a group of mothers of young children (age birth to 18 months), who had been reported to the child welfare system but whose children remained at home, 36 percent experienced depressive symptoms.<sup>50</sup>
- ◆ Parental mental health conditions were among the factors that predicted behavioral disorders and specialty mental health service use over three years.<sup>51</sup>

## Challenges Associated with Meeting the Mental Health Needs of Young Children in the Child Welfare System

### *What Services Are Young Children with Mental Health Needs in the Child Welfare System Receiving?*

Research demonstrates that young children with child welfare involvement should receive a range of services and supports to ensure their optimal development. The target of these interventions include enhancing relationships with caregivers and improving social emotional competencies of young children; promotion of social emotional skills and well-being; helping parents in supporting the social emotional development of their children; increasing parents' and caregivers' ability to support the social emotional competence of their children and facilitating access to needed developmentally appropriate services and supports.<sup>52</sup>

These strategies should include:

- ◆ **Assessments** with a focus on maltreatment or risk of maltreatment and placement history. These assessment should include key components such as:<sup>53</sup>
  - medical history and status;
  - developmental assessment; and
  - mental health evaluation.
- ◆ Core elements of an assessment should encompass:
  - child/caregiver interactions;
  - family/parent functioning;
  - assessment of risks;
  - individual and family characteristics of caregivers;
  - caregiver mental health status; and
  - caregiver's parenting competencies.

- ◆ **Effective intervention strategies promote parent/caregiver and child relationships and foster attachment. These include:**
  - parent-child psychotherapy;
  - parent/caregiver-child interactions guidance, coaching and supports;
  - relationship-based approaches;
  - empirically-supported parent education strategies; and
  - social-emotional competency development and skills-building.

### **Many young children in the child welfare system are not receiving needed developmental supports.**

- ◆ While many children who are maltreated may be candidates for early intervention services, research shows that few are typically enrolled.<sup>54</sup>
- ◆ Less than 40 percent of states report that an individual with social-emotional developmental expertise is part of the multi-disciplinary team that determines eligibility for Part C services.<sup>55</sup>
- ◆ Among young children with identified needs, the rate of service use is very low. Only 20 percent of children age birth to 2 used developmental services.<sup>56</sup>
- ◆ Twelve months after an investigation of maltreatment, only 28 percent of children still younger than 36 months of age were reported by case-workers to have an Individualized Family Service Plan (IFSP), the mechanism for determining service planning and access for the Early Intervention Programs for Infants and Toddlers with Disabilities (Part C) services.<sup>57</sup>

- ◆ Approximately 37 to 67 percent of the families of infants and toddlers with substantiated cases of maltreatment received parent training or family counseling through child welfare systems (prior to 18-month follow-up) but it is unclear the extent to which these services focus on enhancing child development.<sup>58</sup>

### Young children in the child welfare system are not receiving the services and supports that they need to meet their social and emotional-related developmental needs.

- ◆ One national study of child welfare agencies in the U.S. found that more than half of all agencies surveyed did not systematically require mental health evaluations of children entering foster care.<sup>59</sup>
- ◆ The majority of child welfare agencies do not screen children in the system for mental health problems and among those that do, few report using valid and reliable screening instruments.<sup>60</sup>
- ◆ A recent study found that only 52 percent of states included relationship-based treatments under the benefits available for Part C services and fewer than 33 percent had programs that supported access to respite services.<sup>61</sup>
- ◆ One study of children in child welfare that included young children (4 to 6 years old) showed no improvement as a result of the mental health services they received leading investigators to question both the quality and appropriateness of the interventions.<sup>62</sup>

### What Are the Most Important Barriers to Care?

#### Child Welfare agencies lack the necessary services, training, and supports to meet the mental health and developmental needs of young children under their auspices.

- ◆ Child welfare workers often do not recognize developmental problems.<sup>63</sup>
- ◆ When children are referred, early interventionists may be unprepared to address the additional challenges inherent in working with maltreated children, their families, and child welfare systems.<sup>64</sup>
- ◆ Despite legislative requirements, many child welfare agencies have not had an adequate referral mechanism for developmental services.<sup>65</sup>

#### Agencies lack a systemic approach for identifying children with mental health and developmental needs.

- ◆ Ninety-four percent of child welfare agencies had policies about screening for *physical health problems*, but only 47.8 percent had policies for mental health problems, and only 57.8 percent for developmental problems.<sup>66</sup>

#### State systems often do not have the supports in place for a collaborative approach that meets the service needs of children and their families.

- ◆ Short-sighted fiscal policies hamper efforts to bring effective strategies to young children and their families.<sup>67</sup>
  - Up to half of all states reported that they fund a variety of mental health services for young children through their mental health authority. These ranged from supporting early childhood mental health specialists in community mental health centers (21 states) to mental health consultation in early childhood programs (26 states) to use of social emotional screening tools (16 states).
  - In 29 states Medicaid will only reimburse for services to young children if they have a diagnosis. Ten states reported that they did not allow Medicaid reimbursement for services delivered in child care settings. Only 16 states reported that they permitted for young children Medicaid reimbursement for mental health consultation without a diagnosis. Recall that up to 40 percent of young children in specialty mental health treatment did not have a diagnosis or were seen as a result of stress-related conditions in the family.<sup>68</sup>
  - Medicaid policies in many states do not permit reimbursement for some empirically-supported services for young children. In addition, services for children without a diagnosis but who may be at risk are significantly under-resourced.<sup>69</sup>
- ◆ Poor provider capacity plagues the mental health system for children in general and young children in particular.
  - A review of top issues that states indicated they faced related to service capacity obstacles included a lack of specialized medical providers, lack of training of child welfare providers to accurately assess mental health needs and the lack of core competency in child maltreatment issues among providers available to them.<sup>70</sup>

- Policy research suggests the acute need to enhance the training of mental health providers to develop competencies in serving young children.<sup>71</sup>
- Recent studies of pre-schoolers indicate variation in the profile of children who experience maltreatment. For example different types of maltreatment and levels of severity are associated with different forms of cognitive functioning and behavioral disorders. This information has implications for practice and practitioners’ training.<sup>72</sup>
- ◆ Only 10 states indicated that they required a mental health assessment upon entry to child welfare. Within this group, four states indicated that they assessed based on developmental or age criteria or type of maltreatment.<sup>73</sup>
- ◆ Children with special health care needs who are at risk of maltreatment face even more obstacles that included poor language access, lack of specialized supports, and difficulty in obtaining mental health services for this population.<sup>74</sup>
  - In a national review of teams that evaluated children with special health care needs, non-English language access was poor to non-existent with less than 30 percent of providers indicating that they could locate or access sign language. Only 20 percent could provide access in a language other than English or Spanish, and only 50 percent were able to provide Spanish language access.
  - Moreover, nearly 70 percent of respondents indicated that they did not have special training or a special program for children with special health care needs. Over 80 percent indicated they needed more time to evaluate children with special health care needs and over 70 percent reported that mental health referrals for children with special health care needs were more difficult than for children without special health care needs.
- ◆ Policy mandates often fall short: While the implementation of the 2003 Child Abuse Protection and Treatment Act (CAPTA) mandates referrals to Part C early intervention programs for children in child welfare with developmental delays, the mandate came with no additional funding. Several challenges then arise including a shortage of professionals trained to provide developmental intervention services to children under 3 and their families, and an apparent lack of resources, and

other support needed to provide services in a way that addresses the needs of abused and neglected children and their families. A recent preliminary survey on CAPTA for Part C providers revealed: that respondents assessed providers’ competence for providing developmentally appropriate services for those referred positively but considered the number of providers needed as inadequate. In addition, respondents were more likely to see a mismatch between early intervention services and parents who were involved with the child welfare system.<sup>75</sup>

- ◆ For young children in child welfare, developmental needs might be identified by child welfare case-workers, primary care clinicians, or caregivers. However, it is unclear who has the ultimate responsibility for different aspects of a child’s wellbeing.<sup>76</sup>
- ◆ For young children involved with child welfare, participation in early intervention services may decrease the frequency of children’s removal from their homes and time spent in out-of-home care. Yet, recent research demonstrates young children involved with child welfare underutilize early intervention services. This may reflect limited identification, poor linkages to available services, or difficulties accessing services.<sup>77</sup>

In sum, there is a paucity of structural supports to engage child welfare systems and other child-serving agencies to be responsive to the developmental needs of young children. These structural deficits manifest in the following ways:

- ◆ systematic mechanisms for identification often do not exist or are weak and inadequate;
- ◆ referral and linkages to ensure complete transitions for young children once they are identified are often tenuous, lack consistency and comprehensiveness, and are rarely systematically applied even within one system or jurisdiction;
- ◆ the absence of effective policies and protocols to ensure that children who are referred for mental health services actually get the services that they need;
- ◆ a shortage of providers with competency to meet the developmental needs of young children and their families across areas of need; and
- ◆ clear delineation of responsibilities for the developmental outcomes for young children in child welfare is not shared across the systems in which these children and their families are engaged.

## What Policy Mandates Exists to Ensure Access to Care for Young Children?

The **Child Abuse Prevention and Treatment Act (CAPTA)** was originally enacted in 1974 (P.L. 93-247). This Act was most recently amended and reauthorized in 2003, by the **Keeping Children and Families Safe Act of 2003 (P.L. 108-36)**. CAPTA provides Federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations for demonstration programs and projects and other activities such as research and evaluation. CAPTA also sets forth a minimum definition of child abuse and neglect.<sup>78</sup>

The 2003 CAPTA amendment addressed the underutilization of Part C early intervention services available for eligible children under age 3 in the child welfare system. The amendment specified that children under age 3 with substantiated cases of abuse or neglect must have access to early intervention under Part C of the Individuals with Disabilities Education Act. States were required to put in place “provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C.” Additionally, the 2004 reauthorization of the **Individuals with Disabilities Education Improvement Act (IDEIA)** required states to describe their “policies and procedures that require the referral for early intervention services under this part of a child under the age of 3 who is involved in a substantiated case of child abuse and neglect” in their application for Part C funding.<sup>79</sup>

*CAPTA is expected to be reauthorized in 2010 which offers an opportunity to address the implementation challenges especially as it relates to service capacity and competency. See recommendations section on page 17.*

The **Fostering Connections to Success and Increasing Adoptions Act** of 2008 helped improve outcomes for children and youth in foster care by promoting permanent families through relative guardianship and adoption incentives, extending support to children who are age 21, improving education and health care supports, and expanding support for American Indian and Alaska native children.

The legislation helped improve health care coordination and access to care for children in foster care by requiring state child welfare agencies to work with Medicaid agencies to create a coordinated health plan to ensure children in foster care have appropriate screenings, assessments, and follow-up treatment and that this information is shared with the appropriate service providers.<sup>80</sup>

The **Patient Protection and Affordable Care Act**, recently signed in March of 2010, included in its provisions \$1.5 billion in mandatory funding over 5 years for high quality, evidence-based, voluntary home visiting programs. The **Maternal, Infant, and Early Childhood Home Visiting Program** of the Affordable Care Act makes grants available to States, Tribes, and territories in order to improve child outcomes through the delivery of home visitation services that focus on child health and development, prenatal and maternal health, parenting skills and supports and the prevention of child abuse and neglect. The law requires states to give *priority* to providing services to identified “high-risk” children and families, including families with histories of child abuse or neglect and families that have been involved with the child protection system.

Forty-nine states, the District of Columbia, and five territories applied for and were awarded funding under this federal initiative.

The legislation requires grantees to conduct a statewide needs assessment in the first six months of funding to identify communities with high concentrations of risks including:

- ◆ premature birth, low-birth weight infants, and infant mortality (including infant death due to neglect), or other indicators of at-risk prenatal, maternal, newborn, or child health;
- ◆ poverty;
- ◆ crime;
- ◆ domestic violence;
- ◆ high rates of high-school drop-outs;
- ◆ substance abuse;
- ◆ unemployment; and
- ◆ child maltreatment.

The needs assessment must also examine the quality and capacity of existing early childhood home visitation programs including the number of families and young children served, possible gaps in service delivery, and the extent to which these programs are meeting the needs of eligible families. Grantees are required to implement an evidence-based program model with measurable outcomes in one of the following areas: improvement in maternal and child health, childhood injury prevention, school readiness and achievement, crime or domestic violence, family economic self-sufficiency, and coordination with community resources and supports.<sup>81</sup>

The **Patient Protection and Affordable Care Act (PPACA)**, also included provisions that can address service capacity and provider competency challenges that states currently face. In addition, several provisions in the law have implications for reducing racial and ethnic disparities. Selected key components include:<sup>82</sup>

- ◆ state work force development grants in PPACA (\$158 million total: \$8 million planning and \$150 million implementation (2010) and SSAN);
- ◆ co-location of primary and specialty mental health in community settings (\$50 million 2010; 2011-2014 SSAN);
- ◆ community health workers grants (SSAN);
- ◆ school-based health centers (2010-2014 SSAN);

- ◆ curricula development grants (SSAN);
- ◆ primary care training (\$125 million 2010; 2011-2014 SSAN);
- ◆ mental and behavioral health care training (\$35 million 2010-2013 to include social workers, psychologists, professionals and paraprofessionals in child and adolescent mental health);
- ◆ public health services workforce loan repayment public health workers (\$195 million 2010; 2011-2015 SSAN);
- ◆ loan repayment pediatric specialist (\$30 million 2010-2014; child/adolescent mental health and behavioral health professionals(\$20 million 2010-2013);
- ◆ centers of excellence for recruitment and retention under-represented minorities (\$50 million 2010-2015);
- ◆ disparities data collection and analysis (SSAN 2010-2014);
- ◆ health centers and clinics (\$34 billion 2010-2015);
- ◆ maternal and child health services for post-partum conditions (\$3 million 2010; 2011-2012 SSAN); and
- ◆ quality improvement (technical assistance) \$20 million and quality improvement measurement (\$17 million) over 4 years

SSAN=legislative language indicates no amount but “such sums as may be necessary.”

## Opportunities for Addressing the Mental Health Needs of Young Children

### *What services should young children in the child welfare system be receiving?*

Evaluations of infants displaying signs of abuse or neglect should have the following: a pediatric assessment to highlight any medical conditions or recommendations for further tests and health screenings; a developmental assessment with standardized measures to determine the infants development; and a mental health assessment that includes family history, infant’s social relatedness, infant’s behavioral organization, their response to stress, signs of maltreatment, and risk for placement disruption.<sup>83</sup>

To support such assessments, child welfare workers need training on what questions to ask to help them identify infants at risk and to understand how children’s developmental and emotional needs can impact parents. They also need knowledge about programs that assess and serve infants and their families such as early intervention and Early Head Start to which to refer families.<sup>84</sup>

- ◆ The American Academy of Pediatrics (AAP) recommends that, when possible, child welfare agencies try to access or establish multidisciplinary teams to routinely conduct health screenings and assessments.<sup>85</sup>

- ◆ Access to specialty mental health services, in one study that included 4 to 5 year old children who received in-home case management services, was associated with an up to 40 percent reduction in out-of-home placements.<sup>86</sup>

### Researchers have begun to identify empirically-supported instruments for assessing the mental health of young children in child welfare.

Screening and assessment tools form a continuum of instruments used to establish need for an intervention or to rule out the existence of a problem. Assessments can reinforce the need for a specific intervention, the intensity of the intervention and the necessity of other supports. It is important that both screening and assessments are accurate and render valid and reliable results. Equally important is the need for screenings and assessments to be accurately interpreted, especially in the case of child maltreatment. It is generally acknowledged that in the field of measurement, especially assessment tools for young children, there are few that meet the gold standard.<sup>87</sup> There are however many tools that have been standardized and validated to screen, assess and provide information on indications of social emotional development, and mental well-being. A study of the substantive and psychometric properties of mental health screenings designed for children age 10 and younger, identified 19 instruments that met review criteria and seven that show above-average measurement properties, and have evidence of validity with families similar to child-welfare involved families.<sup>88</sup>

Policy and practice-related research indicates use of standardized and validated screening and assessment tools is inconsistent. Among many clinicians rates of use of standardized tools are low.<sup>89</sup> Obstacles to the use of standardized and validated tools include lack of reimbursement for the extra time spent contacting an assessment, lack of providers' knowledge of its added value and poor provider training.<sup>90</sup> A range of screening and assessment tools for young children and for young children who have been exposed to trauma can be reviewed in two NCCP documents: *Social Emotional Development in Early Childhood: What Every Policymaker Should Know* and *Strengthening Policies to Support Children, Youth and Their Families Who Experience Trauma*.<sup>91</sup>

### Use of research-informed effective practices is also gaining traction and have been developed specifically for or adopted for use with young children involved in the child welfare system. (See Box 2).

There are a number of interventions designed for young children who have experienced maltreatment or may be at increased risk for child welfare involvement. Common targets of effective strategies include:

- ◆ support for and development of strong, appropriate attachments;
- ◆ support for and development of the ability to form strong, nurturing relationships with parents or primary caregivers; and
- ◆ development of social emotional competence including the ability to form strong peer and adult relationships and interact positively, and to manage and regulate emotions.

The vast body of research from both developmental science and neuroscience that point to the pivotal and important role of the first years of life compels an urgent policy response. Nowhere is the need for immediacy more acute and apparent than when it comes to young children who have experienced maltreatment or for whom there appears clear risks. The practice response and underlying policies must ensure quality. The existence of data that demonstrates the effectiveness of an intervention is crucial especially strategies that reflect the settings where young children frequent, with the types and levels of maltreatment young children in child welfare experience, and bound by the cultural, economic and social forces that shape their lives.

Box 2 describes a range of empirically-supported interventions that have been used with young children in child welfare. For policymakers and practitioners charged with implementing these and other practices there is the need to ensure optimal conditions for implementation including, workforce competence, workforce capacity, fiscal resources, family and caregiver engagement and accountability. Accountability requires that adopted practices meet the cultural and linguistic needs of the population of focus and attain similar or superior outcomes across groups of young children who have been maltreated or who are at risk of child welfare involvement.

**Box 2: Evidence-based interventions used by practitioners working with children involved in the foster care system to address the developmental needs often associated with maltreatment.**

**Parent Child Interaction Therapy (PCIT):** is a short-term, evidence-based parent training intervention for families with young children (ages 2 to 6) who experience behavioral, emotional, or family problems. The program consists of two phases: Child Directed Interaction (CDI) and Parent Directed Interaction (PDI). CDI focuses on strengthening parent-child attachment before the second phase PDI teaches structured and consistent discipline. During the initial didactic session a coach will model and role play with the parent certain skills. Following this the coach prompts the parent while interacting with the child through a hearing device. Typically treatment lasts for 10 to 16 weekly, one-hour sessions. Progress on the parent-child interactions is coded at each session and treatment is complete once parents have mastered the skills taught in the both the CDI and PDI phases and the child's behaviors are within normal limits.

Source: Herschell, A.; Calzada, E.; Eyberg, S. M.; McNeil, C. B. 2002. Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice* 9: 9-16 <http://pcit.phhp.ufl.edu/Literature/HershelCalzadaEybergMcNeil2002.pdf>

**Triple P – Positive Parenting Program:** promotes positive parenting and caring relationships between parent and child by offering information to parents through a variety of sources including: multi-media, professional consultations, and self-directed modules. Triple P involves several tiers of training including: Standard, Group, Enhanced, Self-directed, and Media. At the first level parents either receive training around managing difficult child behaviors and setting behavior goals as a single family (Standard) or in groups (Group). The Standard Triple P is a 10-session program which reviews causes of children's behavior problems, strategies for encouraging children's development, and strategies for managing misbehavior. The sessions include modeling, rehearsal, self-evaluation, homework tasks, and observations of parent and child interactions. In Group Triple P parents learn positive parenting skills in groups of 10-12 parents over 8 sessions. The Self-Directed Triple P includes a parent's self-help workbook for a 10-week self-help program. The Enhanced Triple P is for families requesting or requiring further assistance. This part of the program is individually tailored often addressing parental issues such as depression or marital communication. Typically three individual therapy modules: Practice, Coping Skills, and Partner Support are used individually or in combination.

Source: Sanders, M. R.; Markie-Dadds, C.; Turner, K. M. T. Theoretical, Scientific and Clinical Foundations of the Triple P-Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence. Accessed Sept. 1, 2010 from: [http://www.triplep.net/files/pdf/Parenting\\_Research\\_and\\_Practice\\_Monograph\\_No.1.pdf](http://www.triplep.net/files/pdf/Parenting_Research_and_Practice_Monograph_No.1.pdf)  
Thomas, R.; Zimmer-Gembeck, M. J. 2007. Behavioral Outcomes of Parent-Infant Interactive Therapy and Triple P Parenting Program: A Review and Meta Analysis. *Journal of Abnormal Child Psychology* 35(3): 475-495.

**Attachment and Bio-behavioral Catch-up Intervention:** targets the dysregulation of infants and toddlers in foster care by helping foster care parents provide nurturing care. The three subcomponents of the intervention help foster parents to: learn to follow the child's lead, the value of touching, cuddling, and hugging their child, and to create conditions where the child can express their emotions and learn to recognize emotions. The program consists of 10 weekly sessions where parents learn about nurturing skills, practice skills while interacting with the child, watch their videotaped interactions with the foster child to see their progress, and discuss questions and any challenges with the trainer.

Source: Mary Dozier, M.; Peloso, E.; Lindhiem, O.; Gordon, M. K.; Manni, M.; Sepulveda, S.; Ackerman, J. 2006. Developing Evidence-based Interventions for Foster Children: An Example of a Randomized Clinical Trial with Infants and Toddlers. *Journal of Social Issues* 62(4): 765-783

**Infant Parent Psychotherapy (IPP):** designed for parents and infants whom have not formed a secure attachment, sometimes related to trauma or violence experienced by the parent or in the home. During therapy sessions parents express thoughts and feelings about: their experiences as a child, the parent's hopes and expectations for the child's future, and the parent's relationship with other people. The therapist observes and gives feedback on the parent's interactions with the infant to help the parent and child form a secure attachment and help promote positive child development.

Source: Lieberman A. F. 1992. Infant-parent psychotherapy with toddlers. *Development and Psychopathology* 4: 559-574. Cicchetti, D.; Rogosch F. A.; Toth S. L. 2006. Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology* 18(3): 623-649.

**Child-Parent Psychotherapy (CPP):** CPP interventions are guided by the unfolding child-parent interactions and by the child's free play with developmentally appropriate toys selected to elicit trauma play and foster social interaction. The initial assessment sessions include individual sessions with the mother to communicate emerging assessment findings, agree on the course of treatment, and plan how to explain the treatment to the child. Weekly joint child-parent sessions are interspersed with individual sessions with the mother as clinically indicated. The interventions target for change maladaptive behaviors, support developmentally appropriate interactions, and guide the child and the mother in creating a joint narrative of the traumatic events while working toward their resolution. The treatment manual includes clinical strategies and clinical illustrations to address the following domains of functioning: play; sensorimotor disorganization and disruption of biological rhythms; fearfulness; reckless, self-endangering, and accident-prone behavior; aggression; punitive and critical parenting; and the relationship with the perpetrator of the violence and/or absent father.

Source Lieberman, A.; Van Horn, P.; Ippen, C. G. 2005. Toward Evidence-Based Treatment: Child Parent Psychotherapy with Preschoolers Exposed to Marital Violence. *The Journal of the American Academy of Child and Adolescent Psychiatry* 44: 1241-1248.

**Multidimensional Treatment Foster Care for Preschoolers (MTFC-P):** MTFC-P is an alternative to residential treatment for foster children ages 6 and under. These young children are especially vulnerable to long-term difficulties in home, school, and community settings and are at high risk for behavioral, emotional, and developmental problems. MTFC-P is specifically tailored to the needs of 3 to 6 year-old foster children and has been shown to be effective at promoting secure attachments in foster care and facilitating successful permanent placements (such as, reunification with birth parents and adoptions). MTFC-P capitalizes on more than 40 years of research and treatment activities that have supported the notion that families, and particularly parents who are skilled and supported, can have a powerful socializing role and positive influence on troubled youth. MTFC-P is delivered through a treatment team approach in which foster parents receive training and ongoing consultation/support from program staff, children receive individual skills training and therapeutic playgroup, and birth parents (or other permanent placement resources) receive family therapy. MTFC-P emphasizes the use of concrete encouragement for pro-social behavior; consistent, non-abusive limit-setting to address disruptive behavior; and close supervision of the child. In addition, the MTFC-P intervention employs a developmental framework in which the challenges of foster preschoolers are viewed from the perspective of delayed maturation (rather than strictly behavioral and emotional problems).

Source: <http://www.mtfc.com/mtfcp.html>

## State and local examples of efforts to address young children in the child welfare system

### Vermont – The Children’s Upstream Project (CUPS)

Vermont assesses all children in child welfare and who are at-risk for placement using the two validated instruments (the ASQ and the CBCL). Fifty percent of all child welfare workers get mental health training. Through the CUPS project it uses mental health consultants to offer training, technical assistance, and support to child care providers and parents who express interest in assistance. The services, as with the other mental health consultation programs, focused on improving the capacity of the caregivers and improving their relationships with each other and the children. Services included training for child care providers in behavioral management, anger management, positive and effective discipline, stress reduction, and stress management.

Additionally, the state has made an effort to expand skills and knowledge regarding early childhood mental health throughout the service delivery system and coordinate services for young children. They believe that the ability to promote social and emotional development of children, identifying needed emotional supports, and addressing mental health issues is not the purview of any one discipline. In line with this philosophy, Vermont’s Early Childhood and Family Mental Health Practice Group is developing a set of competencies for educators, therapists, childcare providers, home health care providers, and **child welfare workers** to address the skills and knowledge necessary to provide services at four different levels. The levels correspond roughly with educational attainment from the associate degree up through a doctorate. The immediate use of the materials is to determine the competencies necessary to bill administrative Medicaid for consultation. The hope is that a special endorsement or certification will be created in the future.<sup>92</sup>

The state funds intensive family-based interventions for all children at risk of an out-of-home placement and bills for parent-child interaction/relationship-based treatments has identified a mechanism for billing appropriately.

### Nurturing the Families of Louisiana Parenting Program

Focusing on the chronic neglect of low income parents of children age birth to 5 years, the *Nurturing the Families of Louisiana Parenting Program* builds nurturing skills as alternatives to abusive child rearing attitudes and parenting practices. This family-based program focuses on teaching age appropriate expectations, discipline with dignity, empathy towards children’s needs, parental and child empowerment, positive self-worth and parent-child role clarification. There are 13 *Nurturing Parenting Programs* for parents and children prenatal to 18 years that maintain an overall objective of stopping cycles of abuse, reducing rates of recidivism, reducing rates of juvenile delinquency and alcohol abuse, and lowering rates of teenage repeat pregnancies. Designed with race and ethnic differences among populations in mind (such as Hmong, African American, Arabic, Haitian and Hispanic), the program incorporates trained facilitators and staff from the surrounding community who have similar backgrounds to targeted parents.

In Louisiana, the curriculum is delivered through a network of community-based family resource centers and supported by the Department for Social Services using Title IV-B (Child Welfare) funding. Provided in group and home-based formats, the *Nurturing the Families of Louisiana* program requires parents and children to attend 16 group based sessions with concurrent intermittent home-based practice sessions. There are 15 competency-related topic areas with 80 available lessons complemented by specialized lessons to meet the individual family needs and reinforce material in home-based instruction. Examples of topics include child development, empathy, discipline (trauma is included but the focus is on familial separation). Individual assessments are performed to create profiles so that curriculum can be targeted to individual parent needs. Together, the parent and parent educator review parenting strengths and weaknesses before developing the Family Nurturing Plan. When possible, families are grouped around competencies for peer support and lessons. For the foster care population, the Nurturing Program model is adapted to the specific family and sessions



are coordinated as supervised visitation for parents and children. The Adult-Adolescent Parenting Inventory-2 instrument (AAPI-2) is also later used for pre- and post-testing to assess knowledge and skills gained after program completion.<sup>93</sup>

### Los Angeles County- Coordinated Services Action Team

LA County implemented its' Coordinated Services Action Team (CSAT)\* to accomplish the following: ensure the consistent, effective, and timely screening and assessment of mental health needs across all populations of children served by Department of Children and Family Services (DCFS); coordinate staff who currently link children to services within and across offices; and to systematically review capacity, access and utilization to current and future services. The CSAT and a Referral Tracking System was largely developed after identifying a lack of a

coordinated vision guiding the systematic mental health screening, assessment, and receipt of appropriate services for foster youth. The CSAT seeks to coordinate, structure, and streamline existing programs and resources to expedite mental health assessments and service linkage, once a positive mental health screen or mental health trigger has been presented.

Each CSAT team collects, manages and analyzes data to provide local DCFS and DMH managers reports that will track trends and utilization patterns. The CSAT Lead will provide aggregate data for all of Los Angeles County to central DCFS and DMH management that will identify global and local trends, capacity issues, service gaps and successful innovations. This centralized data is also used as a means of quickly identifying and tracking problems with specific providers, types of services, and the CSAT Referral Tracking System itself.<sup>94</sup>

## Recommendations

- ◆ The federal government, states, territories, and tribes should promote and incentivize the use of effective (empirically supported) behavioral screenings and/or assessments for children aged birth to 5.
- ◆ Child abuse prevention and treatment strategies can and should be integrated for best outcomes at the population level and the federal government, states, territories, and tribes should promote this integration.
- ◆ In order to best serve children, federal, state and tribal government policies including fiscal policies should fund supports and treatment for the parent or primary caregiver not just the parent or the child.
- ◆ State, territories, and tribes should increase prevention and early intervention mental health services for both children who are victimized and who were at-risk of maltreatment, and the federal government should increase fiscal supports for these efforts.
- ◆ States, territories, and tribes should use the provisions within the Affordable Care Act to ensure that their most vulnerable citizens are appropriately serve including young children with special

health care needs that also need access to mental health services and supports. Specifically:

- enhanced resources for provider capacity, cultural and linguistic competency and specialization offer opportunities to increase the number of service providers with competencies in early childhood development and behavioral health, child maltreatment and young children, empirically supported and culturally appropriate assessments and treatment for young children, and interagency collaboration and systems development;
- funding for centers of excellence offers the opportunity to promote the development of centers focused on the unique needs of young children and their caregivers in the child welfare system and at risk of entry;
- conducting comparative analysis research and work in quality that includes a focus on young children in child welfare; and
- leveraging the opportunities including funding through the federal initiative to collect data on disparities could provide states and tribes with needed information on who they are serving and how effectively.

- ◆ The federal government should make vulnerable children across the age span but particularly young children, their siblings and their families a health care finance policy priority. Specifically within the Affordable Care Act it should:
  - provide guidance and opportunities to health exchanges and to health insurance plans to develop effective, culturally and linguistically responsive strategies to meet the mental health needs of young children with child welfare involvement and at risk for child welfare involvement;
  - ensure compliance with the Wellstone-Domenici Mental Health Parity law\* as it pertains to young children, their caregivers and families; and
  - document outcomes for young children with child welfare involvement or at risk for involvement as a result of changes to health care financing including reforms as a result of the Children’s Health Insurance Reauthorization Act (CHIPRA).\*\*
- ◆ States, territories, and tribes should improve their efforts to collect information on both caregivers and children who are investigated for abuse or neglect so that such information can be used to better identify risk and preventive factors for promoting well-being of children in Child Welfare.
- ◆ States, territories, tribes, and their localities charged with addressing the needs of young children who interact with the child welfare system need to develop and track shared outcomes for the mental health and well-being of these children. The federal government, state and tribes should make these data available to support planning and foster accountability.
- ◆ States and localities charged with meeting the needs of young children should track expenditures in child welfare and across sectors that support meeting their mental health and related needs.
- ◆ The federal government through Congress should amend CAPTA to include the following:
  - Annually report on indicators of social-emotional wellbeing of those served by the Part C program based on a range of demographic factors including race/ethnicity and income.
  - Annually report data on children deemed at risk for social-emotional developmental delay but who are at risk but not eligible for Part C including information on outcomes for these children.
  - Require access to a range of empirically-supported practices, including validated screenings to identify risk of social-emotional delay and relationship-based/family-focused treatments, for young children and their families.
  - Ensure that the professional team that determines eligibility includes expertise in social-emotional development for young children.
  - Ensure through incentives that states develop guidelines and have written agreements in place to support completed referrals for young children at risk for social emotional delay but are not eligible for Part C services.
- ◆ The federal government should better leverage the system improvement opportunities for young children in child welfare by aligning fiscal strategies with the outcomes attained through efforts like the Child and Family Services Review.
- ◆ The federal government should offer opportunities for states to be innovative by establishing funding that supports demonstration which focus on worker training, application of reimbursement rates based on bundling multiple interventions and services including parenting-related interventions

\* The Paul Wellstone and Pete Domenici Mental Health Parity law, enacted in 2008, requires equity in the provision of mental health and substance-related disorder benefits to that of physical health benefits under group health plans.

\*\* The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized the Children’s Health Insurance Program (CHIP). CHIPRA finances CHIP through FY 2013. It will preserve coverage for the millions of children who rely on CHIP today and provides the resources for States to reach millions of additional uninsured children.

## APPENDIX

# Strengthening Early Childhood Mental Health Supports in the Child Welfare System Participant List

National Center for Children in Poverty, June 29, 2009

Mary Lee Allen  
Director, Child Welfare and Mental Health  
Children's Defense Fund

William Arroyo  
Medical Director of the Child, Youth, and Family  
Administration  
Los Angeles County Department of Mental Health

Daphne Terry Babrow  
Georgia Infant and Child Health Services

Patti Banghart  
Research Associate  
National Center for Children in Poverty

Shirley Berger  
Research and Policy Coordinator  
Bureau of Child and Adolescent Services  
NYC Department of Health and Mental Hygiene

Johanna Bick  
Graduate Student  
University of Delaware

Charles Biss  
Director of the Child, Adolescent and Family Unit  
Vermont Department of Mental Health

Janice L. Cooper  
Director, Child Health and Mental Health  
National Center for Children in Poverty

Frances B. Duran  
Policy Associate  
Georgetown University Center for Child and  
Human Development

Sonia A. Garcia  
Director  
Woodhull Medical and Mental Health Center

Tracey Garrett  
Clinical Director  
Progressive Life Center

Heather Halonie  
Intertribal Child Welfare Training Partnership,  
Wisconsin

Louisa Higgins  
Research Analyst  
National Center for Children in Poverty

Kadija Johnston  
Director  
Infant-Parent Program  
University of California, San Francisco

Laurel K. Leslie  
Associate Professor of Medicine and Pediatrics  
Tufts Medical Center, Floating Hospital for Children

Sally Melant  
CPS Division Administrator for Permanency  
Texas Department of Family and Protective Services

Julie McCrae  
Research Assistant Professor  
University of Pittsburgh  
Child Welfare Education and Research Programs

Geoff Nagle  
Director  
Tulane Institute of Infant and Early Childhood  
Mental Health

Delfy Peña Roach  
Parent Advocate, New Mexico

Ron Prinz  
Carolina Distinguished Professor  
Psychology Department  
University of South Carolina

Martha Reeder  
Program Manager, Early Childhood Initiative  
National Alliance of Children's Trust and Prevention  
Funds

Lenora Reid-Rose  
Director, Cultural Competence and Diversity  
Initiatives  
Coordinated Care Services, Inc.

Karen J. Saywitz  
Associate Director, UCLA TIES for Families  
Department of Pediatrics, UCLA School of Medicine  
Center for Healthier Children, Families and  
Communities

Charles J. Sophy  
Medical Director  
Los Angeles County Department of Children and  
Family Services

Dan Torres  
Associate  
Center for the Study of Social Policy

Anthony J. Urquiza  
Director, Mental Health Services/Clinical Research  
CAARE Diagnostic and Treatment Center  
Department of Pediatrics - U.C. Davis Children's  
Hospital

Allison Wallin  
Post-Doctoral Fellow  
Infant Caregiver Lab  
University of Delaware

## Endnotes

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- \* Note on graphs:
- Graph 1: Based on total unduplicated victimized children in 2006 (N=808,451).
- Graph 2: Based on total death, N=1,168 reported in 39 states in 2006.
- Graph 3: Based on unduplicated victimized young children under age 6 (N=347,552); Age 6-18 (N=457,252).
- Graph 4: Based on unduplicated victimized young children under age 6 (N= 347,552).
- Graph 5: Based on all investigated cases (N= 1,119,142).
- Graph 6: Based on unduplicated victimized young children (N=347,552).
- Graph 7: Based on victimized young children (N=381,226). The sample includes multiple types of perpetrators.
- Graph 8: Based on victimized young children (N=381,226) and age 6-18 (N=550,242). The sample includes multiple types of maltreatment.



**National Center for Children in Poverty**  
Mailman School of Public Health  
Columbia University

215 West 125th Street, New York, NY 10027  
TEL 646-284-9600 ■ FAX 646-284-9623  
[www.nccp.org](http://www.nccp.org)