6 Children with Multiple Risks

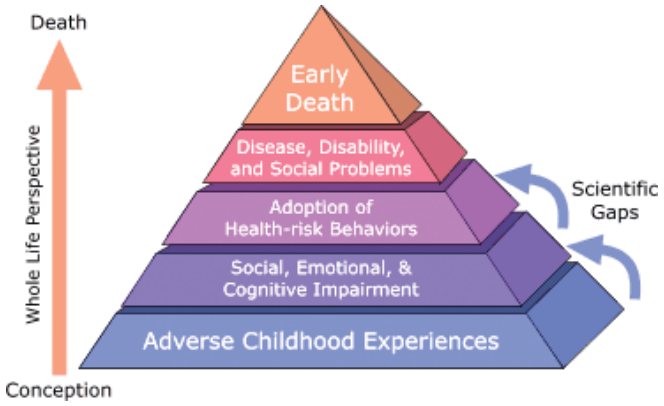
Preventing Toxic Stress and Meeting the Needs of Children and Families with Multiple Serious Risk Factors

Researchers and state leaders are coming to terms with troubling findings and data about childhood risk factors. Adverse early childhood experiences, which have a long-term impact on human development and health, are much more common than previously realized. According to the Center on the Developing Child, serious disruptions in any aspect of early development (physical, emotional, social, and cognitive) cause the body and brain to change in ways that can have long-term negative effects on health.[223] Studies have connected early exposure to traumatic events, especially child maltreatment and violence, to increased chances of behavioral problems, impaired social and emotional functioning, and learning difficulties.[224]

Data collected as part of the Adverse Childhood Experiences (ACE) Study, a collaboration between the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Health Appraisal Clinic in San Diego, show that two-thirds of adults report they were exposed to at least one ACE while under age 18, and over 20 percent reported three or more. The ACE study uses data solicited from 1995–97 from over 17,000 individuals in Southern California. Participants reported whether they had ever experienced any of the following when they were under age 18: abuse (physical, emotional, or sexual); neglect (physical or emotional); or household dysfunctions (violence toward their mother or any household member with mental illness; substance abuse issues or time in jail; or parent separation or divorce).[225] The more ACE exposures, the more likely a person was to report a range of negative health and behavioral problems as an adult (see Figure 2: The Adverse Childhood Experiences Study Pyramid, below).

Taking this data together with research on the conditions of children today is cause for concern. One in four children under age 6 now live in

FIGURE 2. The Adverse Childhood Experiences Study Pyramid



Source: CDC. (2010). The ACE Pyramid. Retrieved from http://www.cdc.gov/ace/pyramid.htm.

families experiencing the deprivations and stress associated with poverty.[226] Just under 23 percent of households with children under age 6 reported food insecurity in 2009; and for households headed by a single mother, the figure is just under 37 percent.[227] Over half of child victims of abuse and neglect in 2009 were under age 8.[228] Some research estimates that up to 50 percent of children in the foster care system have experienced trauma.[229] Among those infants who enter foster care, half will stay in foster care for more than two years.[230] Over half of children who are homeless may have witnessed traumatic, violent events. Natural disasters, such as Hurricane Katrina, also expose children to situations that negatively impact their development.[231] Children in military families with a deployed parent experience increased risk partly depending on trauma experienced by the deployed parent and on how well the remaining parent is coping. Some research shows increases in the rate of child maltreatment in military families since deployment abroad increased.[232]

State leaders gathered at EC 2010 were well aware of the growing risk that children in their states are facing. Participants in EC 2010 state team meetings reiterated their desire to do more to address the impact of adverse experiences on children. Some participants reported seeing rising rates of distress, economic insecurity, substance abuse, child abuse or neglect, and trauma among families they serve. This was particularly true for those from states with areas of deep rural poverty (including tribal lands), where concerns about accessing appropriate, high-quality physical and behavioral health services are paramount. However, most participants had backgrounds in early care and education, but nevertheless felt unprepared to deal with these complex issues. Some state discussions were enriched by the inclusion of Substance Abuse and Mental Health Services Administration (SAMHSA) grantees, such as the System of Care representatives working to support children with serious emotional disturbances. Conversation about serving children with multiple risks often focused on the importance of coordinating across systems in order to provide supports or treatment to parents and children together and to ensure access to high-quality early care and education programs as a respite and support for these children.

Areas of particular focus that emerged from EC 2010 discussions and subsequent exploration of related issues for this report include:

- Ensuring children involved in child welfare have access to high-quality early care and education, early intervention, and infant and early childhood behavioral health care.
- Making connections between maternal substance abuse treatment and supportive services for children.
- Building capacity of child-serving programs and communities to identify and address early childhood trauma.

Ensuring Children Involved in Child Welfare Have Access to High-Quality Early Care and Education Programs, Early Intervention, and Infant and Early Childhood Behavioral Health Care

Linking children in the child welfare system to the range of supports they need is a challenge for state policymakers. Part of the challenge can be overcoming negative assumptions of potential partners and early childhood professionals about intentions of the child welfare system and its workforce.[233] Another issue is the need to increase system and workforce capacity to address unique developmental needs of very young children, especially infants and toddlers who have experienced trauma. National 2009 data indicate that a third of victims of maltreatment were under age 4, including 12.6 percent under age 1.[234] Strategies include:

Creating partnerships between child welfare and Head Start and Early Head Start programs: Partnerships between child welfare systems and Early Head Start programs or other high-quality early care and education programs hold promise for young children in foster care or at risk of foster care placement.[235] Early Head Start programs provided a package of comprehensive health, mental health, nutrition, and social services as well as continuity of care that could be protective for very young children.[236] Federally funded research on 23 such local partnerships from 2002–07 found that most were successful in promoting safe and stimulating home environments, enhancing caregivers' parenting skills, improving access to health and social services, and establishing Memorandums of Understanding that helped guide the partnership.[237] The Office of Head Start recently issued guidance reiterating the importance of serving children in child welfare (foster children are categorically eligible for services and grantees may also prioritize children with open cases within the child welfare system who remain in parental custody).[238]

Connecticut provides an example of how a state has moved from a pilot begun in 1999 to a new statewide initiative to connect local child welfare agencies and Head Start and Early Head Start programs. State-level leadership came from the Head Start State Collaboration office and Connecticut Department of Children and Families (DCF). Results of the effort include a simplified and standardized referral process for DCF-involved children being enrolled in Head Start and Early Head Start programs. Treatment plans have also been aligned across DFC and Head Start and Early Head Start family partnership agreements, and the DCF data system has been modified to better identify children under age 5 to participate.[239]

Prioritizing children in the child welfare system for child care subsidy assistance: Thirty-eight states provide child care subsidies to children in "protective services," as the state defines this term. For example, **Louisiana**'s Child Care and Development Fund (CCDF) lead agency partners with the child welfare agency to provide respite services to children in protective care. Protective care is defined under these circumstances as services offered to individuals under 13 years of age who are in danger or threatened with danger of abuse, neglect, or exploitation; or who are without proper custody or guardianship; and for whom the need for services has been determined by the state agency responsible for the provision of abuse and neglect complaint investigations. Children in foster care are also considered to be in protective services.[240] In some cases, Louisiana waives requirements that

protective services families pay copayments and meet work and education eligibility requirements that apply to others receiving child care subsidies. Thirteen states also waive work and education requirements for protective services families.[241] **Massachusetts**' child care policies address needs of children in the child welfare system in two ways. Foster care families receive prioritization on the state wait-list for child care subsidies for low-income eligible children. Children living in their homes with open cases of abuse and neglect are eligible for "Supportive Child Care," a separate line item of $88 million that provides an early education and care experience for children involved with the Department of Children and Families. The state has implemented an "immediate access" policy to ensure that all children with referrals from their social workers have immediate access to full-time child care.

Ensuring that children in the child welfare system (including infants and toddlers) have access to screening and treatment for behavioral health needs: Behavioral health services are also critical for children involved in the child welfare system. High proportions of young children in the child welfare system have behavioral health needs, but a fraction of these children receive treatment. The vast majority of states screen participating children for physical health problems, but just under half do so for behavioral health issues.[242] The Child Abuse and Protection Treatment Act (CAPTA) mandates that all children under age 3 who have been abused or neglected receive referrals to screening under Part C of the Individuals with Disabilities Education Act (IDEA) and services to address infant and early childhood mental health. **Massachusetts** went beyond this requirement by further including infants and toddlers living in homes where abuse and neglect reports for *other* family members have been supported.[243]

Identifying behavioral health needs among infants and toddlers is complicated. States have to help professionals learn how very young children show their distress and what the most effective treatments seem to be. One basic issue has to do with requiring screenings routinely and using appropriate tools for very young children. For example, **Indiana** implemented a rule that all children would receive mental health screenings within five days of an open case, and, if indicated, that they receive a comprehensive mental health assessment within 10 days of the screening.[244] A third of children removed from their homes were deemed at risk, and when children received treatment, they were more likely to experience stable placements. Leaders in the state mental health agency have worked closely across systems, collaborating with the Medicaid authority to introduce a tool (the Child and Adolescent Needs and Strengths [CANS] and CANS 0–5 for young children) to help tailor treatment plans for children and families and to justify use of Medicaid to pay for rehabilitation services.[245]

Increasing knowledge of infant and toddler development and implications for child welfare and judicial system decisions: States are taking different approaches to increasing understanding of infant and toddler needs. For example, Massachusetts' child welfare agency has identified a high-level program manager to respond to the needs of young children and their families.[246] In doing so, the state acknowledges that many young children are involved in the child welfare system and that the impact of early childhood trauma has implications for these young children and across their lifespan.[247]

Leaders in **Arkansas**' Department of Human Services and Department of Child and Family Services partnered to bring the ZERO TO THREE court-community partnership model to

a pilot in a central Arkansas child and family court. All children under age 3 placed out of the home are eligible. A community coordinator works to address underlying issues that may contribute to bringing the family to court. This includes bringing together local service providers and churches to identify appropriate resources that participating families may need, such as mental health services, housing, and transportation. Parents also receive coaching to improve the quality of supervised visits with their children and to increase capacity to recognize and respond appropriately to the cues of their infants and toddlers. An agreement with a nearby Early Head Start reserves 10 spots for participating children. A cross-section of court personnel, community agency staff, foster parents, and lawyers together received training in infant and toddler development and mental health. The initiative started with $300,000 in American Recovery and Reinvestment Act (ARRA) funding in 2009 but is now sustained by other sources.

Making Connections Between Maternal Substance Abuse and Supportive Services for Children

In the field of substance abuse treatment, there is a growing recognition that treatment for parents (especially for mothers) must include consideration of any children and the broader family context. National data indicate that almost 12 percent of children under the age of 18 live with at least one parent with substance abuse issues, and that figure is almost 14 percent for children under age 3.[248] Some estimate that 10 percent of births each year may involve prenatal exposure to drugs or alcohol, but that the vast majority of babies are sent home with this vulnerability undetected. Effective health promotion, prevention of, and treatment for substance abuse among parents demands involvement of multiple state agencies to provide a continuum of comprehensive services delivered across different developmental stages of life.[249]

Including children when mothers need residential treatment: A promising approach is linking services to children of mothers in residential substance abuse treatment. States differ in their policies on this matter. Federal funding sources, such as the Substance Abuse Prevention and Treatment (SAPT) Block Grant, require "therapeutic interventions" for children in custody of women in treatment but do not specify for whom, or what services must be delivered for children. In keeping with the trend toward family-centered treatment, some states have specified services for children. **Georgia** and **Washington** have extensive Therapeutic Child Care guidelines that set the tone and content for children's services in residential treatment programs.

Massachusetts is unique in allowing any child under age 18 to live with their mother in state residential treatment centers. State contracts and licensing rules for these residential treatment centers require that children in residences receive a range of services (including physical and developmental screening) and that the facility have formal linkages with early intervention and necessary services. At the state level, the Bureau of Substance Abuse Services has a women's services coordinator who sits on the statewide Children's Behavioral Health Initiative and other interagency groups that work to better coordinate services and increase access to children's services.[250] Entre Familia is a residential substance abuse treatment program for Latina women and their children located in Boston. First funded through SAMHSA's Women, Children and Family Treatment Program, the program serves approximately 60 families per year with a 6-12 month length of stay. A majority of women served

live in poverty, are involved in the criminal justice and child welfare systems, and have not graduated from high school. In addition to substance use disorders, many also have a history of trauma and mental health problems. Entre Familia provides a variety of treatment and support services for the women and their children, with a strong focus on engaging other family members and strengthening the family unit. By working with women and children together, the center focuses on improving outcomes for the mothers and their children and uses family as a powerful motivator in the mother's treatment and recovery. Participants in the program have shown significant reductions in drug use and criminal involvement.[251]

Supporting substance-exposed newborns and their families: In 2003, the CAPTA reauthorization included a requirement that states have policies and procedures that address the needs of infants born and identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. This requirement includes identification and referral of the infants and the development of a plan for safe care. In 2005, the Administration for Children and Families (ACF) awarded five-year grants to four programs in **Colorado**, **Massachusetts**, **Ohio**, and **Oregon** to develop models to implement CAPTA requirements and capture lessons learned for addressing substance-exposed newborns.

In **Maine**, a federal Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant, which focused on the rural area of Washington County, will be used to provide lessons learned for other community collaborations, including a curriculum for working with families with substance-exposed infants. This community was selected in part because one-third of the county's infants are born at risk due to factors such as exposure to substances or low birth weight, along with high rates of babies in protective custody. The nearest neonatal intensive care unit is 90 miles away, making follow-up care difficult to access for substance-exposed infants. The local Project LAUNCH "bridging" project matches high-risk expectant and new mothers with nurses or early childhood professionals. In partnership, they develop an individualized plan to "bridge" gaps, such as lack of transportation, child care, and other necessities. The mother also receives support addressing the concerns, developmental questions, or social and emotional needs of the young child and family.[252] The Washington County model also provides home visits in coordination with the statewide Maine Families home visiting program, using the T. Berry Brazelton Touchpoints model to strengthen parenting skills.[253]

Providing access to respite child care: Early care and education can play a role in supporting parents dealing with substance abuse issues. Difficulty finding child care has been linked to higher self-report of child neglect for mothers entering substance abuse treatment programs.[254] Four states (**Arizona**, **New York**, **Washington**, and **Wisconsin**) make children whose parents are in substance abuse treatment programs (as part of a Temporary Assistance for Needy Families [TANF] recipient's approved plan, for example) eligible for subsidies to help pay for child care.[255]

Building Capacity of Child-Serving Agencies and Communities to Identify and Address Early Childhood Trauma

Some states are connecting the research on toxic stress and adverse experiences for young children to policy and practice. One approach is to ensure that those working with children and families are more sensitive to and better able to identify behaviors that have roots in traumatic

experiences, and to link children and families to appropriate follow-up services.[256] The National Child Traumatic Stress Network has research and resources to help policymakers plan for creating trauma-informed systems that serve children. Some state activities include:

Drawing on existing data sources to understand the scope of the problem: Illinois has developed the capacity to integrate several data sources including child welfare, mental health treatment paid with Medicaid for adults and children, substance abuse, and juvenile justice information. Through a contract with researchers at Chapin Hall at the University of Chicago, these data sources have shed new light on the most vulnerable families in the state. Twenty-three percent of families involved in some way in these systems have, in fact, been multiple system users, which indicates a need to develop a cross-system approach to support them. The hope is that this data is used to inform new efforts to support multiple system families with very young children.[257] The state was also able to tap this data set to assess the needs of vulnerable families as required to submit the state application for new federal Maternal, Infant, and Early Childhood Home Visiting program funds.

In addition, some states have invested in parent surveys similar to the federal Child and Adolescent Health Survey to gather information about young children, their home environments, the services they access, and their health and early education practices. Such information can be helpful in identifying areas for state and community prevention and public education activities. **Washington** has used funding from the Bill and Melinda Gates Foundation to build on the CDC's Behavioral Risk Factor Surveillance System to inform efforts to track and address adverse childhood experiences.

TRAUMA IN EARLY CHILDHOOD

In one study of children aged 2-5, a little more than half had experienced a severe stressor in their lifetime. The most common traumatic stressors for young children include:

- Accidents
- Physical trauma
- Abuse
- Neglect
- Exposure to domestic and community violence

Source: National Child Traumatic Stress Network, http://www.nctsnet.org, (n.d.).

Educating the child welfare workforce on the signs and impact of early childhood trauma: In 2005, **Illinois** passed legislation that required services addressing trauma to be included among the range of supports provided to children in the child welfare system. Since then, all 3,500 Department of Child and Family Services (DCFS) staff (including caseworkers, managers, and clinicians) has received multiple trainings in trauma-informed care through a "learning collaborative" model designed to facilitate peer-to-peer learning and support to implement change in practice.[258] One such change is the use of new standardized tools, such as the Child and Adolescent Needs and Strengths (CANS) for child welfare to inform planning and case decisions.[259]

DCFS also developed a field support program to enhance the transfer of knowledge from the learning collaboratives to the field through ongoing practice application with supervisors throughout the state. The department also created an Office of Trauma Informed Practice dedicated to providing ongoing training and consultation throughout DCFS-administered services and programs in order to further the enhancement of trauma-informed practice. DCFS contracts with the Erickson Institute, a Chicago-based graduate school for early childhood development, to administer developmental screenings for children birth to age 5 who enter the foster care system. DCFS is a contributing member of the Illinois' Childhood Trauma Coalition, an organization dedicated to integrating information about childhood trauma throughout the service array of child-serving systems in Chicago, including child care and early education programs.[260]

Educating and empowering communities to interrupt the cycle of adverse early childhood experiences: Washington is engaged in a multiyear, statewide effort to understand the prevalence of adverse childhood experiences; educate state and local leaders; and engage communities in an effort to stop the compounding effect of multiple adverse childhood experiences.[261] A state-level Family Policy Council consisting of governor's staff, legislators, and leaders from seven agencies have served as the umbrella agency for 42 Community Public Health and Safety Networks across the state. Washington's authorizing statute specifies that network membership include 13 citizens "without fiduciary interest" in order to keep leadership in the hands of parents rather than professionals.[262] Using this state-to-local mechanism, Washington gathered information and brought in national experts to educate stakeholders about the ACE research. Each network developed community-specific plans to lower rates of these negative experiences and to promote thriving families. Several studies have documented results, including reduced rates of teen pregnancy, school drop-out, out-of-home placements of children, and juvenile crime in active network communities.[263] Washington continues to promote the importance of this issue. A coinvestigator of the original ACE study conducted an ACE study specific to the state that was released in July 2010.[264] In the current budget cycle, the governor has proposed to replace the state level council with a public-private partnership to collaborate with the community-level networks, which would be continued.[265]

States are **preventing toxic stress and meeting the needs of children and families with multiple serious risk factors** by:

- Ensuring children involved in child welfare have access to high quality early care and education programs, early intervention, and early childhood mental health care.
- Making connections between maternal substance abuse treatment and supportive services for children.
- Building capacity of child-serving agencies and communities to identify and address early childhood trauma.