

December 2014

CHILD WELFARE TOOLKIT

EC



FOR
EARLY CHILDHOOD
PROFESSIONALS



Materials and
tools to support
collaboration with
the child welfare
system (DCF)



This project is funded by a two-year federal grant from the Children's Bureau of the Administration of Children and Families awarded to the Collaborative for Educational Services.

SYSTEM CHANGE for
SUCCESSFUL CHILDREN

Safe
Confident

Strong
Competent

Secure
Creative



Partnership for Resilient Infants+Toddlers



TWO TOOLKITS ARE AVAILABLE ONLINE:

Early Childhood Toolkit for Child Welfare Professionals

Child Welfare Toolkit for Early Childhood Professionals



collaborative.org /early-childhood/scsc

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SYSTEM
CHANGE for
SUCCESSFUL
CHILDREN

CHILD WELFARE TOOLKIT

Materials and tools assembled by the System Change for Successful Children project to enhance your work with the child welfare system and high-need children ages birth to five and their families

INSIDE:

- ▶ Understanding and collaborating with the child welfare system (DCF)
- ▶ Trauma-informed practice guidelines
- ▶ Resources to support young children and their families
- ▶ Accessing family support, early childhood mental health and other services
- ▶ Handouts to share with parents/caregivers
- ▶ And much more!

FOR
EARLY CHILDHOOD
PROFESSIONALS





Partnership for Resilient **Infants+Toddlers**

SCSC is funded by a federal grant to the Collaborative for Educational Services (CES) from the Children's Bureau of the Administration of Children and Families.

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Everyone is a learner

Child Welfare Toolkit for Early Childhood Professionals

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Safe
Confident

Strong
Competent

Secure
Creative



SYSTEM
CHANGE for
SUCCESSFUL
CHILDREN

1

Impact of Early Abuse and Neglect

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CHILD WELFARE
TOOLKIT



FOR EARLY CHILDHOOD PROFESSIONALS



FAST FACTS



Impact of
Early Abuse
and Neglect

Adverse Childhood Experiences (ACES)

WHAT ARE THEY?

Damaging emotional experiences in childhood that increase the incidence of poor physical and mental health in adulthood. The more ACES a child experiences, the more important it is to take immediate action to improve the long-term wellbeing of the child and prevent poor outcomes.

TYPES:

Types of ACES

Child abuse: physical, emotional, sexual

Child neglect: chronic hunger, poor supervision, emotional, medical, educational neglect

Substance abuse: by a parent or household member

Loss of a parent: by death, divorce, abandonment, or other reason

Domestic violence: witnessing, conflict, weapons, threats, all physical and emotional forms of violence.

Mental illness, depression, suicide: of parent or household member

Imprisonment: of parent or household member

WHY DO ACES MATTER?

Children with 4 ACES as compared to 0 are 12 times more likely to have a long list of chronic health problems as adults. They are also at much higher risk for later depression, promiscuity, abuse of IV drugs and suicide attempts.

What Early Educators can do

COUNT how many ACES child has experienced.

REFER to Early Intervention (ServiceNet REACH) or the public School (over age 3) for developmental screening.

FOLLOW UP to make sure the child receives needed services.

REFER to early childhood mental health specialists using evidence-based practice to improve attachment, attunement and positive parenting.

BE CONSISTENT AND RESPONSIVE with special attention to self-regulation support

ADVOCATE AGAINST PLACEMENT CHANGES and help kids stay connected to important people they've lost.

MAINTAIN CONTACT AND COLLABORATE WITH THE DCF WORKER

and others working with the family, like home visitors, therapists, Early Intervention, etc.

See Toolkit item 1-M for more details.

Typical Social Emotional (SE) Development

NEWBORN



INDICATORS of typical SE development

Eating

Sleeping

Regulation/engagement

COMPLICATIONS for typical SE development

Prematurity

Prenatal drug exposure

Medical complications

RED FLAGS

- 1. Failing to gain weight
- 2. Lethargic
- 3. Not sleeping for more than brief periods; wakes screaming
- 4. Not able to be soothed by holding and cuddling

With any concern seek additional information about child's history and experiences.

1. **CONSIDER:** What may be the underlying cause of lack of weight gain? Does baby have reflux, or vomiting after eating? Prematurity causing poor sucking reflex? Is baby not waking for feedings, or is caregiver not waking baby for feedings?

TIPS FOR CAREGIVERS: Regular weight checks with pediatrician. Document food intake. Feed on demand. If baby is not waking for feedings, wake infant on a regular schedule (usually every 2-3 hours) for feeding. Provide consistency, love and affection.

- 1,2. **CONSIDER:** Are lethargy and low weight gain related to an underlying medical issue or prenatal drug exposure?

TIPS FOR CAREGIVERS: Medical follow up and assessment. Check to see if child is receiving adequate nutrition. Is baby overstimulated (related to drug exposure/prematurity) and presenting as lethargic in an effort to reduce stimulation? If yes, reduce stimulation – bright lights, loud sounds etc.

- 3,4. **CONSIDER:** Are sleep and soothing challenges related to prenatal drug exposure or trauma?

TIPS FOR CAREGIVERS: If so, share the background information and explain to the caregiver how it affects the child's behavior. See Toolkit 2-K and 2-L for more information. Teach caregiver the Five 'S' system: Swaddle, place baby in Side or Stomach position (in your arms only as stomach sleeping has been linked to SIDS), Shushing sounds, Swinging, Sucking reflex (pacifier, finger).

4. **CONSIDER:** Has the baby been injured? Is this related to prenatal drug exposure?

TIPS FOR CAREGIVERS: This can be very discouraging for a new caregiver and may impact attachment. Encourage caregiver to try to be consistent and loving even if baby is irritable—s/he may need extra support to cope. Consider that the infant may have reflux or an underlying medical issue. Reassure caregiver that infant will likely eventually enjoy holding and cuddling. Keep stimulation low. If baby is overstimulated by bright lights, loud sounds, eye contact, reduce these as needed. As the baby grows, his or her ability to tolerate will increase.



Typical Social Emotional (SE) Development



TWO MONTHS

INDICATORS of typical SE development

Baby smiles when you talk to him/her

When you are out of sight and then return, baby gets excited

Recognizes caregiver's voice from others

Cries in different ways; waves arms and kicks legs

Wants to suck not for feeding but for comfort

Cries when hungry, wet, tired, or wants to be picked up, but stops when picked up

COMPLICATIONS for typical SE development

Neglect and abuse

Exposure to violence

Change of caregiver

Lack of stimulating environment

Prenatal drug exposure

Medical complications

RED FLAGS

1. Flat affect, no smiling or desire to engage
2. No eye contact with primary caregiver
3. Weight loss or plateau
4. Baby doesn't engage with caregiver(s) or seems indifferent to them
5. Never cries
6. Weight loss or plateau
7. Heightened startle reflex and can't recover
8. Extreme sensitivity to bright lights and loud sounds and can't recover
9. Frequent hiccuping or drooling

With any concern seek additional information about child's history and experiences.

- 1-3. **CONSIDER:** Is this related to prenatal drug exposure? Effects can be seen months after the birth. Was there trauma? Was the infant neglected or is the infant being neglected or left for long periods by him/herself?

TIPS FOR CAREGIVERS: Encourage caregiver's responsiveness to the baby's crying and other cues. Model for caregiver how to hold and talk to child; play games like peek-a-boo; and interpret and respond to the baby's different cues, e.g. eye brightening, body language like turning toward and away from stimuli, facial expressions. Encourage holding and gentle engagements between infant and caregiver. Consult with pediatrician. Consider autism spectrum, vision and hearing screening. Assess mental health of caregiver and look for community supports.

4. **CONSIDER:** Are there any home environment challenges like lack of consistency in feeding routine, domestic violence or other interpersonal tensions, etc. Is reflux or other medical condition causing the weight loss? Is the infant being neglected?

TIPS FOR CAREGIVERS: Encourage caregiver to establish a fun and predictable eating schedule in a calm, unemotional environment with few distractions. Consider professional referrals: Early Intervention (EI), medical, nutritionist, etc.

5. **CONSIDER:** Has the infant learned that their cries will not be answered? Is the affect of the baby flat due to prenatal drug exposure?

TIPS FOR CAREGIVERS: Encourage caregiver to offer comfort regularly, even if child doesn't cry, and to respond quickly when child looks distressed or begins to whimper or cry. Remind caregivers that crying is the way a baby expresses their needs and should be answered at all times. You cannot spoil an infant by being responsive.

- 6, 7. **CONSIDER:** Is this related to prenatal drug exposure?

TIPS FOR CAREGIVERS: Encourage caregiver to lower stimulation in the environment by limiting bright light, loud noise, rough touch, etc. Eye contact can be overstimulating for some infants with sensory issues. Consider referral for EI services, specifically Occupational Therapy (OT) evaluation for sensory issues.

8. **CONSIDER:** This may be a symptom of prenatal drug exposure. It indicates that the baby's central nervous system is not regulated.

TIPS FOR CAREGIVERS: See Toolkit 2-K and 2-L for more information.



Typical Social Emotional (SE) Development

FOUR MONTHS



INDICATORS of typical SE development

- High pitched squeal in delight; laughing
- Stops crying when hears voice other than caregiver
- Baby makes sound when sees toys or people
- Watches hands; plays with fingers
- Watches toys hanging above
- Begins to roll to grab toys
- Baby helps to hold bottle or holds onto breast when feeding
- When in front of mirror, baby smiles and coos
- Cries differently for different things

COMPLICATIONS for typical SE development

- Neglect and abuse
- Exposure to violence
- Change of caregiver
- Lack of stimulating environment
- Prenatal drug exposure
- Medical complications

RED FLAGS

1. Flat affect, no smiling or desire to engage
2. No eye contact with caregiver
3. Baby doesn't engage with caregiver or seems indifferent
4. Never cries or cries all of the time
5. Doesn't make sounds by themselves or with others
6. Weight loss or plateau
7. Heightened startle reflex and can't recover
8. Extreme sensitivity to bright lights and loud sounds and can't recover

With any concern seek additional information about child's history and experiences.

- 1,3,4. **CONSIDER:** Is there an attachment concern? Is the caregiver responsive to the needs of the infant? Is the child on the autism spectrum? Has the child experienced a number of changes in caregivers?

TIPS FOR CAREGIVERS: Encourage caregiver to expose infant to behaviors associated with positive emotions: laughing, tickling, smiling, etc. Try “serve and return” multiple times with child—even if child doesn’t overtly engage. Model for caregiver how to hold and talk to child; play games like peek-a-boo; and interpret and respond to the baby’s different cues, e.g. eye brightening, body language like turning toward and away from stimuli, facial expressions. Assess caregiver’s mental health and find local resource for support. Refer for dyadic therapy with a therapist who has experience with infants and caregivers.

- 2,4. **CONSIDER:** Is the baby being regularly engaged with? Is the child being neglected? Has there been a number of changes in caregivers? Is there a developmental delay?

TIPS FOR CAREGIVERS: Encourage caregiver to provide consistency, love and affection. Seek professional assessment for possible autism spectrum, hearing concerns, vision concerns.

5. **CONSIDER:** Is the baby being regularly engaged with? Is the child being neglected? Has there been a number of changes in caregivers? Is there a developmental delay?

TIPS FOR CAREGIVERS: Model for caregiver talking to/for the baby and frequent verbal engagement, such as narrating daily activities, reading nursery rhymes, finger plays, singing, etc. Medical assessment for hearing and vision. Early Intervention (EI) referral for developmental assessment.

6. **CONSIDER:** Does the home environment challenges like lack of consistency in feeding routine, domestic violence or other interpersonal tensions, etc.? Underlying medical concern?

TIPS FOR CAREGIVERS: Encourage caregiver to establish a fun and predictable eating schedule in a calm, unemotional environment with few distractions. Weight checks with pediatrician. Consider reflux or other feeding issue.

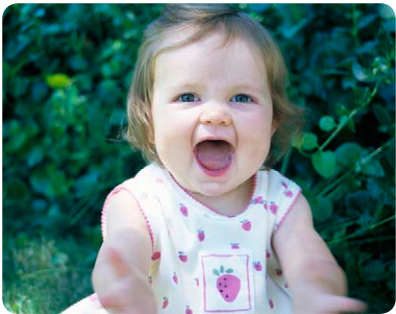
- 7,8. **CONSIDER:** Is this related to prenatal drug exposure? Is baby overstimulated?

TIPS FOR CAREGIVERS: Encourage caregiver to lower stimulation in the environment by limiting bright light, loud noise, rough touch, etc. Consider referral to EI, specifically for Occupational Therapy (OT) evaluation for sensory issues.



Typical Social Emotional (SE) Development

SIX MONTHS



INDICATORS of typical SE development

- Imitates moves of others
- Smiles at self in mirror; will pat mirror to engage with image
- Separation anxiety can begin
- Reacts differently with strangers
- When caregiver calls out to baby while out of sight, baby will turn toward voice
- Makes sounds like ba, ka, da
- Caregiver copies sounds of baby and baby will repeat back to caregiver
- Puts feet to mouth
- Baby moves toward out-of-reach object

COMPLICATIONS for typical SE development

- Neglect and abuse
- Exposure to violence
- Change of caregiver
- Lack of stimulating environment
- Prenatal drug exposure
- Medical complications

RED FLAGS

1. Flat affect, no smiling or desire to engage
2. No eye contact with caregiver
3. Baby doesn't engage with caregiver or seems indifferent
4. Never cries or cries all of the time
5. Doesn't make sounds by themselves or with others
6. Weight loss or plateau
7. Doesn't seek out caregiver when hurt, injured, upset or scared
8. Not rolling over, sitting up or beginning to scoot

With any concern seek additional information about child's history and experiences.

- 1-3. **CONSIDER:** Has infant had multiple changes in caregivers? Is there an attachment concern? Is infant on autism spectrum or has significant developmental delays? Are there vision or hearing concerns?

TIPS FOR CAREGIVERS: Encourage caregiver to expose infant to behaviors associated with positive emotions: laughing, tickling, smiling, etc. Model for caregiver how to hold and talk to child; play games like peek-a-boo; and interpret and respond to the baby's different cues, e.g. eye brightening, body language like turning toward and away from stimuli, facial expressions. Consult with pediatrician about possible physiological causes. Consider autism, vision and hearing screening. Early Intervention (EI) referral.

4. **CONSIDER:** Has the child experienced trauma, grief and/or loss? Is there an underlying medical concern? Prenatal drug exposure?

TIPS FOR CAREGIVERS: Seek professional assessment. Consider referral to dyadic therapy with an early childhood therapist. Encourage caregiver to provide consistency, love and affection. Encourage caregiver to find outside support to help them through this difficult time.

5. **CONSIDER:** Is the infant developmentally delayed? Are there hearing concerns? Is the child being neglected and/or spending a lot of time by him/herself?

TIPS FOR CAREGIVERS: Hearing screening. Model for caregiver talking to/for the baby and encourage frequent verbal engagement, such as narrating daily activities, reading nursery rhymes, finger plays, singing, etc. Encourage caregiver to respond to any attempts to communicate with sound and to increase auditory stimulation in the environment. EI referral.

6. **CONSIDER:** Does the home environment have challenges like lack of consistency in feeding routine, domestic violence or other interpersonal tensions, etc.? Is caregiver providing enough food to infant? Underlying medical issue?

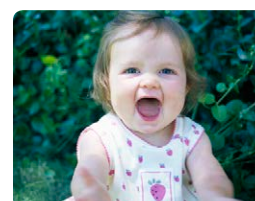
TIPS FOR CAREGIVERS: Encourage caregiver to establish a fun and predictable eating schedule in a calm, unemotional environment with few distractions. Weight checks with pediatrician. Consider referral to a nutritionist.

7. **CONSIDER:** Are the child's social emotional needs being met by caregiver? Is the infant being neglected? Is there an attachment concern? Is the child on the autism spectrum?

TIPS FOR CAREGIVERS: Anticipate child's need for comfort and provide, even if child doesn't indicate the need. Watch closely child's verbal and non-verbal cues for initiating comforting. Referral to dyadic therapist if necessary. Medical assessment for possible autism?

7. **CONSIDER:** Is the child developmentally delayed? Was the child premature and this has caused a delay? Is the child being engaged with on a regular basis and gross motor skills being encouraged?

TIPS FOR CAREGIVERS: Encourage caregiver to place baby on the tummy for "tummy time," for short and increasingly longer periods if the child resists. Ensure regular engagement and encouragement. Refer for an EI assessment.



Typical Social Emotional (SE) Development

SIX MONTHS to a YEAR



INDICATORS of typical SE development

Finds primary caregiver extremely important

Unhappy when primary caregiver leaves

Draws away from strangers

Talks to caregiver in babbling sounds

Imitates behaviors of others

Eating is a major source of interaction

Will not play nicely with other infants; this is because the child doesn't identify others as equal beings

Needs to feel sure that someone will take care of them

COMPLICATIONS for typical SE development

Neglect and abuse

Exposure to violence

Change of caregiver

Lack of stimulating environment

Prenatal drug exposure

Medical complications

RED FLAGS

1. Flat affect, no smiling or desire to engage with people or toys
2. Unwilling to explore surroundings
3. No or poor eye contact with caregiver
4. Doesn't make sounds by themselves or with others
5. Weight loss or plateau
6. Doesn't seek out caregiver when hurt, injured, upset or scared
7. Will indiscriminately go to any adult for comfort, whether known or not known
8. Not rolling over, sitting or beginning to scoot and crawl

With any concern seek additional information about child's history and experiences.

ADDRESSING RED FLAGS

SIX MONTHS to a YEAR

- 1-3. **CONSIDER:** Has the child experienced trauma, change in caregivers and/or experienced abuse or neglect? Autism spectrum? Medical concern?
TIPS FOR CAREGIVERS: Have one caregiver spend more time with infant and engage with toys. Model smiling, laughing and engagement through play (peek-a-boo, finger plays, nursery rhymes, songs). Consider medical assessment. Early Intervention (EI) referral.
4. **CONSIDER:** Has the child been neglected or lacked interaction and engagement with caregivers? Experienced trauma? Developmentally delayed or autism spectrum?
TIPS FOR CAREGIVERS: Encourage caregiver to use books and toys with sounds, sing songs, play patty cake and other finger plays. Early Intervention referral. Consider medical assessment.
5. **CONSIDER:** Neglect of child? Medical issues, such as pain associated with eating due to reflux? Does the child have difficulty eating solid foods? Has the child been sick?
TIPS FOR CAREGIVERS: Pediatrician involvement, possible nutritionist referral. Encourage caregiver to use a weight and nutritional journal, daily and weekly.
6. **CONSIDER:** Is there an attachment concern? Has the child been abused or neglected? Does the caregiver have mental health issues preventing them from engaging/being attentive to the needs of the child?
TIPS FOR CAREGIVERS: Encourage caregiver to help child identify and name feelings (e.g. “You seem scared. I want to give you a hug because you are scared, OK?”) and model expressing affect. Caregiver should reinforce whenever the child initiates comforting. Attempt to comfort the child, even if they cue that they do not need comfort (initially using mild comfort such as touch on the arm and increasing to more typical comforting when hurt). Consider dyadic therapy.
7. **CONSIDER:** Has the child experienced neglect or abuse? Is there an attachment concern? Does the caregiver have mental health issues that are disrupting attachment with the child?
TIPS FOR CAREGIVERS: Consider professional therapy to help with attachment. Seek out a therapist with training in an evidence-based model designed to improve attachment. Redirect the child back to the primary caregiver. Limit excessive visitors to the home and when they are present, encourage them to redirect the child back to primary caregiver.
8. **CONSIDER:** Was the child premature? Is the child developmentally delayed? Is there a medical condition such as cerebral palsy?
TIPS FOR CAREGIVERS: Encourage caregiver to place baby on the tummy for “tummy time,” for short and increasingly longer periods if the child resists. Refer for an Early Intervention assessment. Medical assessment to rule out underlying medical issue. Help caregiver improve home environment opportunities for movement, e.g. opportunities to be on the floor and sufficient uncluttered floor space. Caregiver should try to be on the floor with the infant to encourage more tummy time.



Typical Social Emotional (SE) Development

ONE to TWO YEARS



INDICATORS of typical SE development

Enjoys interacting with familiar adults

Finds primary caregiver still important

Shows fear or nervousness around strangers

Begins to be demanding, assertive and independent; increase in temper tantrums

Copies others

Shows interest in pretend play

Waves bye-bye

Possessive of own things

Plays alone but beginning to play with others

Notices emotions of others

COMPLICATIONS for typical SE development

Neglect and abuse

Exposure to violence

Change of caregiver

Lack of stimulating environment

Prenatal drug exposure

Medical complications

RED FLAGS

1. Flat affect, no smiling or desire to engage with people or toys
2. Unwilling to explore surroundings
3. Lacks emotion or response when toy is taken from them by another child
4. Doesn't make sounds by themselves or with others
5. Not sleeping for long periods or naps
6. Doesn't seek out caregiver when hurt, injured, upset or scared
7. Will indiscriminately go to any adult for comfort, whether known or not known

With any concern seek additional information about child's history and experiences.

ADDRESSING RED FLAGS

ONE to TWO YEARS

- 1-3. **CONSIDER:** Has the child experienced abuse and/or neglect? Have there been multiple caregivers? Is the child on the autism spectrum?

TIPS FOR CAREGIVERS: Be consistent and a safe haven for child. Encourage exploration in safe, quiet places. Engage in fun activities with child. Assess for trauma and toxic stress. Support caregiver to encourage child to express emotions to other children/adults. Express emotions for child, such as 'I'm sad when my toys are taken' followed by 'stop, don't take my toys.'

4. **CONSIDER:** Has child experienced abuse and/or neglect? Is there a family history of speech delays?

TIPS FOR CAREGIVERS: At this age, children should be talking and babbling regularly. Refer for EI assessment. Encourage caregiver to have regular "serve and return" verbal engagement and to incorporate reading, singing, and playing interactive games into daily routines. Therapeutic intervention if related to trauma.

5. **CONSIDER:** Has child experienced abuse and/or neglect? Has the child ever been on a schedule? Has the child experienced trauma and having nightmares or afraid to sleep? Is the child on the autism spectrum?

TIPS FOR CAREGIVERS: Encourage caregiver to provide a consistent sleep schedule and predictable, comforting nap and bedtime routines. Address any underlying trauma that might be affecting sleep through a dyadic therapy referral to an early childhood therapist. If the child is on the autism spectrum—sleep disturbances are common. Melatonin has been used, as prescribed by a pediatrician.

6. **CONSIDER:** Has child experienced abuse and/or neglect? Is or was the caregiver suffering from mental health issues that prevented him or her from responding to the child appropriately?

TIPS FOR CAREGIVERS: Encourage caregiver to help child identify and name feelings (e.g. "You look scared" or "That must have hurt a lot") and model expressing affect. Start with gentle comfort, like light hand on child's arm (if tolerated) and then slowly increase. Caregiver should reinforce whenever the child initiates comforting.

7. **CONSIDER:** Has child experienced abuse and/or neglect? Are there attachment concerns due to trauma? Has the child had multiple caregivers and may therefore see any adult as a source of comfort?

TIPS FOR CAREGIVERS: Consider professional therapy to help with attachment. Seek out a therapist with training in an evidence-based model designed to improve attachment. Explain the need for the caregiver to provide a safe base for child and to provide comfort even when the child doesn't seem to be seeking it. Redirect the child back to the primary caregiver. Limit excessive visitors to the home and when they are present, encourage them to redirect the child back to primary caregiver. Refer for Early Intervention (EI) assessment.



Typical Social Emotional (SE) Development

TWO to THREE YEARS



INDICATORS of typical SE development

Still considers primary caregiver important; fears their departure

Stranger anxiety peaks again

May use security item to self soothe

Imitates adult behavior (washing dishes, mopping floor)

Can do things with others; listen to story, engage in play

Needs to develop sense of self by doing things by themselves

Tests boundaries and limits

Says NO often

Lots of emotions that can vary quickly; sad, happy, scared, angry etc.

Fears loud noises, quick moves, and large animals

COMPLICATIONS for typical SE development

Neglect and abuse

Exposure to violence

Change of caregiver

Lack of stimulating environment

Prenatal drug exposure

Medical complications

RED FLAGS

1. Flat affect, no smiling or desire to engage with people or toys
2. Unwilling to explore surroundings
3. Lacks emotion or response when toy is taken from them by another child
4. Crying all of the time; unable to be soothed
5. Not sleeping for long periods or naps
6. Doesn't seek out caregiver when hurt, injured, upset or scared
7. Will indiscriminately go to any adult for comfort, whether known or not known

With any concern seek additional information about child's history and experiences.

ADDRESSING RED FLAGS

TWO to THREE YEARS

- 1-4. **CONSIDER:** Has the child experienced abuse, neglect or trauma? Had multiple changes in caregivers? On the autism spectrum? Does the caregiver have mental health issues? Has the child been exposed to violence?

TIPS FOR CAREGIVERS: Pediatrician referral, refer for Early Intervention assessment. Seek additional information about child's history. Provide safe space for child to explore. Caregiver should be the secure base from which the child can explore. Limit contact with strangers, so as not to discourage exploration

- 2, 6. **CONSIDER:** Has the child experienced abuse, neglect or trauma? Had multiple changes in caregivers? On the autism spectrum? Does the caregiver have mental health issues? Has the child been exposed to violence?

TIPS FOR CAREGIVERS: Explain the need for the caregiver to provide a safe base for the child's exploration and to encourage fun exploration in a variety of environments, adjusting for the child's temperament and any sensory issues. Encourage caregiver to help child identify and name feelings (e.g. "You look scared" or "That must have hurt a lot") and model expressing affect. Start with gentle comfort, like light hand on child's arm (if tolerated) and then slowly increase. Caregiver should reinforce whenever the child initiates comforting.

5. **CONSIDER:** Has child experienced abuse and/or neglect? Has the child ever been on a schedule? Has the child experienced trauma and having nightmares or afraid to sleep? Is the child on the autism spectrum?

TIPS FOR CAREGIVERS: Encourage caregiver to provide a consistent sleep schedule and predictable, comforting nap and bedtime routines. Address any underlying trauma that might be affecting sleep through a dyadic therapy referral to an early childhood therapist. If the child is on the autism spectrum—sleep disturbances are common. Melatonin has been used, as prescribed by a pediatrician.

6. **CONSIDER:** Has child experienced abuse and/or neglect? Is or was the caregiver suffering from mental health issues that prevented them from responding to the child appropriately?

TIPS FOR CAREGIVERS: Encourage caregiver to help child identify and name feelings (e.g. "You look scared" or "That must have hurt a lot") and model expressing affect. Start with gentle comfort, like light hand on child's arm (if tolerated) and then slowly increase. Caregiver should reinforce whenever the child initiates comforting.

7. **CONSIDER:** Has child experienced abuse and/or neglect? Are there attachment concerns due to trauma? Have they had multiple caregivers and therefore see any adult as a source of comfort?

TIPS FOR CAREGIVERS: Consider professional therapy to help with attachment. Seek out a therapist with training in an evidence-based model designed to improve attachment. Explain the need for the caregiver to provide a safe base for child and to provide comfort even when the child doesn't seem to be seeking it. Redirect the child back to the primary caregiver. Limit excessive visitors to the home and when they are present, encourage them to redirect the child back to primary caregiver. Refer for Early Intervention (EI) assessment.



FAST FACTS



Impact
of Early Abuse
and Neglect

Brain Development

WHAT IS IT?

“Conception to three is the most critical time in [brain development and] human development. Anything is possible during this time.” (Phyllis Porter, MA)

Fostering early brain development has a lasting impact and creates the connections necessary for lifelong social-emotional and cognitive success.

Wiring the Brain

Repeated experiences (positive and negative) create pathways/“wiring” in the brain that allow it to fire off messages more quickly and consistently. The more repeat messages are fired off, the more solid the wiring becomes. Positive experiences cause development of productive wiring. Bad/scary experiences cause development of maladaptive wiring.

Don't Use It then Lose It: Pruning

When a wiring pathway is infrequently used, the brain will prune it. Pruning is most rapid between 1-3 years old. When skills such as emotion regulation are not used or the child focuses on basic survival skills instead, the pathway will be pruned and is much harder to develop later

Toxic Stress impacts brain
development and can lead to
developmental delays

Caregiver Tips for Healthy Brain Development

- Ensure good health, safety and nutrition
- Help children feel safe and secure
- Consistent ‘Serve and Return’ interactions
- Talk, read, sing to and have conversations with child
- Consistent, responsive and loving caregiving
- Encourage safe exploration and play
- Establish flexible routines
- Be responsive to crying
- Remove physical and emotional threats
- Really listen to them; respond to verbal and non-verbal cues

What to Do

- Request Early Intervention or public school evaluation
- Help family to seek professional help when needed
- Advocate to minimize placement changes
- Assign consistent, responsive and nurturing caregiver to each child

FAST FACTS



Impact
of Early Abuse
and Neglect

Levels of Stress—Toxic Stress

WHAT IS IT?

We all have levels of stress in our lives. A little bit of stress can actually be a good thing. But too much stress or prolonged stress can have lasting harmful effects, especially for young children whose brains and bodies are still developing.

Positive Stress

Normal and part of healthy development. Causes brief increase in heart rate, mild elevation in hormone levels. Examples: first day at new child care, short and temporary separation from primary caregiver or receiving immunizations.

Tolerable Stress

Activates body's alert system in cases such as loss of loved one, natural disaster, frightening injury. Time-limited activation is buffered by the responsiveness of adults in child's life. With adult support and responsive care, the brain and organs are able to recover from stress.

Toxic Stress

Strong, frequent or prolonged adversity such as physical abuse, emotional abuse, chronic neglect, exposure to domestic violence. Creates stress response that disrupts development of brain architecture and other organ systems. Body's stress response system is always or frequently on. Interferes with healthy early childhood development in many developmental domains.

WHAT TO DO?

Refer child who has experienced Toxic Stress to Early Intervention (or public school over 3) and/or to early childhood mental health specialists using evidence-based practice to improve attachment, attunement, and positive parenting. Remember that high quality early education/child care is also a powerful protective factor that will contribute to improved short and long-term outcomes for the child.

FAST FACTS



Impact
of Early Abuse
and Neglect

Types of Trauma

WHAT IS IT?

Trauma can be “a single event, a connected series of traumatic events, or chronic lasting stress.”

— Diagnostic Classification: 0-3R

Single Incident

This is a single exposure to a traumatic event. Some examples include: crime victim, serious accident, natural disaster. In most cases post traumatic growth (PTG = healing) can occur.

Chronic

This can be a single type (like abuse) repeated over a period of time, or a variety of types repeated over a period of time. Some examples include: domestic violence, toxic stress caused by child abuse and neglect, war. Anxiety occurs in most cases. There is impaired functioning, but resiliency is accessible and PTG is possible.

Complex Cumulative

This type of trauma is repetitive, cumulative, and usually increases over time. Some examples include: ongoing physical or sexual abuse, war, captivity. There is impaired functioning in all domains in most cases that may include severe anxiety and psychiatric manifestations. Resiliency is lost, and PTG is much more difficult.

WHAT TO DO?

Refer child who has experienced trauma to Early Intervention (or public school over 3) and/or to early childhood mental health specialists using evidence-based practice to improve attachment, attunement, and positive parenting. Remember that high quality early education/child care is also a powerful protective factor for traumatized children.

Domain Specific Signs of Trauma In Infants and Toddlers

Attachment	Physical	Affect Regulation	Behavioral Control	Cognition	Self-Concept
Difficulty trusting others	Sensorimotor problems	Problems with emotional regulation	Poor impulse control	Difficulty paying attention	Lack of predictable sense of self
Uncertain about predictability of others	Hypersensitivity to physical contact	Easily upset and/or difficulty calming	Self-destructive behavior	Lack of sustained curiosity	Poor sense of separation
Interpersonal difficulty	Somatization	Difficulty describing emotions	Aggressive or oppositional behavior	Problems processing information	Disturbance of body image
Social Isolation	Increased medical problems	Difficulty knowing internal state	Excessive compliance	Problems focusing/ completing tasks	Low self-esteem
Difficulty seeking help	Problems with coordination/ balance	Problems with communicating needs	Sleep and eat disturbances	Difficulty anticipating consequences	Shame
Clingy, difficulty with separations			Reenacting of traumatic event	Learning difficulties/ developmental delays	Guilt
			Pathological self-soothing practices	Problems with language development	

Source: National Child Traumatic Stress Network



Social Policy Report Brief

How Abuse and Neglect Affect Children's Minds and Bodies

The Society for Research in Child Development (SRCD) is an international, interdisciplinary organization of scientists, established in 1933 by the National Academy of Sciences.

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This brief summarizes a longer report. The full report and references are available online at www.srkd.org under *Social Policy Report* on the Publications tab.



Why Does This Matter?

More than 676,000 children in the United States are abused and neglected annually, and 1,500 die as a result. Maltreatment harms children's mental health and academic achievement, and increases their risk for chronic diseases of aging. In addition to the human costs, the estimated costs of this maltreatment—billions of dollars annually—have raised calls for better understanding of how maltreatment harms children and more effective approaches to prevention and treatment. New studies on the neurobiological science of maltreatment show that child abuse and neglect alter children's biological systems, including brain development.

Policy and Practice Implications

Research suggests that the period from birth to age 3 is a critical window for identifying families at risk for abuse and neglect, and treating child victims using evidence-based practices. Efforts should focus on:

- Including universal mental health screening in U.S. Child Protective Services evaluations and access to evidence-based behavioral therapies paired with appropriate psychiatric assessments
- Preventing emergence of maltreatment through programs proven effective in the community; examples include the Nurse-Family Partnership, the Safe Environment for Every Kid program, and the Positive Parenting Program, or Triple P

Because the adverse effects of maltreatment can become biologically embedded early in children's development, efforts to treat child abuse and neglect should be renewed and expanded.

Policy and Practice Implications (continued)

- Preventing recurrence of maltreatment; though this has proven more difficult than prevention, some success at reducing recidivism among parents has been seen with multiple referrals to U.S. Child Protective Services using Parent-Child Interaction Therapy
- Offering coordinated systems of care for children and families in the child welfare system, including comprehensive mental and physical health care, with caseworkers, pediatricians, and psychologists working as teams
- Treating victims of maltreatment with evidence-based approaches specific to those who have experienced trauma; such interventions can include the judicious use of psychotropic medications

What the Research Says

- Children are at greatest risk of victimization before age 3, a time of rapid brain development.
- Abused or neglected children are at greater risk for poor health in adulthood, including chronic aging diseases like diabetes, cancer, and heart and lung disease, than nonmaltreated children.
- Abuse and neglect are “toxic stressors”—chronic, uncontrollable events resulting in strong, frequent, or prolonged activation of the body’s stress-management systems.
- Exposure to toxic stress early in development shapes how three integrated systems work: the immune system (which protects against disease), the neuro-endocrine system (which releases hormones to control bodily functions), and the central nervous system (which is comprised of the brain and spinal cord).
- Researchers are beginning to understand how the chronicity, severity, and timing of maltreatment shape the functions of these systems. Researchers can now examine the effects of interventions on helping children regain normal psychobiological functioning.
- Few maltreatment-prevention programs that have been proven effective have been scaled up to work in communities. Evidence is limited on the effectiveness of programs that prevent recurrence of maltreatment.

Facts at a Glance

- U.S. Child Protective Services agencies receive more than 3 million reports of abuse and neglect annually. Some 60% to 65% of these reports are investigated, and approximately 20% of investigations identify at least one child as a victim of abuse or neglect.
- Repeated occurrences of abuse and neglect are seen among families involved in the child welfare system, and approximately 40% of families re-enter the system within five years.
- In a nationally representative sample of children involved with the U.S. child welfare system, between 18% and 22% had significant emotional and behavioral problems as reported by parents, teachers, or other youth, compared to 8% of children in the general population.
- In a given year, new cases of maltreatment are estimated to cost \$80 billion to \$124 billion for medical and mental health services, lost productivity, and crime. Most of this is paid for by taxpayers.
- The Federal Child Abuse Prevention and Treatment Act defines child abuse and neglect as, at minimum, “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.”

This brief summarizes a longer *Social Policy Report* by Sara R. Jaffee, Associate Professor of Psychology at the University of Pennsylvania and Reader in Gene-Environment Interplay at King's College London, and Cindy W. Christian, Chair, Child Abuse and Neglect Prevention at The Children's Hospital of Philadelphia, and Professor of Pediatrics at The Perelman School of Medicine at the University of Pennsylvania. The *Social Policy Report* is based on the proceedings of an expert panel meeting convened by the Administration of Children, Youth, and Families, Department of Health and Human Services (DHHS) in partnership with the National Institute on Drug Abuse and the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development within the National Institutes of Health, DHHS.

The *Social Policy Report* is published quarterly. See the Policy & Media tab at www.srcd.org for recent issues.

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Want to speak to an expert?

Contact SRCD at
communications@srcd.org

How to Build the Child's Social-Emotional "House"

Visualize the house as the social-emotional well-being within all of us. We each have our own individual "house," with all its individual intricacies and unique sections. This is a slow process that happens over a lifetime, but without proper foundation (the base of the house) in the early years, it is impossible to build a solid structure throughout our lives.

Clearing space:

Clearing the space for the baby's social-emotional foundation begins as early as being pregnant. Parents make emotional space for the baby.



Usually this can't be done by one person. Family, friends, partners, community professionals need to be there to help.

Starting the foundation:

A solid foundation is needed for every person's social-emotional house. Without it, everything on top will be compromised.



A group of skilled people need to assist with the building. Family, friends, professionals all are needed to help the baby build their foundation.

To help the baby build a solid foundation: caregivers need to protect the child, make them feel safe and be consistent in meeting their needs. Infants need to learn that the world is a safe place and that adults can be trusted to meet their needs.

Watch the cracks!



Little foundational cracks (or emotional cracks in the child's social-emotional development) appear over time if the foundation was not built well.



Unaddressed, these little cracks become bigger and start affecting the structural integrity of the entire house.

Cracks begin to form when there is no consistent caregiver, or an abusive/neglectful caregiver.

Foundation failure:



FOUNDATION FAILURE

As time passes, the smaller emotional cracks/ issues continue to grow, ultimately compromising the entire structure.



This was probably a grand building at one point, but without a solid foundation, it crumbles and begins to degrade.

If the social-emotional building blocks for the foundation are not there in the beginning, behavioral and emotional concerns develop in the child which can easily extend into relational, behavioral, emotional and health concerns in adulthood.

A house doesn't need to be fancy or grand - it needs to be solid from the ground up.



To ensure the social-emotional health of a child – consistent, responsive caregiving and a supportive environment are critical components.

*****Remember though, it is never too late to do repairs.*****

Adults can help kids repair their foundation--sometimes professional help is needed. When children are older and the damage to the house is more severe, the repairs are more difficult and costly. This is why intervening early on is so critical.

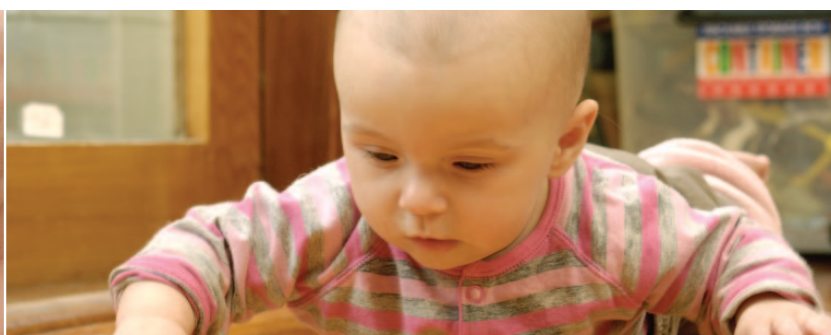
Child development and trauma specialist practice resource: 0 – 12 months

Developmental trends		
The following information needs to be understood in the context of the overview statement on child development:		
0-2 weeks		
<ul style="list-style-type: none"> anticipates in relationship with caregivers through facial expression, gazing, fussing, crying 	<ul style="list-style-type: none"> is unable to support head unaided hands closed involuntarily in the grasp reflex 	<ul style="list-style-type: none"> startles at sudden loud noises reflexively asks for a break by looking away, arching back, frowning, and crying
By 4 weeks		
<ul style="list-style-type: none"> focuses on a face 	<ul style="list-style-type: none"> follows an object moved in an arc about 15 cm above face until straight ahead 	<ul style="list-style-type: none"> changes vocalisation to communicate hunger, boredom and tiredness
By 6-8 weeks		
<ul style="list-style-type: none"> participates in and initiates interactions with caregivers through vocalisation, eye contact, fussing, and crying 	<ul style="list-style-type: none"> may start to smile at familiar faces may start to 'coo' 	<ul style="list-style-type: none"> turns in the direction of a voice
By 3-4 months		
<ul style="list-style-type: none"> increasing initiation of interaction with caregivers begins to regulate emotions and self soothe through attachment to primary carer can lie on tummy with head held up to 90 degrees, looking around can wave a rattle, starts to play with own fingers and toes 	<ul style="list-style-type: none"> may reach for things to try and hold them learns by looking at, holding, and mouthing different objects laughs out loud follows an object in an arc about 15 cm above the face for 180 degrees (from one side to the other) notices strangers 	May even be able to: <ul style="list-style-type: none"> keep head level with body when pulled to sitting say "ah", "goo" or similar vowel consonant combinations blow a raspberry bear some weight on legs when held upright object if you try to take a toy away
By 6 months		
<ul style="list-style-type: none"> uses carer for comfort and security as attachment increases is likely to be wary of strangers keeps head level with body when pulled to sitting 	<ul style="list-style-type: none"> says "ah", "goo" or similar vowel consonant combinations sits without support makes associations between what is heard, tasted and felt 	<ul style="list-style-type: none"> may even be able to roll both ways and help to feed himself learns and grows
By 9 months		
<ul style="list-style-type: none"> strongly participates in, and initiates interactions with, caregivers lets you know when help is wanted and communicates with facial expressions, gestures, sounds or one or two words like "dada" and "mamma" watches reactions to emotions and by seeing you express your feelings, 	<ul style="list-style-type: none"> starts to recognise and imitates happy, sad, excited or fearful emotions unusually high anxiety when separated from parents/carers is likely to be wary of, and anxious with, strangers expresses positive and negative emotions 	<ul style="list-style-type: none"> learns to trust that basic needs will be met works to get to a toy out of reach looks for a dropped object may even be able to bottom shuffle, crawl, stand knows that a hidden object exists waves goodbye, plays peekaboo

Source: Victoria, AU Department of Human Services, © 2012 State of Victoria

Child development and trauma specialist practice resource: 0 – 12 months

Possible indicators of trauma		
<ul style="list-style-type: none"> increased tension, irritability, reactivity, and inability to relax increased startle response lack of eye contact sleep and eating disruption 	<ul style="list-style-type: none"> loss of eating skills loss of acquired motor skills avoidance of eye contact arching back/inability to be soothed uncharacteristic aggression 	<ul style="list-style-type: none"> avoids touching new surfaces eg. grass, sand and other tactile experiences avoids, or is alarmed by, trauma related reminders, eg sights, sounds, smells, textures, tastes and physical triggers
<ul style="list-style-type: none"> fight, flight, freeze response uncharacteristic, inconsolable or rageful crying, and neediness increased fussiness, separation fears, and clinginess withdrawal/lack of usual responsiveness limp, displays no interest 	<ul style="list-style-type: none"> unusually high anxiety when separated from primary caregivers heightened indiscriminate attachment behaviour reduced capacity to feel emotions – can appear ‘numb’ ‘frozen watchfulness’ 	<ul style="list-style-type: none"> loss of acquired language skills genital pain: including signs of inflammation, bruising, bleeding or diagnosis of sexually transmitted disease
Trauma impact		
<ul style="list-style-type: none"> neurobiology of brain and central nervous system altered by switched on alarm response behavioural changes 	<ul style="list-style-type: none"> regression in recently acquired developmental gains hyperarousal, hypervigilance and hyperactivity 	<ul style="list-style-type: none"> sleep disruption loss of acquired motor skills lowered stress threshold lowered immune system
<ul style="list-style-type: none"> fear response to reminders of trauma mood and personality changes loss of, or reduced capacity to attune with caregiver loss of, or reduced capacity to manage emotional states or self soothe 	<ul style="list-style-type: none"> insecure, anxious, or disorganised attachment behaviour heightened anxiety when separated from primary parent/carer indiscriminate relating reduced capacity to feel emotions - can appear ‘numb’ 	<ul style="list-style-type: none"> cognitive delays and memory difficulties loss of acquired communication skills
Parental/carer support following trauma		
<p>Encourage parent(s)/carers to:</p> <ul style="list-style-type: none"> seek, accept and increase support for themselves, to manage their own shock and emotional responses seek information and advice about the child’s developmental progress maintain the child’s routines around holding, sleeping and eating seek support (from partner, kin, MCH nurse) to understand, and respond to, infant’s cues 		
<ul style="list-style-type: none"> avoid unnecessary separations from important caregivers maintain calm atmosphere in child’s presence. Provide additional soothing activities avoid exposing child to reminders of trauma expect child’s temporary regression; and clinginess - don’t panic tolerate clinginess and independence take time out to recharge 		



Source: Victoria, AU Department of Human Services, © 2012 State of Victoria

Child development and trauma specialist practice resource: 12 months – 3 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

By 12 months

- enjoys communicating with family and other familiar people
 - seeks comfort, and reassurance from familiar objects, family, carers, and is able to be soothed by them
 - begins to self soothe when distressed
 - understands a lot more than he can say
 - expresses feelings with gestures, sounds and facial expressions
 - expresses more intense emotions and moods
 - does not like to be separated from familiar people
 - moves away from things that upset or annoy
 - can walk with assistance holding on to furniture or hands
 - pulls up to standing position
 - gets into a sitting position
 - claps hands (play pat-a-cake)
 - indicates wants in ways other than crying
 - learns and grows in confidence by doing things repeatedly and exploring
 - picks up objects using thumb and forefinger in opposition (pincer) grasp
 - is sensitive to approval and disapproval
- May even be able to:**
- understand cause and effect
 - understand that when you leave, you still exist
 - crawl, stand, walk
 - follow a one step instruction – “go get your shoes”
 - respond to music

By 18 months

- can use at least two words and learning many more
 - drinks from a cup
 - can walk and run
 - says “no” a lot
 - is beginning to develop a sense of individuality
 - needs structure, routine and limits to manage intense emotions
- May even be able to:**
- let you know what he is thinking and feeling through gestures
 - pretend play and play alongside others

By 2 years

- takes off clothing
 - ‘feeds’/‘bathes’ a doll, ‘washes’ dishes, likes to ‘help’
 - builds a tower of four or more cubes
 - recognises/identifies two items in a picture by pointing
 - plays alone but needs a familiar adult nearby
 - actively plays and explores in complex ways
- May even be:**
- able to string words together
 - eager to control, unable to share
 - unable to stop himself doing something unacceptable even after reminders
 - tantrums

By 2½ years

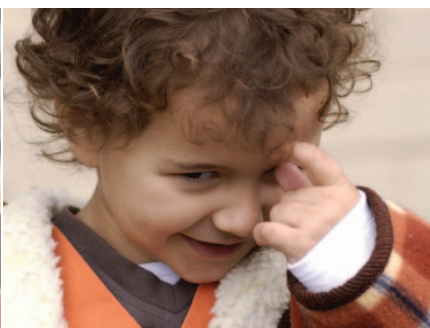
- uses 50 words or more
- combines words (by about 25 months)
- follows a two-step command without gestures (by 25 months)
- alternates between clinginess and independence
- helps with simple household routines
- conscience is undeveloped; child thinks “I want it, I will take it”

By 3 years

- washes and dries hands
- identifies a friend by naming
- throws a ball overhand
- speaks and can be usually understood half the time
- uses prepositions (by, to, in, on top of)
- carries on a conversation of two or three sentences
- helps with simple chores
- may be toilet trained
- conscience is starting to develop; child thinks “I would take it but my parents will be upset with me”

Child development and trauma specialist practice resource: 12 months – 3 years

Possible indicators of trauma		
<ul style="list-style-type: none"> behavioural changes, regression to behaviour of a younger child increased tension, irritability, reactivity, and inability to relax increased startle response sleep and eating disruption 	<ul style="list-style-type: none"> loss of eating skills loss of recently acquired motor skills avoidance of eye contact inability to be soothed uncharacteristic aggression 	<ul style="list-style-type: none"> avoids touching new surfaces eg. grass, sand and other tactile experiences avoids, or is alarmed by, trauma related reminders, eg sights, sounds, smells textures, tastes and physical triggers
<ul style="list-style-type: none"> fight, flight, freeze uncharacteristic, inconsolable, or rageful crying, and neediness fussiness, separation fears, and clinginess withdrawal/lack of usual responsiveness loss of self-confidence 	<ul style="list-style-type: none"> unusually anxious when separated from primary caregivers heightened indiscriminate attachment behaviour reduced capacity to feel emotions – can appear ‘numb’, apathetic or limp ‘frozen watchfulness’ 	<ul style="list-style-type: none"> loss of acquired language skills inappropriate sexualised behaviour/ touching sexualised play with toys genital pain, inflammation, bruising, bleeding or diagnosis of sexually transmitted disease
Trauma impact		
<ul style="list-style-type: none"> neurobiology of brain and central nervous system altered by switched on alarm response behavioural changes 	<ul style="list-style-type: none"> regression in recently acquired developmental gains hyperarousal, hypervigilance and hyperactivity sleep disruption 	<ul style="list-style-type: none"> loss of acquired motor skills lowered stress threshold lowered immune system greater food sensitivities
<ul style="list-style-type: none"> fear response to reminders of trauma mood and personality changes loss of, or reduced capacity to attune with caregiver loss of, or reduced capacity to manage emotional states or self soothe 	<ul style="list-style-type: none"> insecure, anxious, or disorganised attachment behaviour heightened anxiety when separated from primary parent/carer indiscriminate relating increased resistance to parental direction 	<ul style="list-style-type: none"> memory for trauma may be evident in behaviour, language or play cognitive delays and memory difficulties loss of acquired communication skills
Parental/carer support following trauma		
<p>Encourage parent(s)/carers to:</p> <ul style="list-style-type: none"> seek, accept and increase support for themselves to manage their own shock and emotional responses seek information and advice about the child’s developmental progress maintain the child’s routines around holding, sleeping and eating avoid unnecessary separations from important caretakers 		
<ul style="list-style-type: none"> seek support (from partner, kin, MCH nurse) to understand, and respond to, infant’s cues maintain calm atmosphere in child’s presence. Provide additional soothing activities avoid exposing child to reminders of trauma. expect child’s temporary regression; and clinginess - don’t panic tolerate clinginess and independence take time out to recharge 		



Source: Victoria, AU Department of Human Services, © 2012 State of Victoria

Child development and trauma specialist practice resource: 3 – 5 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Between 3-4 years

- communicates freely with family members and familiar others
- seeks comfort, and reassurance from familiar family and carers, and is able to be soothed by them
- has developing capacity to self soothe when distressed
- understands the cause of feelings and can label them
- extends the circle of special adults eg. to grandparents, baby-sitter
- needs adult help to negotiate conflict
- is starting to manage emotions
- is starting to play with other children and share
- has real friendships with other children
- is becoming more coordinated at running, climbing, and other large-muscle play
- can walk up steps, throw and catch a large ball using two hands and body
- use play tools and may be able to ride a tricycle
- holds crayons with fingers, not fists
- dresses and undresses without much help
- communicates well in simple sentences and may understand about 1000 words
- pronunciation has improved, likes to talk about own interests
- fine motor skill increases, can mark with crayons, turn pages in a book
- day time toilet training often attained

Between 4-5 years

- knows own name and age
- is becoming more independent from family
- needs structure, routine and limits to manage intense emotions
- is asking lots of questions
- is learning about differences between people
- takes time making up his mind
- is developing confidence in physical feats but can misjudge abilities
- likes active play and exercise and needs at least 60 minutes of this per day
- eye-hand coordination is becoming more practised and refined
- cuts along the line with scissors/can draw people with at least four 'parts'
- shows a preference for being right-handed or left-handed
- converses about topics and understands 2500 to 3000 words
- loves silly jokes and 'rude' words
- is curious about body and sexuality and role-plays at being grown-up
- may show pride in accomplishing tasks
- conscience is starting to develop, child weighs risks and actions; "I would take it but my parents would find out"



Source: Victoria, AU Department of Human Services, © 2012 State of Victoria

Child development and trauma specialist practice resource: 3 – 5 years

Possible indicators of trauma		
<ul style="list-style-type: none"> • behavioural change • increased tension, irritability, reactivity and inability to relax • regression to behaviour of younger child • uncharacteristic aggression • Reduced eye contact 	<ul style="list-style-type: none"> • loss of focus, lack of concentration and inattentiveness • complaints of bodily aches, pains or illness with no explanation • loss of recently acquired skills (toileting, eating, self-care) • enuresis, encopresis 	<ul style="list-style-type: none"> • sleep disturbances, nightmares, night terrors, sleepwalking • fearfulness of going to sleep and being alone at night • inability to seek comfort or to be comforted
<ul style="list-style-type: none"> • mood and personality changes • obvious anxiety and fearfulness • withdrawal and quieting • specific, trauma-related fears; general fearfulness • intense repetitive play often obvious • involvement of playmates in trauma related play at school and day care • separation anxiety with parents/others • loss of self-esteem and self confidence 	<ul style="list-style-type: none"> • reduced capacity to feel emotions - may appear 'numb', limp, apathetic • repeated retelling of traumatic event • loss of recently acquired language and vocabulary • loss of interest in activities • loss of energy and concentration at school 	<ul style="list-style-type: none"> • sudden intense masturbation • demonstration of adult sexual, knowledge through inappropriate sexualised behaviour • genital pain, inflammation, bruising, bleeding or diagnosis of sexually transmitted disease • sexualised play with toys • may verbally describe sexual abuse, pointing to body parts and telling about the 'game' they played • sexualised drawing
Trauma impact		
<ul style="list-style-type: none"> • behavioural changes • hyperarousal, hypervigilance, hyperactivity • loss of toileting and eating skills 	<ul style="list-style-type: none"> • regression in recently acquired developmental gains • sleep disturbances, night terrors 	<ul style="list-style-type: none"> • enuresis and encopresis • delayed gross motor and visual-perceptual skills
<ul style="list-style-type: none"> • fear of trauma recurring • mood and personality changes • loss of, or reduced capacity to attune with caregiver • loss of, or reduced capacity to manage emotional states or self soothe • increased need for control • fear of separation 	<ul style="list-style-type: none"> • loss of self-esteem and self confidence • confusion about trauma evident in play...magical explanations and unclear understanding of causes of bad events • vulnerable to anniversary reactions set off by seasonal reminders, holidays, and other events 	<ul style="list-style-type: none"> • memory of intrusive visual images from traumatic event may be demonstrated/ recalled in words and play • at the older end of this age range, children are more likely to have lasting, accurate verbal and pictorial memory for central events of trauma • speech, cognitive and auditory processing delays
Parental/carer support following trauma		
<p>Encourage parent(s)/carers to:</p> <ul style="list-style-type: none"> • seek, accept and increase support for themselves to manage their own shock and emotional responses • remain calm. Listen to and tolerate child's retelling of event • respect child's fears; give child time to cope with fears • protect child from re-exposure to frightening situations and reminders of trauma, including scary T.V. programs, movies, stories, and physical or locational reminders of trauma 		
<ul style="list-style-type: none"> • accept and help the child to name strong feelings during brief conversations (the child cannot talk about these feelings or the experience for long) • expect and understand child's regression while maintaining basic household rules • expect some difficult or uncharacteristic behaviour • seek information and advice about child's developmental and educational progress • take time out to recharge 		

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Department of
Human Services

What a child welfare worker can do for young children who have experienced trauma

1. Recognize the signs and symptoms of child traumatic stress and how they vary in different age groups.
2. Recognize that the child welfare system interventions have the potential to either lessen or exacerbate the impact of previous traumas.
3. Decrease the risk of system-induced secondary trauma by serving as a protective and stress-reducing buffer for children:
4. Develop trust with children through listening, frequent contacts, and honesty in order to mitigate previous traumatic stress.
5. Avoid repeated interviews, especially about experiences of sexual abuse.
6. Avoid making professional promises that, if unfulfilled, are likely to increase traumatization.
7. Understand the impact of trauma on development and attachment formation.
8. Understand the cumulative effect of trauma.
9. Ensure developmental screening for young children to identify potential trauma-related developmental challenges and the need for further evaluation and/or services.
10. Consider, carefully, the potential developmental risks to young children when making the decision to remove or change placement.
11. Try to avoid placement changes for children between 6-24 months of age, when safely possible, since this is when attachment is being consolidated.
12. Plan transitions well to allow young children to preserve memories and maintain routines.
13. Gather and document psychosocial and medical information regarding all of the traumas in the child's life to make better-informed decisions.
14. Educate resource parents about the impact of trauma on children of different ages and ask them about reactions and behaviors that could be trauma-related.
15. Assess whether a resource parent is reluctant to attach to a child given that the child is likely to move. Explain that forming a secure attachment, even if short term, is beneficial to the child.

Source:

Adapted from:
The National Child Traumatic Stress Network
Child Welfare Trauma Training Toolkit: Trainer's Guide—2nd Edition
January 2013
www.NCTSN.org
Module 5, pp.79-80

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[*Helping*] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you [*help*] has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a [*helper*]. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the last 30 days.

0=Never	1=Rarely	2=A Few Times	3=Somewhat Often	4=Often	5=Very Often
---------	----------	---------------	------------------	---------	--------------

- _____ 1. I am happy.
- _____ 2. I am preoccupied with more than one person I [*help*].
- _____ 3. I get satisfaction from being able to [*help*] people.
- _____ 4. I feel connected to others.
- _____ 5. I jump or am startled by unexpected sounds.
- _____ 6. I feel invigorated after working with those I [*help*].
- _____ 7. I find it difficult to separate my personal life from my life as a [*helper*].
- _____ 8. I am losing sleep over traumatic experiences of a person I [*help*].
- _____ 9. I think that I might have been “infected” by the traumatic stress of those I [*help*].
- _____ 10. I feel trapped by my work as a [*helper*].
- _____ 11. Because of my [*helping*], I have felt “on edge” about various things.
- _____ 12. I like my work as a [*helper*].
- _____ 13. I feel depressed as a result of my work as a [*helper*].
- _____ 14. I feel as though I am experiencing the trauma of someone I have [*helped*].
- _____ 15. I have beliefs that sustain me.
- _____ 16. I am pleased with how I am able to keep up with [*helping*] techniques and protocols.
- _____ 17. I am the person I always wanted to be.
- _____ 18. My work makes me feel satisfied.
- _____ 19. Because of my work as a [*helper*], I feel exhausted.
- _____ 20. I have happy thoughts and feelings about those I [*help*] and how I could help them.
- _____ 21. I feel overwhelmed by the amount of work or the size of my case[work]/load I have to deal with.
- _____ 22. I believe I can make a difference through my work.
- _____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [*help*].
- _____ 24. I am proud of what I can do to [*help*].
- _____ 25. As a result of my [*helping*], I have intrusive, frightening thoughts.
- _____ 26. I feel “bogged down” by the system.
- _____ 27. I have thoughts that I am a “success” as a [*helper*].
- _____ 28. I can't recall important parts of my work with trauma victims.
- _____ 29. I am a very sensitive person.
- _____ 30. I am happy that I chose to do this work.

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Disclaimer

This information is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a health problem without consulting a qualified health or mental health care provider. If you have concerns, contact your health care provider, mental health professional, or your community health center.

Self-scoring directions, if used as self-test

1. Be certain you respond to all items.
2. On some items the scores need to be reversed. Next to your response write the reverse of that score (i.e. 0=0, 1=5, 2=4, 3=3). Reverse the scores on these 5 items: 1, 4, 15, 17 and 29. Please note that the value 0 is not reversed, as its value is always null.
3. Mark the items for scoring:
 - a. Put an **X** by the 10 items that form the **Compassion Satisfaction Scale**: 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.
 - b. Put a **check** by the 10 items on the **Burnout Scale**: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29.
 - c. **Circle** the 10 items on the **Trauma/Compassion Fatigue Scale**: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28.
4. Add the numbers you wrote next to the items for each set of items and compare with the theoretical scores.

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Your Scores On The ProQOL: Professional Quality of Life Screening

For more information on the ProQOL, go to <http://www.isu.edu/~bhstamm>

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Based on your responses, your personal scores are below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 37 (SD 7; alpha scale reliability .87). About 25% of people score higher than 42 and about 25% of people score below 33. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 33, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout _____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 22 (SD 6.0; alpha scale reliability .72). About 25% of people score above 27 and about 25% of people score below 18. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 27 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Compassion Fatigue/Secondary Trauma _____

Compassion fatigue (CF), also called secondary trauma (STS) and related to Vicarious Trauma (VT), is about your work-related, secondary exposure to extremely stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called VT. If your work puts you directly in the path of danger, such as being a soldier or humanitarian aide worker, this is not secondary exposure; your exposure is primary. However, if you are exposed to others’ traumatic events as a result of your work, such as in an emergency room or working with child protective services, this is secondary exposure. The symptoms of CF/STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 13 (SD 6; alpha scale reliability .80). About 25% of people score below 8 and about 25% of people score above 17. If your score is above 17, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

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FAST FACTS



Impact
of Early Abuse
and Neglect

Vicarious Trauma: Compassion Fatigue and Self Care

WHAT IS IT?

Vicarious Trauma is when you experience a profound shift in your world view due to working with people who have experienced trauma. Compassion Fatigue is the inability to react sympathetically to a crisis, because of overexposure to previous crisis. Self Care is taking the time to do the things that help you take care of yourself.

CHARACTERISTICS:

Compassion Fatigue:

- Similar to burn out
- Cumulative
- Predictable
- Builds over time
- Results in work dissatisfaction
- If unaddressed could lead to serious health problems

Vicarious Trauma:

- Narrows focus
- Intrusive imagery
- Unfolds over time
- Cumulative – effect of work
- Changes the meaning of life
- Affects our world view

WHAT TO DO?

Self care is essential if you work with trauma survivors. It is important to develop coping strategies. Give some thought to the things you can do to take care of yourself: Escape —get away from it all. Rest—have times where you have no goal or time line. Play—Engage in activities that lighten your spirits. Find Help—Talk with your supervisor, call EAP if available, consult with a therapist / counselor.

Signs in Your Life:

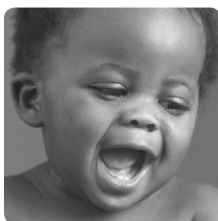
- or energy for yourself
- Difficulty managing your emotions
- Problems managing boundaries
- Disconnection from loved ones
- Physical problems
- Loss of meaning and hope
- Resentment of co-workers

Physical / Psychological Signs:

- Hyperarousal
- Repeated thoughts or images
- Feeling numb
- Unable to tolerate strong emotions
- Increased sensitivity to violence
- Cynicism
- Generalized despair
- Guilt regarding your own happiness
- Anger – Disgust – Fear

5 Simple Steps

to brighten the future for the very young children
in your early education program



1 ENROLL THE CHILD IN HIGH QUALITY CARE

If a child or sibling is not yet enrolled, help the family enroll the child in a high quality early education/child care setting, either in a center or family child care home and obtain releases that enable you to maintain frequent contact with DCF workers, therapists, home visitors, and others who work with the family. Collaboration benefits the child and facilitates access to detailed information about children and their families. Head Start is free for eligible families and can prioritize DCF children

- ▶ See Toolkit Section 5A—Referring to High Quality Child Care/Early Education and 7B—High Quality Early Learning: Importance and Access for Parents
- ▶ To help parents identify high quality programs, see Toolkit Section 7C—Choosing Quality Child Care

2 REFER THE CHILD FOR FREE DEVELOPMENTAL EVALUATION

Refer the child for free developmental evaluation by an early intervention program (Service Net REACH, locally) or public school after age 3, and follow up to make sure that any barriers to a successful evaluation are eliminated and the family engages with services.

- ▶ See Toolkit Section 6-B—Early Intervention and 6-A, Successful Community Referrals

3 EXPLORE OTHER EARLY LEARNING AND FAMILY SUPPORT OPTIONS

Explore eligibility and options for other high quality early learning and family support programs and become skilled at helping families to access these opportunities, such as:

- ▶ Home visiting/early literacy programs like Early Head Start, Healthy Families and the Parent-Child Home Program; local family centers, educational playgroups and parent-child activities; parent education workshops and parent support groups
- ▶ See Toolkit Section 6A-M—Community Resources for Families with Young Children

4 REFER TO EVIDENCE-BASED EARLY CHILDHOOD MENTAL HEALTH SERVICES

Refer to specialized early childhood mental health services that use evidence-based therapy modalities to promote healthy attachments, improved parent-child attunement and positive parenting skills.

- ▶ See Toolkit Section 6H—Child Behavioral Health Initiative (CBHI) and Community Mental Health Services and 6I—Finding the Right Therapy for Young Children and their Families

5 ADVOCATE FOR PLACEMENT CHANGES TO BE KEPT TO AN ABSOLUTE MINIMUM AND HELP MAINTAIN CAREGIVER RELATIONSHIPS

Do everything possible to keep placement changes to an absolute minimum and maintain children's relationships with primary caregivers when out-of-home placement or placement changes are unavoidable.

- ▶ See Toolkit Section 3H—Transitions and Out-of-Home Placements

Reclaiming a Love for Learning

Written by Heather Forbes, LCSW

Children are vulnerable. In an optimal environment, they are not expected to experience this vulnerability until later in life when their minds and nervous systems are equipped to handle elevated levels of fear, stress, and overwhelm. Yet, the key phrase here is “optimal environment.” Unfortunately, we live in the “real” world, so children will often find themselves in situations that are far from the optimal and the result can be childhood trauma.

Childhood trauma happens at both the emotional and psychological level and it can have a negative impact on the child’s developmental process. During a traumatic event (abuse, neglect, adoption, accidents, birth trauma, etc.), the lifelong impact is even greater if the child believes he is powerless, helpless, and hopeless. When a child experiences one or all of these feelings, he begins to believe the world is dangerous. Repeated experiences of these feelings will create a lasting imprint from which he operates and behaves. A framework based in fear and survival becomes the child’s viewpoint of the world around him.

These early life experiences then influence the child’s ability to “behave,” or more correctly expressed, the child’s ability to stay “regulated.” Trauma impacts a child’s ability to stay calm, balanced, and oriented. Instead, children with traumatic histories often find themselves in a “dysregulated” state, which manifests into a child who does not behave, cannot focus, and/or lacks motivation. It is not a matter of choice or a matter of “good” child versus “bad” child; it is simply an imprint from the child’s past history. It’s the child’s new normal.

When working with children like this in the classroom, the most effective way to work with them is to work at the level of regulation, relationship, and emotional safety instead of at the level of behavior. These children’s issues are not behavioral; they are regulatory. Working at the level of regulation, relationship, and emotional safety addresses more deeply critical forces within these children that go far beyond the exchanges of language, choices, stars, and sticker charts.

Traditional disciplinary techniques focus on altering the left hemisphere through language, logic, and cognitive thinking. These approaches are ineffective because the regulatory system is altered more effectively through a different part of the brain known as the limbic system. The limbic system operates at the emotional level, not at the logical level. Therefore, we must work to regulate these children at the level of the limbic system, which happens most easily through the context of human connection.

When the teacher says to a non-traumatized child, “Andy, can you please settle down and quietly have a seat?” Andy has the internal regulatory ability to respond appropriately to his teacher because trauma has not interrupted his developmental maturation of developing self-regulation tools and feeling like he is safe in the world. However, when Billy (the traumatized child) is asked the same question, his response is much different. He takes the long way around the classroom to his seat, he continues to not only talk but projects his voice across the room as if he is still out in the playground, and once seated continues to squirm and wiggle.

Traditionally, we have interpreted Billy as a disruptive child, pasted the label ADHD (attention deficit hyperactivity disorder) onto him, and reprimanded him for his “naughty” behavior. What we have failed to see is that Billy cannot settle down on his own. His internal system has not experienced the appropriate patterning to know how to be well behaved like his classmate Andy and Billy does not know he is safe in this world, even if he is now in a safe environment.

Reclaiming a Love for Learning (2)

The brain-body system is a pattern-matching machine. A child with little internal self-control will pattern himself according to his past external experiences. If his past experiences have been chaotic, disruptive, and overwhelming (trauma), he will continue acting this way until new patterns are established. Thus, a child coming into a calm and safe classroom is still likely to be acting as if he is in his previous chaotic and unsafe environment. A child can be taken out of trauma but not so easily can the trauma be taken out of the child. Past patterns of chaos are now the current framework for navigating his world; he knows no different.

The most effective way to change these patterns comes through safe, nurturing, attuned, and strong human connection. For the student in the classroom, it comes through the teacher-student relationship. The reality is, for our traumatized children to learn and achieve academically, science is showing that they must be engaged at the relational level prior to any academic learning.

Heather T. Forbes, LCSW

Parent and author of:

Beyond Consequences, Logic & Control: Volume 1 & Volume 2, Dare to Love, and Help for Billy

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Source: Beyond Consequences Institute eNewsletter, Issue 8 | www.beyondconsequences.com

Notes

Behavior as Communication

- 2-A Fast Facts | Attachment
- 2-B Why is Attachment Important?
- 2-C Attachment Differences
- 2-D Secure vs. Insecure
- 2-E Circle of Security
- 2-F On the Path to Trust and Security
- 2-G Fast Facts | Temperament
- 2-H Infant-Toddler Temperament Tool
- 2-I Challenging Behavior Diagram
- 2-J Fast Facts | Emotion Regulation
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- 2-M Prenatal Drug and Alcohol Exposure Charts

CHILD WELFARE
TOOLKIT



FOR EARLY CHILDHOOD PROFESSIONALS



FAST FACTS



Behavior
as
Communication

Attachment

WHAT IS IT?

“A deep and enduring emotional bond that connects one person to another across time and space”

— Ainsworth, 1973; Bowlby, 1969

TYPES:

Securely Attached:

A child who experiences responsive, nurturing, consistent caregiving is more likely to be securely attached and have a positive self image. This optimistic view of self extends to others who are perceived as trustworthy, caring, and protective.

Secure attachment is a major protective factor for children.

Insecurely Attached: :

A child who experiences inconsistent, unresponsive or insensitive caregiving can develop an insecure attachment style and have an internal working model that perceives themselves, their environment, and others negatively and not to be trusted.

Insecure attachment is a major risk factor for children.

WHAT TO DO?

Refer child and caregiver to effective, evidence-based therapy. Some examples are: Dyadic Developmental Psychotherapy, Infant-Parent Psychotherapy, Child-Parent Psychotherapy, Play Therapy for a child 2/3 years or older if caregiver is unavailable or Attachment Self-Regulation and Competency Therapy. **Ask area mental health clinics what type of therapy they can provide that is specialized for infants, toddlers or preschoolers.**

Secure Attachment:

65% of general population has secure attachment

Child explores freely when caregiver is present

Typically will engage with strangers.

Visibly upset when caregiver leaves and happy when they return

Trusts that his/her needs will be met

Insecure Attachment:

35% of the population has insecure attachment

Child appears anxious or uninterested in the environment. Child is wary of strangers, or appears uninterested.

Will avoid or appear uninterested or angry when absent caregiver returns.

Does not trust that his/her needs will be met

Why is attachment important?

Infants develop a 'sense of self' through relationships with other people

Influences ability to maintain commitments to work and/or school as older child and adult

Informs child's view and engagement in future relationships

Builds trust, empathy, conscience, and compassion for others

The quality of caregiver/child relationship has a profound effect on child's social-emotional development, personality formation and social competence.

Influences ability to raise healthy, happy children of their own

Impacts child's ability to focus on learning and growing

Attachment Differences

SECURE ATTACHMENT

65% of general population has Secure Attachment

Child: Explores freely when caregiver is present
Typically will engage with strangers
Visibly upset when caregiver leaves and happy when he/she returns

Child's world view: Trusts that his/her needs will be met

Attachment figure: Quick to respond, sensitive, consistent

ANXIOUS-AVOIDANT ATTACHMENT

20% of general population has Anxious-Avoidant Attachment

Child: Not very explorative, emotionally distant
Often ignores/avoids caregiver upon reunion
Strangers not treated differently than caregiver

Child's world view: Subconsciously believes his needs will not be met

Attachment figure: Distant, disengaged or little engagement

Attachment Differences (2)

ANXIOUS-RESISTANT or AMBIVALENT ATTACHMENT

10-15% of general population has Anxious-Resistant or Ambivalent Attachment

Child: Anxious, insecure, angry
Wary of strangers, even when caregiver is present
Highly upset upon separation but ambivalent upon reunion with caregiver

Child's world view: Can't consistently rely on her needs being met

Attachment figure: Inconsistent, sometimes sensitive, sometimes neglectful

DISORGANIZED ATTACHMENT (INSECURE)

10-15% of general population has Disorganized Attachment

Child: Depressed, angry, completely passive, nonresponsive
Will sometimes freeze
No organized, behavioral way to deal with stress
Often see caregiver as frightening or frightened

Child's world view: Severely confused with no strategy to have his needs met

Attachment figure: Distant, disengaged, aggressive, frightened

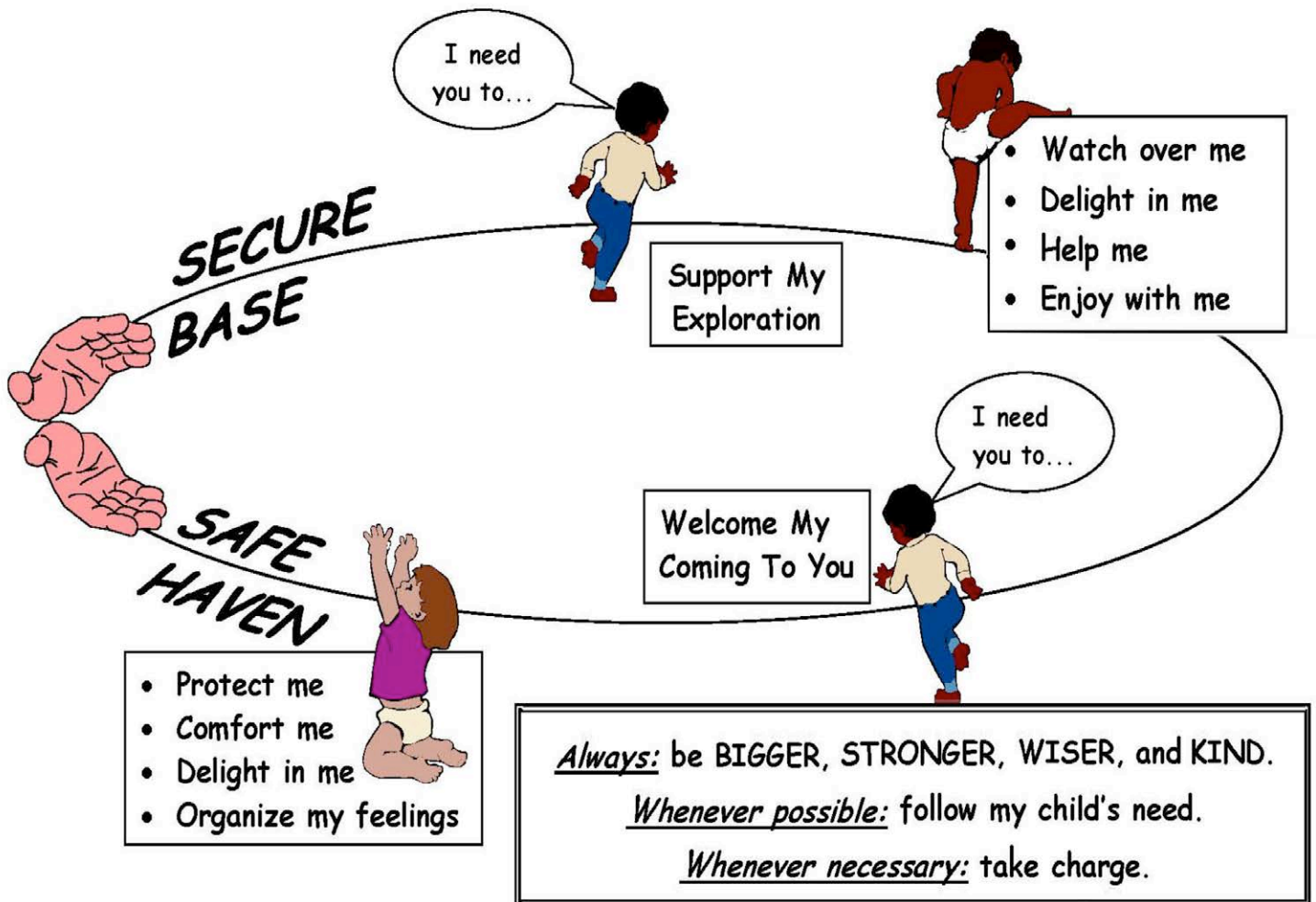
Looking at the Differences Between
Securely Attached Children and Insecurely Attached Children
- Adapted from Murphy, J., "Rethinking the Way you Parent", Oct. 2002.

SECURELY ATTACHED CHILD	INSECURELY ATTACHED CHILD
"Time out" is effective	"Time in" is effective - Promote connection
Encourage Independence	Encourage Dependence
Offer/allow choices	Help child make appropriate choices
Ask child about her feelings	Help child to interpret her feelings
Reinforce social norms and behavioral expectations	Model social norms and appropriate behavior
Touch is a wanted connection - affection is comforting	Touch can be uncomfortable and threatening - unless it is on the child's terms
Child has a sense of safety and appropriate boundaries	Child is not aware of physical danger - can be a risk taker
Child will learn social skills through experience and observation	Social skills do not come naturally - internalization of skills may take time and consistent modeling
Supervision of child eases with age and ability	Child needs intensive supervision regardless of age
Self control is developing	Poor self control - low frustration tolerance
Child feels remorse	Feelings are disorganized - often expressed as anger
Child's ability to feel empathy is developing	Child may have little to no empathy - may take time and modeling

Source: Murphy, J., Rethinking the Way you Parent, October 2002

CIRCLE OF SECURITY

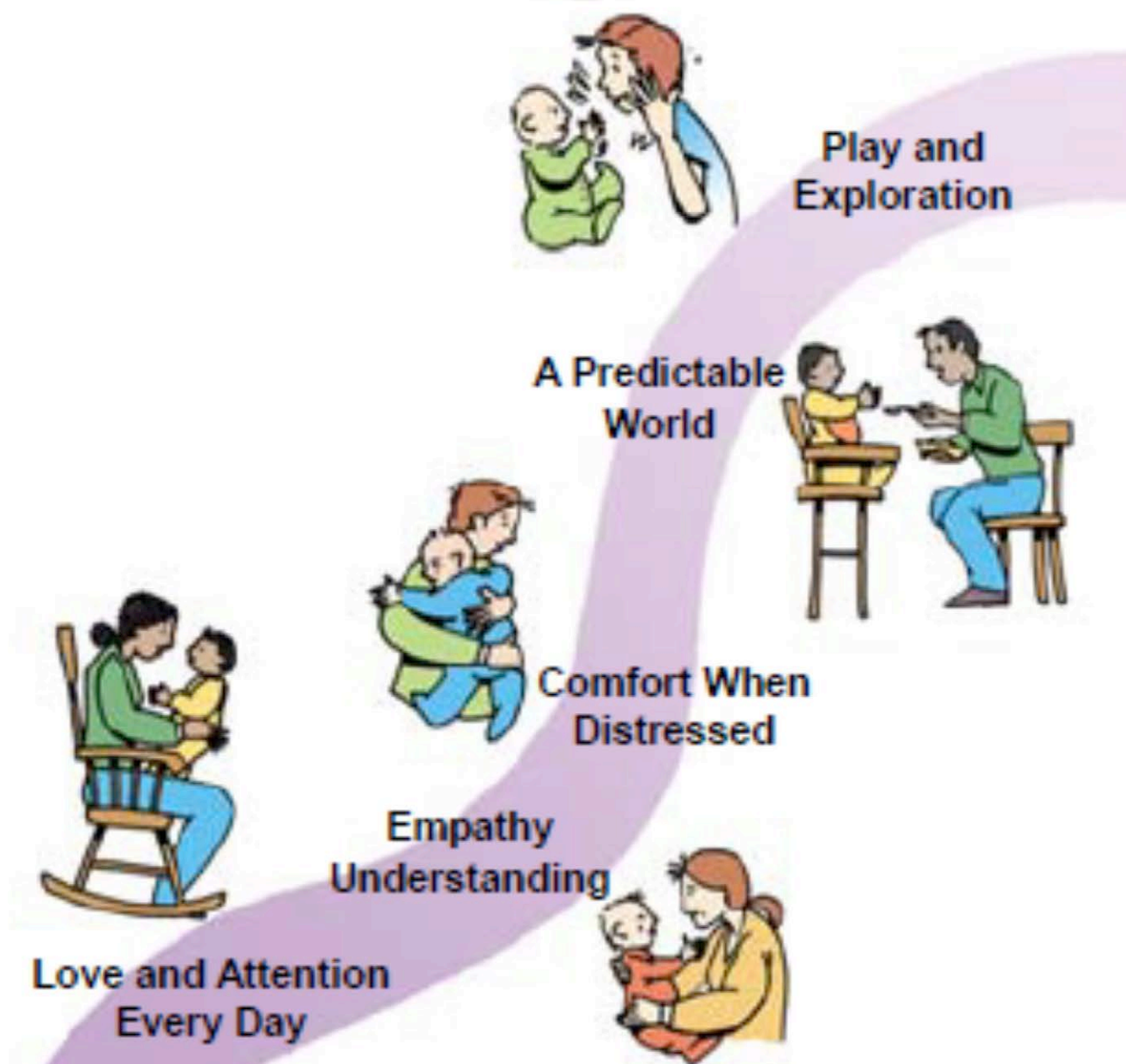
PARENT ATTENDING TO THE CHILD'S NEEDS



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circleofsecurity.org

Source: Circle of Security.org, ©1998 Cooper, Hoffman, Marvin, & Powell

On the Path to Trust and Security



Source: Kelly, Zuckerman, Sandoval, and Buehlman, 2003

FAST FACTS



Behavior
as
Communication

Temperament and Goodness of Fit

WHAT IS IT?

Everybody is born with a temperament. Temperament refers to aspects of an individual's personality. It is thought to be innate, rather than learned. It is a fixed entity with both positive and negative characteristics.

WHY DOES TEMPERAMENT MATTER?

Some temperaments in children make it more challenging for caregivers to do their job. A caregiver's temperament and a child's temperament are important to consider when thinking about why it may be a challenging relationship. Knowing about your own temperament vs. that of a child can be very helpful when working on improving your caregiving skills. A good match between the child and the caregiver (goodness of fit) can help facilitate a secure and positive attachment. When there is a mismatch, the adult must adjust rather than the child.

HOW CAN THE DCF SOCIAL WORKER USE THIS INFORMATION?

When assigning child to a classroom or primary provider, think about the child's temperament and goodness of fit.

Educate staff about temperament and goodness of fit.

Offer them the temperament checklist (Toolkit 2-G).

Help educators plan adjustments they can make in order to improve temperamental fit with a child.

When working with families, think about the temperaments of all involved, including yourself!

INFANT TODDLER TEMPERAMENT TOOL (IT³)

SUPPORTING A “GOODNESS OF FIT”



INTRODUCTION TO TEMPERAMENT

Temperament is an important feature of social and emotional health. The word “temperament” refers to the way we approach and react to the world. It is our own personal “style” and is present from birth. There are three general types of temperaments: easy-going, slow-to-warm, and active.

Easy-going children are generally happy and active from birth and adjust easily to new situations and environments. Slow-to-warm children are generally observant and calm and may need extra time to adjust to new situations. Children with active temperaments often have varied routines (eating, sleeping, etc.) and approach life with zest.

There are nine common traits that can help describe a child’s temperament and the way he or she reacts to and experiences the world. The **Temperament Chart** on the next page explains these traits in more detail. They are:

- Activity level
- Regularity
- Adaptability
- Distractibility
- Sensitivity
- Persistence
- Intensity
- Approachability
- Mood

GOODNESS OF FIT

Each caregiver and parent also has his or her own temperament. The compatibility between adult and child temperaments can affect the quality of relationships. This compatibility is often called “goodness of fit.” Goodness of fit happens when an adult’s expectations and methods of caregiving match the child’s personal style and abilities. Goodness of fit does not mean that adult and child temperaments have to match. The parent or caregiver does not have to change who they are. They can simply adjust their caregiving methods to be a positive support to their child’s natural way of responding to the world. For example, if a child is highly active, a caregiver may pack extra activities in the diaper bag for waiting times at visits to the doctor, grocery store lines, etc. For a child who needs some extra time in approaching new activities, a caregiver might stay close by, giving the child time to adjust and feel safe.

The Infant Toddler Temperament Tool (IT³) was developed for the Center for Early Childhood Mental Health Consultation, an Innovation and Improvement Project funded by the Office of Head Start. (Grant #90YD026B)

Source: The Infant Toddler Temperament Tool (IT³) | Center for Early Childhood Mental Health Consultation

T E M P E R A M E N T T R A I T S

DIMENSIONS	TYPICAL BEHAVIORAL INDICATOR	THE ADULT ...	THE CHILD ...
ACTIVITY LEVEL refers to the general level of motor activity when one is awake or asleep. Motor activity involves large and small muscle movement like running, jumping, rolling over, holding a crayon, picking up toys, etc.	HIGH ACTIVITY	has difficulty sitting still.	is squirmy and active.
	LOW ACTIVITY	sits back quietly and prefers sedentary activities.	prefers less noise and movement.
DISTRACTIBILITY is the ease with which one can be distracted, or one's level of concentration or focus.	HIGH DISTRACTIBILITY	has difficulty concentrating, and paying attention when engaged in an activity and is easily distracted by sounds or sights during activities.	is very distracted by discomfort, noticing even small signals of discomfort such as hunger, feeling sleepy, etc.
	LOW DISTRACTIBILITY	has a high degree of concentration, pays attention when engaged in an activity, and is not easily distracted by sounds or sights during activities.	can handle discomfort and does not seem very bothered at all.
INTENSITY refers to the energy level of one's emotional response, both positive and negative.	HIGH INTENSITY	has strong/intense positive and negative reactions.	
	LOW INTENSITY	has muted emotional reactions.	
REGULARITY relates to the predictability of biological functions such as eating, sleeping, etc.	HIGHLY REGULAR	has predictable appetite, sleep, and elimination patterns.	
	IRREGULAR	has unpredictable appetite, sleep, and elimination patterns.	
SENSITIVITY describes how sensitive one is to physical stimuli such as light, sound, and textures.	HIGH SENSITIVITY	is sensitive to physical stimuli including sounds, tastes, touch, and temperature changes; is a picky eater and has trouble sleeping in a strange bed.	
	LOW SENSITIVITY	is not sensitive to physical stimuli, including sounds, tastes, touch and temperature changes; can fall asleep anywhere and tries new foods easily.	
APPROACHABILITY is one's initial response to new places, situations, or things.	HIGH APPROACHING	eagerly approaches new situations or people.	
	LOW APPROACHING	is hesitant and resistant when faced with new situations, people or things.	
ADAPTABILITY describes how easily one adjusts to changes and transitions.	HIGH ADAPTABILITY	transitions easily to new activities and situations.	requires a very small amount of time to feel OK in new situations.
	LOW ADAPTABILITY	needs more time for transitioning to new activities or situations.	may cry or stay close to caregiver before approaching a new situation.
PERSISTENCE relates to the length of time one continues in activities in the face of obstacles.	HIGH PERSISTENCE	continues with a task or activity in the face of obstacles and does not get easily frustrated.	
	LOW PERSISTENCE	moves on to a new task or activity when faced with obstacles and gets frustrated easily.	
MOOD is one's tendency to react to the world mainly in a positive or negative way.	POSITIVE MOOD	reacts to the world in a positive way and is generally cheerful.	
	SERIOUS MOOD	reacts to situations in an observant, sometimes more serious way; tends to be thoughtful about new situations.	

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 2 •

Source: The Infant Toddler Temperament Tool (IT³) | Center for Early Childhood Mental Health Consultation

DIRECTIONS FOR COMPLETING THE **TODDLER** VERSION OF IT³

FOR INFANTS 18 TO 36 MONTHS.

COMPLETION TIME: 5-10 MINUTES.

I AM COMPLETING THE IT³ FOR MYSELF AND _____
(TODDLER'S NAME)

Complete this brief **TODDLER** version of the IT³ to determine the “goodness of fit” between you and the child you have in mind for this activity. Remember, there are no “good” or “bad” temperamental traits; we are all born with unique personalities that make us special. The results and “goodness of fit” suggestions will help you to enhance your caregiving methods as a positive support for the child.

Please rate yourself and the toddler on the following nine traits. For each trait, fill in the circle that comes closest to describing your regular behaviors and those of the infant. You can refer to the previous page and chart of Temperament Traits for definitions of each trait.

Use the following statements to focus your thinking as you review each trait for yourself and the toddler:

- More often than not, I behave in a way that can be described as:
- More often than not, the toddler behaves in a way that can be described as:

DIMENSIONS	TYPICAL BEHAVIORAL INDICATOR	I AM ...	MY TODDLER IS...
1. ACTIVITY LEVEL	Highly Active	<input type="radio"/>	<input type="radio"/>
	Less Active	<input type="radio"/>	<input type="radio"/>
2. DISTRACTIBILITY	Easily Distracted	<input type="radio"/>	<input type="radio"/>
	Less Distracted (More Focused)	<input type="radio"/>	<input type="radio"/>
3. INTENSITY	Intense Personality	<input type="radio"/>	<input type="radio"/>
	Relaxed Personality	<input type="radio"/>	<input type="radio"/>
4. REGULARITY	Highly Regular	<input type="radio"/>	<input type="radio"/>
	More Spontaneous (Irregular)	<input type="radio"/>	<input type="radio"/>
5. SENSITIVITY	Highly Sensitive	<input type="radio"/>	<input type="radio"/>
	Less Sensitive	<input type="radio"/>	<input type="radio"/>
6. APPROACHABILITY	Highly Approachable	<input type="radio"/>	<input type="radio"/>
	Less Approachable	<input type="radio"/>	<input type="radio"/>
7. ADAPTABILITY	Highly Adaptable	<input type="radio"/>	<input type="radio"/>
	Less Adaptable	<input type="radio"/>	<input type="radio"/>
8. PERSISTENCE	Highly Persistent	<input type="radio"/>	<input type="radio"/>
	Less Persistent	<input type="radio"/>	<input type="radio"/>
9. MOOD	Positive Mood	<input type="radio"/>	<input type="radio"/>
	Serious Mood	<input type="radio"/>	<input type="radio"/>

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 3 •

Source: The Infant Toddler Temperament Tool (IT³) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

ACTIVITY LEVEL

Refers to the general level of motor activity when one is awake or asleep. Motor activity involves large and small muscle movement like running, jumping, rolling over, holding a crayon, picking up toys, etc.

I am ...	My toddler is ...
● Highly Active	● Highly Active

You and your child share a similar activity level.

- Enjoy scooting, crawling, walking, running and climbing inside and outside with your child.
- Make sure that you and your child both take time for rest. Help your child learn to take a break by modeling the signs of feeling tired, as well as ways that you like to take rests — for example, relaxing in a chair with a book, taking a deep breath, or coloring.
- If your child is younger, describe the signals he/she gives to let you know that he/she is ready for a break. *“I see you are looking around at other things and you are wiggling in my lap. How about we go outside for a while?”*

I am ...	My toddler is ...
● Highly Active	● Less Active

You and your child seem to differ in activity level. Here are some ideas to help you support your child’s lower level of activity.

- Make sure there are specific quiet areas that are still in full view where your child can relax and observe. For example, use beanbag chairs that toddlers can move around the room and sit in when they need time for themselves.
- Do not require your child to participate in movement or other active activities (such as dancing while you play a song) until he/she is ready to join.
- Let your child know he/she can take breaks during the day if he/she is tired.
- Give positive attention to your child when he/she successfully transitions to naptime or another quiet experience.
- Support your child in playing with things he/she enjoys such as books, puzzles, blocks, dolls, etc.
- Allow your child to wake up at his/her own pace and re-enter classroom activities.

I am ...	My toddler is ...
● Less Active	● Highly Active

You and your child seem to differ in activity level. Here are some ideas to help you support your child’s higher level of activity.

- Allow extra time for outdoor activities (for example, crawling, running, climbing, etc.) so that your child can “let off steam.”
- Provide many indoor opportunities to support your child’s large muscle skills, such as creating an obstacle course with pillows and cushions, dancing to music, etc.
- Use your child’s energy level as an example to excite other children. *“You are jumping up and down to the music. Jason and Lei, would you like to join him?”*
- Give advance warning of naptime, because it may be hard for your child to transition to resting. Start winding down from active play about 30 to 60 minutes before bedtime or napping.

I am ...	My toddler is ...
● Less Active	● Less Active

You and your child share a similar activity level.

- Enjoy cozying up on the couch or in a chair with a book or soothing music.
- Establish brief, consistent times during the day for outlets of physical activity. This will help you and your child feel ready to get moving.
- Expand favorite activities as a way to get in some movement. For example, stand up and act out a favorite story with your child, or put on his/her favorite music and rock and sway together around the room.
- Support your child if he/she is not ready to join others in highly active play. Narrate what you see and let him/her observe. *“The kids are chasing each other. Do you see them going fast?”*

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 4 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

DISTRACTIBILITY

Is the ease with which one can be distracted or one's level of concentration or focus.

I am ...	My toddler is ...
● Easily Distracted	● Easily Distracted

You and your child share a similar level of distractibility.

- Try to limit distractions while spending time with your child. For example, choose to listen to music or read a book rather than having the music on in the background while reading.
- Help your child learn to recognize the signs of becoming overstimulated. You can do this by talking about what overstimulates you and how you refocus your attention. *"The television is making it hard for me to cook dinner. I am going to turn it off so I can pay attention."*
- Label the signals your child provides to communicate that he/she is getting distracted or overstimulated. *"You are yawning and turning away from me when I sing. I think you are done with the song."*

I am ...	My toddler is ...
● Easily Distracted	● Less Distracted

You and your child seem to differ in the area of distractibility. Here are some ideas to support the fit between you and your child's more focused nature.

- Accommodate your child by allowing longer experiences that he/she can handle. *"You are so busy looking at the stories — would you like to look at a few more?"*
- Give your child frequent reminders that a transition is coming, so he/she can be prepared in advance: *"It's almost time for lunch. We have about five minutes left for playtime."* When possible use many different ways to remind children of transitions. Adults can use picture cards to remind children what is happening next, a gentle tap on the shoulder, a simple transition song, or other methods that support the child's style of learning.
- Encourage your child to interact with other children while playing, and notice and describe interactions between him/her and other children. *"Adam is looking at the red ball you have. Could you roll it back and forth?"*

I am ...	My toddler is ...
● Less Distracted	● Easily Distracted

You and your child seem to differ in the area of distractibility. Here are some ideas to support the fit between you and your child's distractibility.

- Use simple step-by-step directions that are clear and easy to understand: *"First put on your shoes. Next, you can put on your coat."*
- Limit the number of choices, so it is easier for your child to respond. *"Do you want milk or juice?"* It can be helpful to hold up the actual choices as a visual reminder.
- Acknowledge when your child is becoming distracted. Then gently redirect his/her attention to the current experience he/she is engaged with. *"I notice you are looking away from the puzzle. Would you like to put one more piece in to finish it up?"*
- Follow your child's lead in play when possible: *"Your car is going fast! Can my car follow?"* Be willing to shorten activities to accommodate his/her emerging ability to concentrate and focus.

I am ...	My toddler is ...
● Less Distracted	● Less Distracted

You and your child share a similar level of focus.

- Take pleasure and joy in your chance to have uninterrupted time with each other and with objects. Use this time to discover together and share laughter.
- When making plans for your day, use advance warnings about transitions and changes in your schedule. You might use visuals to help with transitions. For example, if you are going to visit someone, you could show that person's photo to your child and give warning. *"In a few minutes we are going to drive over to visit Ms. Lohmann."*
- Because it may be easy to get lost in one type of activity, consider planning several activities to provide a variety of experiences during the day, such as, climbing or crawling outside, interactive play like "Peekaboo" or hide-and-seek, sharing stories with colorful pages, and taking part in daily routines.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — TODDLER VERSION

• 5 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

INTENSITY

Refers to the energy level of one's emotional response, both positive and negative.

I am ...	My toddler is ...
● Intense	● Intense

You and your child both have fairly intense personalities.

- Enjoy sharing big smiles and laughter while recognizing your child's similarly big frowns and tears.
- Help your child learn to accept his/her big feelings by providing descriptions of those feelings as well as ways to calm down when the feelings (positive or negative) become too big. *"You are kicking your legs and waving your arms to the music — are you excited?"*
- Model the types of reactions you would like to see in your child. For example, if you are feeling frustrated, take a few deep breaths to calm down.
- Find ways to sooth your child when he/she is feeling strong emotions (for example, rubbing his/her back, swaying to gentle music, singing softly, gently holding, etc.). Be sure to share your most successful strategies with your child's caregivers.

I am ...	My toddler is ...
● Intense	● Relaxed

You and your child seem to differ in the area of intensity. Here are some ideas to support the fit between you and your child's "low intensity."

- Because your child may not have strong reactions, try to label possible emotions for him/her. *"You are frowning. Are you sad that the puppy ran off?"*
- Support emotions as your child experiences them. *"You feel upset that it is time to go outside. You are not done with your puzzle."*
- Provide cozy, quiet areas so that your child is not overwhelmed by active situations. You can use beanbag chairs, pop-up tents, or pillows and blankets to create safe areas for your child to calmly observe and take in activities around him/her.
- Create activities that promote emotional awareness, such as asking your child how he/she feels each morning. Share how you feel as well. Try creating a feelings chart with pictures of different emotions that can help your child identify how he/she is feeling.

I am ...	My toddler is ...
● Relaxed	● Intense

You and your child seem to differ in the area of intensity. Here are some ideas to support the fit between you and your child's level of intensity.

- Try to accommodate strong emotional reactions by putting yourself in your child's shoes. Ask yourself, *"What must it be like to be my child in this situation?"*
- Help your child through a strong negative reaction by relating it to you. For example: *"I don't like it when people take my things without asking either. How can we make this better?"*
- When your child is having a strong negative reaction, try to remain calm and be a "safe place" for your child. *"I know you are upset right now. I will be right here when you need me."*
- Label your child's emotions and help to validate them. *"I can tell you are really excited right now to have this applesauce. That's great! In a few minutes you may be a little calmer, and I can give you your spoon to use by yourself!"*

I am ...	My toddler is ...
● Relaxed	● Relaxed

You and your child both have fairly relaxed personalities.

- Consider practicing, identifying, and labeling emotions with your child, so that he/she can recognize and accept his/her own and others' emotions. Look at storybooks about emotions. Reflect together on what you see.
- Take time to explain to your child what others may be feeling. *"The baby is crying! She dropped her toy."*
- Label your child's emotions, paying special attention to both obvious and subtle clues in their behavior, like furrowed brows, upturned eyes, looking away, cooing, clenching of fists, babbling, waving arms, etc.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — TODDLER VERSION

• 6 •

Source: The Infant Toddler Temperament Tool (IT³) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

REGULARITY

Relates to the predictability of biological functions such as eating, sleeping, etc.

I am ...	My toddler is ...
● Highly Regular	● Highly Regular

You and your child share a similar level of regularity.

- Follow your instincts of maintaining a consistent and predictable routine for you and your child.
- Share your child's preferred daily routine with others who care for him/her.
- Help your child learn to feel comfortable with unplanned interruptions in his/her schedule by using descriptions to label how it makes you feel when this happens.
- Support him/her by using a picture schedule. For example, use single-object pictures to create a schedule that shows your child that he/she will eat breakfast first and then get dressed.

I am ...	My toddler is ...
● Highly Regular	● More Spontaneous

You and your child seem to differ in the area of regularity. Here are some ideas to support the fit between you and your child's spontaneity.

- Try to allow your child to nap or rest for shorter or longer than other children if it seems necessary. Have your child use quiet toys while awake if others are still resting.
- Watch your child closely to notice his/her eating patterns — and try your best to accommodate them.
- Provide many opportunities for diaper changing or toileting.
- Give advance reminders when transitions are coming, so that your child can be prepared.

I am ...	My toddler is ...
● More Spontaneous	● Highly Regular

You and your child seem to differ in the area of regularity. Here are some ideas to support the fit between your spontaneity and your child's regularity:

- Accommodate your child's regular appetite by providing meals at the same time each day.
- Recognize how your child lets you know that it's time to use the bathroom.
- Try to provide your child with a routine nap schedule that he/she can feel secure with.
- Try to give advance reminders to your child when the daily schedule will be disrupted.

I am ...	My toddler is ...
● More Spontaneous	● More Spontaneous

You and your child share a similar level of spontaneity.

- Enjoy the spontaneity of the day. For example, if you planned to go outside but your child is interested in the water and bubbles as you wash dishes, let him/her join in by providing a sponge and a bowl of warm sudsy water.
- Be prepared for change as you plan for the day. This will also be helpful for your child. If he/she gets tired a little earlier, go with it and make time to rest. Or, if your child is not showing signs of being tired, let him/her stay up a little longer doing some quiet activities.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

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Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

SENSITIVITY

Describes how sensitive one is to physical stimuli such as light, sound, and textures.

I am ...	My toddler is ...
● Highly Sensitive	● Highly Sensitive

You and your child share a similar level of sensitivity.

- Enjoy the quiet, cozy moments of your day together, like nap and bedtime, as times to connect. Use these times to talk softly about your day or sing songs in a soothing tone.
- When you find yourselves in environments that are louder or brighter than you both enjoy, help your child adjust by finding a quiet space to be together.
- Provide soft clothing and textures for your child.
- Use a warm, supportive tone to help your child as he/she works through emotions.

I am ...	My toddler is ...
● Highly Sensitive	● Less Sensitive

You and your child seem to differ in the area of sensitivity. Here are some ideas to support the fit between you and your child's lower sensitivity.

- Engage your child in activities with lots of sensory experience (for example, playing a song while dancing and holding hands with others, finger painting, water play, play dough, etc.)
- Use a funny, dramatic voice while reading stories. Be silly!
- Even though your child may have lower sensitivity, still check in to see if he/she is handling a stimulating situation well. *"It's loud in here — how are you feeling?"*
- Offer new kinds of foods for your child to try.
- Draw positive attention to your child when he/she is enjoying a new experience. *"You are playing with the sudsy water and are pouring it in and out. How does it feel on your hands?"*

I am ...	My toddler is ...
● Less Sensitive	● Highly Sensitive

You and your child seem to differ in the area of sensitivity. Here are some ideas to support the fit between you and your more sensitive child.

- When engaging in a stimulating experience such as music, offer your child other less stimulating options such as quiet reading time or an area close by to safely observe.
- React sensitively when your child is overwhelmed by his/her surroundings. Help find a quiet activity. *"I notice you are tightening your fists and frowning. Is the bright light bothering your eyes?"*
- Let your child know when you are about to touch him/her. *"I am going to pick you up gently now so we can go and put on a fresh diaper."*
- Give your child experiences with sensory materials by putting sand, dirt, corn starch, water, etc., inside sealed plastic baggies.
- Offer tools that your child can use to experience new textures at his/her own pace. For example, have tongs available for picking up textured objects, paint brushes for experimenting with sticky glue, gloves for finger painting, etc.

I am ...	My toddler is ...
● Less Sensitive	● Less Sensitive

You and your child share a similar level of sensitivity.

- Have fun singing loudly and dancing to music together.
- Provide fun activities using bubbles, sand, water, sandpaper, or feathers. These activities let your child explore sounds, textures, and smells.
- Label these experiences for your child. *"You are popping so many bubbles!"*
- Even though you can both tolerate high levels of sensory input, take time to check in and notice when it is too much, and describe how this feels for your child. This will also help him/her learn how to monitor his/her experiences and reactions to the environment.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 8 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

APPROACHABILITY

Is one's initial response to new places, situations, or things.

I am ... My toddler is ...
☒ **Highly Approachable** ☒ **Highly Approachable**

You and your child both share a similar tendency to approach new situations or people.

- Share the pleasure with your child as you take on new adventures and outings to museums (even if he/she just watches people go by), playgroups, parks, or the zoo.
- Take time to be around other children and families if possible.
- Be close by to help your child as he/she learns to interact with others. Sometimes very approachable children may come into contact with a child who is less open to new people. The more approachable child may need help to navigate the situation.

I am ... My toddler is ...
☒ **Highly Approachable** ☒ **Less Approachable**

You and your child seem to differ in the area of approachability. Here are some ideas to support the fit between you and your child's lower level of approachability.

- Be your child's safe base. Introduce him/her to new surroundings and people from the safety of your arms or while holding hands. Talk to him/her gently and in a reassuring way about what is going.
- Help others connect with your child by letting them know to take it slow. Share your child's favorite toys or activities with the other person to build a connection.
- Don't make your child participate in a new experience if he/she seems unsure. If possible, provide a space for him/her to observe what is going on until he/she is ready to take part.
- Be careful not to label your child as "shy." Letting others know that he/she just needs a little time to watch and take it slow is more gentle and respectful. Labels can stick over time.
- Prepare children for new things. For example, if your child will be going to a new child care center, drive by and visit before the first day.

I am ... My toddler is ...
☒ **Less Approachable** ☒ **Highly Approachable**

You and your child seem to differ in the area of approachability. Here are some ideas to support the fit between you and your child's high approachability.

- Try to accommodate your child's wish to explore new situations. Explore during nature walks, listen and dance to new music, taste new foods, take part in new social experiences like playdates, etc.
- Provide games and activities that encourage side-by-side or cooperative play like wagons, balls that can be rolled back and forth, puppets, water table play, blocks and vehicles, etc.
- Even though your child likes to be social, sometimes certain situations call for the help of an adult. *"You are so happy to see Arianna and you gave her such a big hug! Arianna is frowning and holding her arms close to her. I think she is trying to say, 'Please be gentle! How about saying, 'Good morning, Arianna,' and giving her a gentle pat on the hand?'"*

I am ... My toddler is ...
☒ **Less Approachable** ☒ **Less Approachable**

You and your child both share a similar tendency to withdraw from new situations or people.

- Just like you, your child might prefer individual interactions or small gatherings of people. Plan for these types of experiences versus many larger group gatherings in one day.
- Take time to talk to your child about new situations as you remain his/her safe base, holding him/her or standing close by. *"The children are splashing in the water."*
- Your child is likely to enjoy playing with the same toy and spending time in familiar places. Encourage him/her to take familiar objects to new places and to have special places to relax, such as on the couch reading stories with you.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

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Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

ADAPTABILITY

Describes how easily one adjusts to changes and transitions.

I am ...

My toddler is ...

● **Highly Adaptable**

● **Highly Adaptable**

You and your child share a similar level of adaptability.

- Just like you, your child will probably find it easy to try new situations and will not feel caught off guard during transitions or disruptions in a usual routine. Continue to use words to narrate when change will occur.
- Continue to enjoy a variety of activities during the day, since you both have an easy time switching between activities.
- Keep an eye out for cues or behavior signaling that your child has had enough changes. *Some* routine is good for all children. Try to keep some things the same each day, like eating, napping, sleeping, etc.

I am ...

My toddler is ...

● **Highly Adaptable**

● **Less Adaptable**

You and your child seem to differ in the area of adaptability. Here are some ideas to support the fit between you and your child's lower level of adaptability.

- Give many advance reminders when transitions are coming so that your child can be prepared.
- Try not to introduce too much too fast. A new child or teacher in the classroom might be scary or confusing for your child, so react sensitively.
- Allow your child to not participate in a new experience if he/she is having difficulty adjusting.
- Let your child know that you are available for comfort. *"I know that this is hard for you since it's so new. Do you want to play with your favorite blocks instead?"*
- Try to keep to a normal daily routine to minimize confusion for your child.

I am ...

My toddler is ...

● **Less Adaptable**

● **Highly Adaptable**

You and your child seem to differ in the area of adaptability. Here are some ideas to support the fit between you and your child's higher level of adaptability.

- Try to accommodate your child's ability to explore new situations by introducing new experiences often.
- Positively reinforce your child by talking about how easily he/she adapts to new classmates, new situations, etc.

I am ...

My toddler is ...

● **Less Adaptable**

● **Less Adaptable**

You and your child share a similarly low level of adaptability.

- Follow your instinct of taking new situations, people, and transitions slowly, with advance preparation and adequate time. Allow extra time when approaching something new, so the experience is not hurried.
- When you have to do something that is new that does not feel good, explain that you feel nervous or uncomfortable, and describe how you might help yourself.
- Describing your experience to your child will help him/her learn to recognize feelings in himself/herself and others, as well as how to help himself/herself.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 10 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

PERSISTENCE

Relates to the length of time one continues in activities in the face of obstacles.

I am ...	My toddler is ...
● Highly Persistent	● Highly Persistent

You and your child share a similarly high level of persistence.

- Have fun providing a range of activities and new objects and take delight watching all the ways your child explores and interacts with his/her surroundings. Like you, he/she may feel really happy working on a problem and discovering all the possible angles.
- Describe this feeling for your child and consider praising his/her efforts rather than the final product.

I am ...	My toddler is ...
● Highly Persistent	● Less Persistent

You and your child seem to differ in the area of persistence. Here are some ideas to support the fit between you and your child's lower level of persistence.

- Provide encouragement as your child attempts a task. *"You scooted so close to the toy! You are almost there!"*
- Provide experiences that your child has already mastered so that he/she can feel successful.
- Encourage emotional vocabulary development by labeling emotional reactions. *"You are stomping your feet and tightening your fists. Are you feeling angry that your tower fell down?"*
- Check in with your child often so that he/she knows you're available to help.

I am ...	My toddler is ...
● Less Persistent	● Highly Persistent

You and your child seem to differ in the area of persistence. Here are some ideas to support the fit between you and your child's higher level of persistence.

- Recognize and offer feedback when your child is working really hard at something. *"You stacked two blocks, your tower is growing."*
- Provide activities that challenge your child. *"You are doing a four-piece puzzle. Would you like to try the new animal puzzle with more pieces?"*
- Check in with your child as he/she persists through a task to make sure he/she doesn't become too frustrated with an activity. *"You are working very hard to get all of the pieces to fit together, and they sometimes fall apart. How are you feeling?"*
- Encourage emotional vocabulary development by asking your child how he/she feels when he/she persists at something. *"You are able to pull your friend Matthew in the wagon, and he is giggling! How does that make you feel?"*

I am ...	My toddler is ...
● Less Persistent	● Less Persistent

You and your child share a similar, lower level of persistence.

- Just as you may do for yourself, break new and challenging activities into smaller parts, and praise your child for his/her efforts.
- Help your child learn how to recognize when he/she is beginning to feel frustrated and what he/she could do to feel better. You can do this by describing your own feelings during frustrating times and what strategies you use to calm down and finish the job.
- Make sure to baby-proof or toddler-proof your home so your child can explore and experience his/her environment.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 11 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

MOOD

Is one's tendency to react to the world primarily in a positive or negative way.

I am ...	My toddler is ...
● Positive Mood	● Positive Mood

You and your child share a similarly positive mood.

- Take delight sharing a giggle or belly laugh at the world around you. Describe your child's happy feelings as you experience these moments together.
- Play fun games throughout the day, such as hide-and-seek and "Peekaboo."
- Look in the mirror together and share smiles.
- Even though you may both have a generally positive mood, remember to also describe feelings of sadness, anger, or fear so that your child learns that these feelings are OK too.

I am ...	My toddler is ...
● Positive Mood	● Serious Mood

You and your child seem to differ in the area of mood. Here are some ideas to support the fit between you and your child's different dispositions.

- Try to match your child's mood when he/she is feeling serious, so that he/she knows that this emotion is OK.
- Try not to force your child into a positive mood; allow him/her to express himself/herself.
- Encourage emotional vocabulary development by labeling emotional reactions. *"Your face tells me you're upset. Did you not like that story?"*
- Allow your child to not participate in an experience if he/she is getting upset.

I am ...	My toddler is ...
● Serious Mood	● Positive Mood

You and your child seem to differ in the area of mood. Here are some ideas to support the fit between you and your child's different dispositions.

- Try to match your child's mood when he/she is feeling cheerful so that he/she knows that this emotion is good.
- Acknowledge when your child is really enjoying an activity. *"Look at the big smile on your face; you look happy riding the tricycle!"*
- Encourage emotional vocabulary development by labeling emotional reactions. *"You are smiling so much! That must mean you liked the clapping!"*
- Check in throughout the day even when your child appears cheerful.

I am ...	My toddler is ...
● Serious Mood	● Serious Mood

You and your child share a similarly serious mood.

- Your child may like choices. As he/she gets older, allow choices for daily routines such as which story to read together before naptime.
- Give your child straightforward information about day-to-day happenings. *"We are going to child care, and I will be back to pick you up after your nap."*
- Try to relate to your child's thoughtful approach to his/her surroundings, and recognize that being thoughtful or serious does not mean being angry.
- Allow time for your child to engage in observing what is going on before joining in.
- Point out cues that your child uses to show engagement or joy. Sometimes these signs might be more subtle than a smile or laughter. You might notice raised eyebrows, bright eyes, or turning towards a sound.

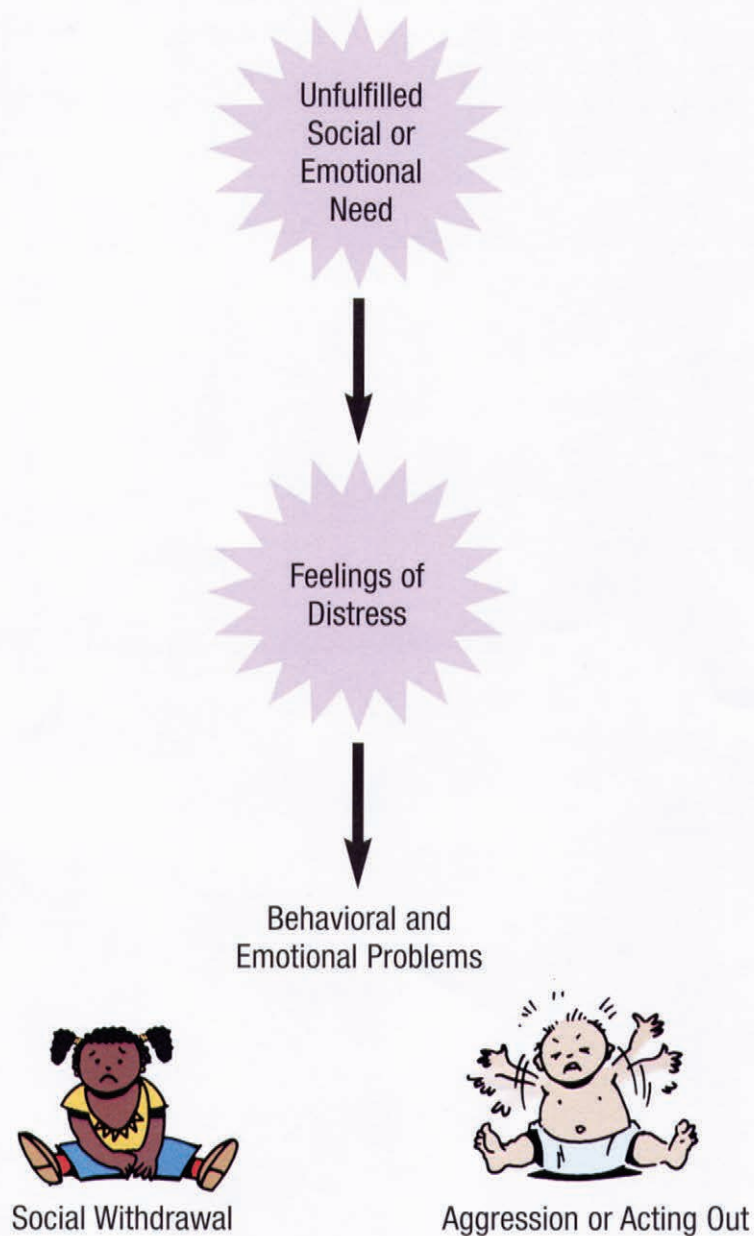
INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 12 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

Challenging Behaviors of Infants and Toddlers

Needs, Feelings, Behaviors



© 2003 Kelly, Zuckerman, Sandoval, & Buehlman

Source: Kelly, Zuckerman, Sandoval, and Buehlman

FAST FACTS



Behavior
as
Communication

Emotion Regulation

WHAT IS IT?

A person's ability to regulate his/her emotional responses (neurophysiological, behavioral, and cognitive) to disruptive situations, i.e. ability to manage feelings and actions in acceptable ways. All young children need help learning to identify their feelings and express them appropriately.

How do children learn emotion regulation?

Regulation of emotions is a developmental achievement which is not present at birth. Emotion regulation starts as the caregiver's responsibility for an infant and slowly shifts to the child. As children become more adept at self soothing and gain language skills, they become more able to say how they feel, and can more effectively control emotional outbursts and regulate their emotions.

What can early educators do to help?

Provide stability

Accept that it is normal for children to have strong emotions, both positive and negative

Talk about your own feelings

Teach children about feelings and encourage children to talk about their feelings

(See Children's Booklist in Toolkit Section 7)

Model emotion regulation for children; apologize and take responsibility when you express your feelings in inappropriate ways

Teach children problem solving techniques

Help children become aware of the early warning signs that build-up to an emotional outburst

Teach children appropriate methods of expressing negative emotion

Praise children's efforts to regulate emotions

WHAT TO DO?

Help staff and caregivers be aware of how their own emotion regulation affects the child and explain the importance of modeling appropriate emotion regulation and teaching children how to regulate their emotions.

FAST FACTS



Understanding
Behavior

Sensory Processing Disorder AKA Sensory Integration Disorder

WHAT IS IT?

Neurological. Brain is unable to organize information coming in from multiple areas such as; sight, hearing, smell, taste, balance, proprioception (muscles etc.), touch. Causes disruptions in daily functioning.

TYPES:

HYPOsensitivity

(under responsive) to touch

Craves touch, even if inappropriate. Unaware of bumping/touching unless done with extreme force or intensity. When seeking out excessive input/ pressure/ touch, they are really trying to calm their bodies and organize their nervous system.

Remember:
Kids can experience both

HYPERsensitivity

(over responsive) to touch

Difficulty interpreting and appropriately responding to touch. They become overstimulated by sensations most don't notice. They can often appear distractible, fidgety or 'zoned out' because they are trying to escape the overstimulation. May become fearful, anxious or aggressive with light or unexpected touch.

WHAT TO DO?

Refer child to Early Intervention (under 3) or to public school (over 3) for Sensory Integration evaluation and services with Occupational Therapist (OT). OT services can also be found at Learning Solutions, Cooley Dickinson Hospital, Baystate Hospital and some community providers. Adapt child care environment as needed.

Recommendations to help
staff and caregivers

HYPOsensitivity (under responsive)

Resistive Activities
(rolling pins with play doh, sidewalk chalk)
Stress relief balls (filling balloon with sand)
Sucking through a curly straw
Blowing activities
Push/pull activities
Bear hugs
Carrying weighted objects in backpack
SLEEP ISSUES:
White noise machine; aromatherapy (lavender lotion);
weighted blanket; heavy activity before bed

HYPERsensitivity (over responsive)

Seamless socks/tagless clothes
Provide quiet area to decompress
Deep pressure massage
Wearing spandex or lycra clothing
Separating textured foods during meals
Bear hugs
Using soft tones, particularly when disciplining
SLEEP ISSUES:
Aromatherapy (lavender lotion); weighted blanket

FAST FACTS



Understanding
Behavior

Prenatal Drug Exposure and Withdrawal

WHAT IS IT?

When the birth mother uses illegal or non-prescribed drugs, alcohol or nicotine sporadically or regularly throughout her pregnancy, the newborn can experience short term withdrawals and may experience long term impacts from the drug exposure. See charts provided in the Toolkit (2-L) for the effects of specific drugs.

WHAT TO DO AND TIPS FOR STAFF AND CAREGIVERS

Provide staff and caregivers with as much medical and prenatal history as available.

Educate staff and parents/caregivers about the possible impacts of specific drugs that the infant may have been exposed to.

Remind staff and caregivers that effects can vary from none to severe and the spectrum of individual reactions is wide.

Refer child for Early Intervention assessment as early as possible.

Advocate for physical or occupational therapy (PT/OT), if warranted due to muscle tone, coordination issues, or sensory issues/sensitivities.

Early educators and caregivers will need to be very consistent and predictable for the infant, as so much of their world is in chaos due to the prenatal drug exposure. The environment may need to be adjusted for children's sensitivities, e.g. to noise, light, touch, etc., and many of these children will need extra caregiver support in learning to self-regulate.

Advocate for no placement changes, especially during the withdrawal period.

Assure staff and caregivers that the infant's irritability and sensitivity is not about them or a reaction to their caregiving, but withdrawal symptoms which should decrease over time and will eventually end.

Reassure caregivers that consistent, responsive caregiving, love, and attention combined with early intervention services can help the child develop coping skills to deal with any ongoing difficulties.

Accessing services early on matters!

Brainstorm with caregivers how to support the child through specific symptoms that may result from particular drug exposure. Consider a dyadic therapy referral for caregivers who are having difficulty attaching or coping.

Impact of Prenatal Drug Exposure

Brain development begins 3 weeks after conception.

Tobacco Exposure	Marijuana Exposure
Central Nervous System (CNS) stress	No major fetal growth issues
Lower birth weight	Mild withdrawal symptoms
Greater muscle tension	Poor autonomic control
More difficulty self-soothing	Executive functioning impairment
More negative affect (higher rate of depression and anxiety)	Attention deficits
Lower IQ throughout childhood	Greater risk for depression
ADHD and impulsivity	Reading and spelling difficulties

****Effects may be subtle, transient or non-existent**

Impact of Prenatal Drug Exposure

Opiate Exposure	Cocaine Exposure	Methamphetamine Exposure
More severe post-natal withdrawals	Low birth weight and smaller head circumference.	Lower arousal
More difficulty swallowing	Neurobehavioral deficits: orientation, regulation, autonomic stability, attention, sensory, jitteriness.	No mental or motor delays seen in infants and toddlers
Possible delay in general cognitive functioning	Poor cueing during feeding	Increased lethargy
Anxiety	Delay in information processing	Low birth weight and smaller head circumference.
Disruptive or inattentive behaviors	General cognitive delay	
Increase rate of seizures	Attention problems in childhood	**few studies have been done on methamphetamine exposure or long term effects.
Hypotonia	Self-regulation issues	

Impact of Prenatal Drug Exposure

Fetal Alcohol Spectrum Disorder (FASD) or Fetal Alcohol Syndrome (FAS)

Alcohol Exposure

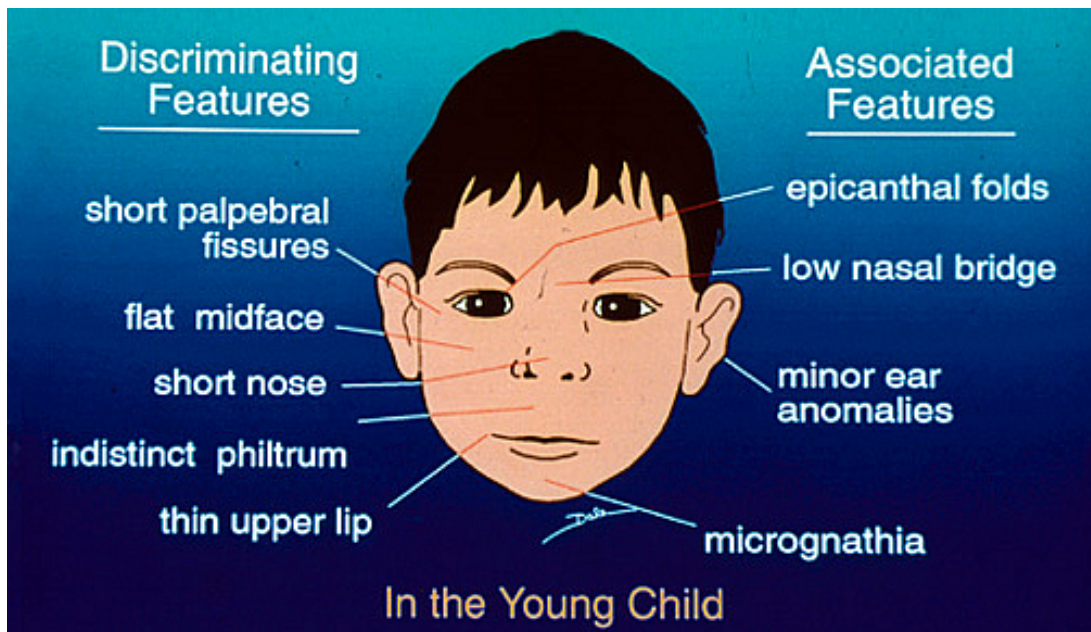
Leading cause of mental retardation	ADHD
Facial and cranial abnormalities*	Inability to foresee consequences
Hyperactivity and poor attention	Inability to learn from previous experiences
Low birth weight and small throughout childhood	Lack of organization
Weakness in core/midline	Poor adaptability
Decrease in social emotional functioning	Poor judgment
Vision impairment	Speech problems

*Facial and cranial abnormalities include: Microcephaly (small head), small or non-existent philtrum (vertical groove above the top lip), thin upper lip, shortening of eye slits, wide set eyes, flattening across nasal bridge, flat midface.

Alcohol is the ONLY TRULY PERMANENTLY DAMAGING DRUG to the brain... others effects can be moderated by environment or brain remapping.

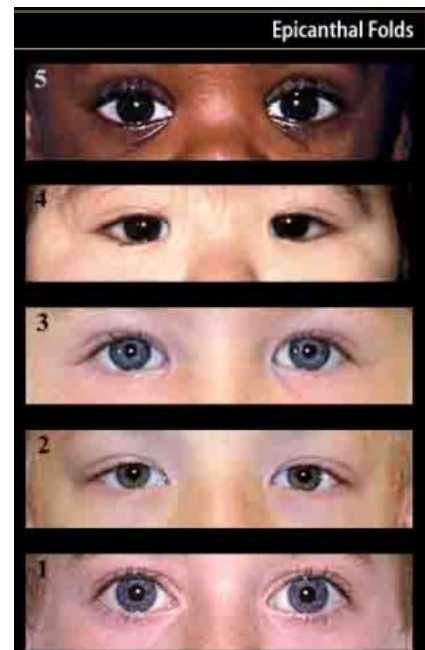
Impact of Prenatal Drug Exposure

Physical features of FAS



But not always....

Fetal Alcohol Spectrum Disorder (FASD) or Fetal Alcohol Syndrome (FAS)



Home Visits

- 3-A Newborn Visits
- 3-B Visits with Young Children
- 3-C Home Visit Outline
- 3-D Parent Child Interaction
- 3-E Fast Facts | Genograms
- 3-F Fast Facts | Post Partum Depression/Mood Complications
- 3-G Fast Facts | Building Protective Factors
- 3-H Fast Facts | Transitions and Out-of-Home Placements
- 3-I Fast Facts | Successful Visitation for Infants and Toddlers

CHILD WELFARE
TOOLKIT



FOR EARLY CHILDHOOD PROFESSIONALS



NEWBORN VISITS

What to Review During Home Visits with Newborns and Caregivers

This is only meant to be a general guide for visits with your smallest clients. Please use your knowledge base and individual observations during the visits to assess the specific child and their needs. Remember that all children are distinct and a complete assessment should be done for each child to ensure that the services are appropriate and specific to them.

Birth Information/Medical:

- Full term baby? 37-42 weeks is full term. Any complications at birth?
- Premature babies commonly have heart murmurs or digestion problems.
- Synagis shots for respiratory concerns? Asthma? Preemies are particularly at risk for respiratory issues and Synagis shots give them extra protection during flu season.
- Maternal health-prenatal care, HIV status (or risk), drugs, prostitution, depression, other risk factors?
- What was their birth weight? The average birth weight is 7 lbs 8 oz. Six lbs and below is concerning. These babies will need extra care. Typically babies lose a couple of ounces in the first couple of days. They should then begin to gain weight. Failure to gain weight or sustained loss of weight may result in 'failure to thrive' diagnosis for baby.
- When babies are born, they receive two Apgar scores. These scores rate the health of a newborn at 1 min and 5 min after birth. Caregivers often won't know the Apgar scores, but they are in the medical records. Typically, most babies receive 9/9 or 8/9. It is a 1-10 scale. A baby with very low Apgar scores usually indicates difficulty at birth.
- When is their next pediatrician appointment? It is usually within the first week. They do not get shots until they are 2 months old. Do they have the child's Mass Health card? Do they have a pediatrician?
- Has the umbilical cord fallen off? Any complications? The cord usually falls off in the first 1-2 weeks. Caregivers should know to roll the diaper down to avoid irritating the area.
- Newborns are usually only washed once a week. They will often have dry skin and newborn acne. The dry skin and the acne should clear up on its own.
- Are they having normal bowel movements? Some newborns only have a bowel movement once every 7-10 days. They should be urinating every day.

Newborn Visits (2)

Development:

- Newborns don't make eye contact. They can only see about 4 inches in front of themselves. Don't expect eye contact. Babies start making eye contact around three months... but this can vary baby to baby.
- Two month old baby should be able to hear well and track the caregiver's voice by rotating her head. Is baby doing this?

Ask About the Baby's Schedule:

- They should sleep from 2-4 hours (usually) at one time. They will often wake to feed and then go back to sleep. If the baby was premature, they will often sleep longer and will need to be woken by the caregiver to ensure they are getting enough to eat.
- Babies can also seem like they are nocturnal. Because the daytime can be very over stimulating, they will simply go to sleep to re-regulate themselves...hence being awake at night when it is quiet and dark. Some babies react to overstimulation by screaming/unable to be soothed and then pass out. Imagine being in dark, quiet water for 9 months and then bursting into the world.
- It is normal for some babies to shed the hair that they were born with. Make note of any older babies that have bald spots or are really flat on the back of their heads...as this may be an indication that the baby is spending too much time on their back in the crib, car seat or floor.

Overstimulation/Sensory Integration Issues:

- This can be even more of a problem in babies exposed to drugs in utero. Usually it takes a baby about three months to begin to self-regulate (and stay awake for longer periods). With a drug-exposed baby, they first have to go through withdrawal and then begin to learn how to self-regulate. Withdrawal can last for a couple of days to a couple of months.
- Babies who are being over-stimulated (irritability/crying, zone out, or fall asleep are signs of over-stimulation), do better with low lights, soft sounds, not a lot of jostling, little eye contact, swaddling. The swaddling makes them feel secure.
- Babies that have been exposed to drugs in utero also can have sensory integration issues. This is when the child/baby has a neurological inability to organize sensory information when it comes through the senses. Example: Instead of coping with bright lights, or turning their head away, a baby becomes very disregulated, irritable, maybe starts crying....You can see this with lights, sounds, touches, feeding....

Newborn Visits (3)

Drug Exposure:

- Withdrawal can be hard on baby and caregiver. Babies can have the jitters, irritability, high pitched screaming, inability to be soothed, stiffness, eating problems, sleeping problems, scratching themselves.
- Babies can be put on Phenobarbital (or other drugs) to ease the effects of the withdrawal. They usually are on it for a couple of weeks. If a baby is six months old and still on Phenobarbital, it is important to find out why. FYI, Phenobarbital is also used to prevent seizures...so make sure to find out why the baby is on Phenobarbital.
- Another thing to look for: symptoms of Fetal Alcohol Syndrome (FAS). The brain is the most sensitive organ to alcohol damage. It is very important to note that some babies may not have any physical characteristics, while others will look like they have physical characteristics, but do not in fact have FAS.

Please refer to Section 2, L-4.3 and L-4.4 for more on physical characteristics of FAS.

This information is also available in the SCSC Early Childhood Train-the-Trainer series at collaborative.org/early-childhood/SCSC (Session 2, slide #20) for physical characteristics.

Fetal Alcohol Syndrome (FAS)

FAS is a leading cause of mental retardation. In layman's terms, it basically prevents the brain from fully developing. It specifically affects midline development. One would also see a small corpus callosum or no corpus callosum through MRI. This connects the left and right brain.

FAS affects the core (central nervous system) of a child (i.e. difficulty rolling, difficulty sitting up unassisted, poor vision, heart murmurs)

Children with FAS often have low birth weight and small heads.

Newborn Visits (4)

Feeding:

- Is the baby feeding at regular intervals? If breastfeeding, any problems? How much formula does she take? Is it regular formula...iron enriched? soy? Is the caregiver receiving WIC for the baby? Babies from low and moderate-income families and babies in foster care are eligible for WIC until they are 5yo.
- Acid reflux is common in drug-exposed babies. If the baby is spitting up a lot of formula (or has projectile vomiting), or is in pain after feeding, these can be signs of acid reflux. Basically the baby's stomach is not tolerating the food and there is a buildup of acid in the stomach and it goes up the esophagus. Sometimes babies do not spit up/throw up but clearly are upset after the feeding. Does the caregiver find that the baby does better sitting up? If so, this also might be a sign of acid reflux. Long exposure to acid reflux can create a feeding aversion in a child. Basically, they associate pain with the feeding. There is medication for acid reflux and it should be treated immediately.
- Premature babies, or drug-exposed babies (or any baby) can have difficulty with their sucking reflex. Sucking reflex doesn't kick in until 36 weeks, so preemies may have not have developed or have a poor sucking reflex. They take the formula very slowly because they cannot suck at the speed of a typical newborn (new babies suck incredibly hard) or poor latching; difficulty keeping the nipple in their mouth, the formula runs out the side of their mouth inside or down their throat. It is important for the caregiver to work with a professional to help the baby improve their latching and the sucking reflex, otherwise they may not be getting enough formula.

Car Seats:

- Babies are in reverse car seats until they are one year old. Also, if a baby is over one and less than 22 lbs, they still need to be reversed.
- Often if a baby is under one and really big, caregiver will put the child in a toddler car seat—front facing. If the child is under one, the car seat always needs to be rear facing.
- Before a year, the child is at greater risk of head and neck injury because of lack of development of those muscles.

A Final Reminder:

- Keep in mind that a quiet baby is not always a “good baby” who is thriving. Babies make their needs known by crying and expect that a caregiver will meet their needs. If this does not happen, the result can be a non-crying baby, with a flat affect. This should be very alarming.
- Lack of crying can indicate that the baby has learned that their cues will not be responded to and therefore there is no point in making a fuss.
- This can be a symptom of early depression and is very likely to significantly disrupt early attachment.



VISITS WITH YOUNG CHILDREN

Home Visits with Toddlers, Preschoolers and their Families

Medical:

- Review case file to see if there were any birth complications:
- Prenatal drug exposure? History of withdrawal symptoms? Are related issues still present? When did they abate? (jittery, poor eye contact, irritability, stiffness, sensory issues etc.)
- Last pediatrician/dentist appointment? Any immunizations? Height, weight and growth percentiles? Vision, hearing? Asthma? Flu shot? Any concerns?
- Any current medical conditions: current treatment or follow-up needed?

Social/Emotional:

- Your observations on the attachment between the child and caregiver: Look for good eye contact, child initiating interactions with caregiver in a variety of ways, caregiver reading and responding appropriately to the child's cues, serve-and- return and playful interactions, child using parent for comfort and safety, child's ability to tolerate brief separations from parent(s).
- Older mobile infants/toddlers: If they have a secure attachment, they should be able to explore their surroundings, with just visual checks with the caregiver. If they are overly clingy or unresponsive to the caregiver, note this and continue to assess the child's attachment.
- Is child soothed by caregiver when upset? Are daily routines consistent and nurturing?
- What is the child's sleeping schedule?
- How often does child wake at night? Is child easy to soothe when they wake?
- Any sleep disturbances? Night terrors, etc.?
- Therapeutic or counseling services? Frequency, duration, name of therapist? Type/quality of therapy?

Visits with Young Children (2)

Developmental:

- Assess the language ability of child. Can you understand them? Are they advanced or delayed according to the range of typical language development? Do they have/need speech therapy?
- Fetal Alcohol Syndrome, Autism, Cerebral Palsy, other?
- Do they have/need physical or occupational therapy?
- Referred to Early Intervention or public school for evaluation? Receiving EI/PS services? If so, describe:

Education:

- Is child at home with caregiver or at an early education or child care program? How do they do in child care/early education? Is it a high quality program/setting?
- If child is in school, how has she/he adjusted? Any behavioral challenges at school?
- Does the child know colors, letters, numbers that are age appropriate?
- Is child on an IEP? What services are provided?
- Any caregiver or educator concerns about learning challenges or progress?

Consider using Toolkit 4-A, Getting to Know the Preschool Child—A Book About Me and My Family, as a way to begin to build a relationship with the Child.

Home Visit Outline

Date: _____ Child: _____	
MEDICAL	SOCIAL-EMOTIONAL
Last doctor appointment:	Adverse childhood experiences (abuse, neglect, trauma, toxic stress, loss of primary caregiver, etc.):
Last dentist appointment:	
Current health concerns:	Attachment or behavioral concerns:
Strengths:	Strengths:
DEVELOPMENT	EDUCATIONAL
EI / public school evaluation:	Childcare \ early education \ school:
	Attending regularly?
Developmental concerns:	Learning challenges:
Strengths:	Strengths:



CHILDREN BIRTH TO AGE 3

Guide to Encouraging Caregiver-Child Interaction

1. OBSERVE

- Pay attention to the frequency and type of caregiver-child interaction you observe.
- Notice how much time the child typically spends alone in a crib, high chair, or child seat and whether he's put in front of the TV or encouraged to use other media for "entertainment."
- Watch for "serve and return" interactions and notice whether it's the child or the parent who initiates them most often.
- How often do the caregivers talk to the child, other than to give them directions about what to do or not to do? Notice the frequency and pattern of caregiver-child conversations.
- Are there age-appropriate books and toys to facilitate caregiver-child interaction in the living area and/or the child's room? How often have you observed the caregivers and child engaged in interactive play, such as Peek-a-boo, tickling games, finger plays, or playing with toys or reading together?
- How do the primary caregivers respond to the child's cues?

2. ASK QUESTIONS

- Ask about the child's daily schedule. How long does she usually sleep at night? Is he a reliable daytime napper? Is her schedule fairly regular or unpredictable from day to day? What are his favorite play activities or books? How does she get the caregiver's attention when she needs something? How does the caregiver know whether the non-verbal baby is hungry, bored, tired, or needs a diaper change? What other caregivers spend time caring for this child and how does the child relate to other caregivers? What are sibling relationships like? What happens at bedtime?
- Ask the caregiver what they've learned so far about the child's personality. Is she more or less physically active than a typical child of the same age? Does she tend to be comfortable right away with new people and situations or is she cautious in new situations until she feels more comfortable? Does he have a sense of humor and like to laugh? Is she easily startled or frightened? Will he sit for five minutes and remain engaged while a story is read to him or is he easily distracted? Does she prefer to play with other children or adults or to play by herself? How does he express his needs and preferences? Expand the conversation beyond yes or no answers by asking for stories and examples.
- Encourage the caregivers to share their questions or concerns about the child's health or development, such as walking, talking, feeding, sleep patterns, crying, aggression, or frequent illness. If the child has not had an early intervention screening, point out that it's a free opportunity for parents to learn about their child's learning style and developmental strengths.

Birth to Age 3

Guide to Encouraging Caregiver-Child Interaction

3. MODEL AND REINFORCE POSITIVE CAREGIVER-CHILD INTERACTION

- “Catch them doing something good.” When you see a serve-and-return interaction, notice it out loud and reinforce its value in building a strong and smart brain by saying things like, “Did you know that interactions like that help make the connections in the child’s brain that make them smarter and more able to solve problems later on?”
- Encourage any routines already in place that include responsive and interactive caregiving and explain why they’re so important. Examples would be reading stories or singing at bedtime; talking to the child and “narrating” what’s happening when feeding, bathing, diapering, or while in the stroller; singing in the car, etc.
- “Speak for the child.” When the parent engages the child in your presence, say things you imagine the child might be feeling, like, “Oh, Mommy, I love it when we play this game together,” or “Look how her eyes light up when you play Peek-a-boo with her.”
- If the caregiver is comfortable with you interacting directly with the child (always ask permission first), converse with the child (whether verbal or non-verbal) and initiate interactive play. Admire out loud all the things the child can do and comment on the ways he communicates, pointing out any cues the child is giving to initiate or end interaction with you. For example, “He seems to be telling me he’s had enough. I noticed him starting to pull away and look in the other direction after we had played Peek-a-boo a few times.”
- Give the parent credit for the child’s abilities. “I notice she’s doing lots of babbling. You must be talking to her a lot. Even though she can’t talk in words yet, having conversations with you is so important for her brain development.”

4. DON’T WAIT TOO LONG TO GET HELP!

- Every day, the child’s brain should be growing at a rapid rate. Every day without adequate interaction and stimulation will set the child’s development back. Get creative and find ways to increase the responsive interactions in the child’s life. If mom is depressed, help dad understand the need to be as interactive and responsive as possible when he’s home. Ask if there is a grandparent or other relative or a family friend who can plan to spend extra time interacting with the child. If there are barriers preventing the parents bringing the child to a family center or parent-child playgroup, there might be someone else close to the family who could provide this kind of enrichment.
- Explore the family’s eligibility and interest in early education and care programs to help meet the child’s needs for stimulation. Home visiting programs like Early Head Start, Healthy Families, the Parent-Child Home Program or Parent Aide/Family Support programs may be available to support and encourage caregiver-child interaction. The family might be eligible for a voucher or income-eligible child care slot if the waiting list is too long for a supportive slot. Encourage high quality early education for siblings, too.

Toolkit 5-A, 5-B, 7-B and 7-C contain materials that explain early education options and importance

- Refer to an ECMH (early childhood mental health) consultant to explore all the options for the specific child and family.

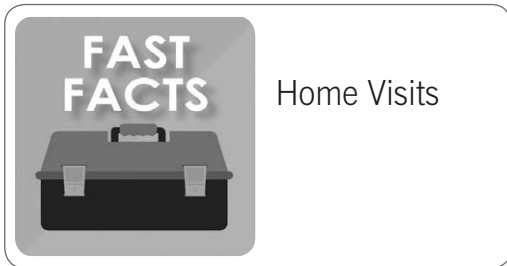
Toolkit 6-F provides more details

- Make a referral for parent-child therapy for the primary caregiver and the child. Ask local mental health service providers at Service Net, the Children’s Clinic, Community Support Options, the Center for Human Development and the Hilltown Community Health Centers for the names of clinicians who have been trained in therapy modalities for parents with children birth to age five, such as the Attachment Self-Regulation and Competency (ARC) and Child Parent Psychotherapy (CPP) models.

Toolkit 6-I provides more details

- Be on the lookout for local parent education classes and workshops and encourage caregivers to participate.

Toolkit 6-J, 6-K and 6-L provide information about locating and referring to resources



Genograms

WHAT IS IT?

A map of a family using symbols to describe relationships, major events and dynamics within the family. It is helpful in organizing family history and to note patterns of maladaptive behaviors such as substance abuse, mental illness, domestic violence etc.

To create a genogram:

Decide how many generations will be represented (oldest generation should be at the top of the page).

Research family history through interviews with members and review of case files.

Design your genogram. Use the sample included in the Toolkit (3-E.2) or use an example from the web or design your own. Ultimately it needs to be a design that works for you and gives you clarity about the family and history.

Choose symbols to represent family members and relationships, both functional and dysfunctional.

Organize the chart beginning with the oldest generation you want to represent at the top.

Look for patterns within the family. This will provide a better understanding of the origin of certain issues within the family and help to identify the best services for individual within the family.

For more information: http://stanfield.pbworks.com/f/explaining_genograms.pdf

Things to remember:

Genograms can vary widely since there is no limitation as to which data can be included.

The genogram is to help you clarify the picture of the family and their patterns.

Ultimately this clarity may allow you to provide the best services for the family.

Recognize that the information you are able to collect is often limited and self-report of family history can be inconsistent.

Avoid using the genogram to make assumptions about the family's motivations or using it to confront them about certain patterns within the family. The genogram should not be used to 'prove your point' about the need for services, as families may see the genogram as your judgment of their family. It is most useful as a tool to help you understand family relationships and dynamics.

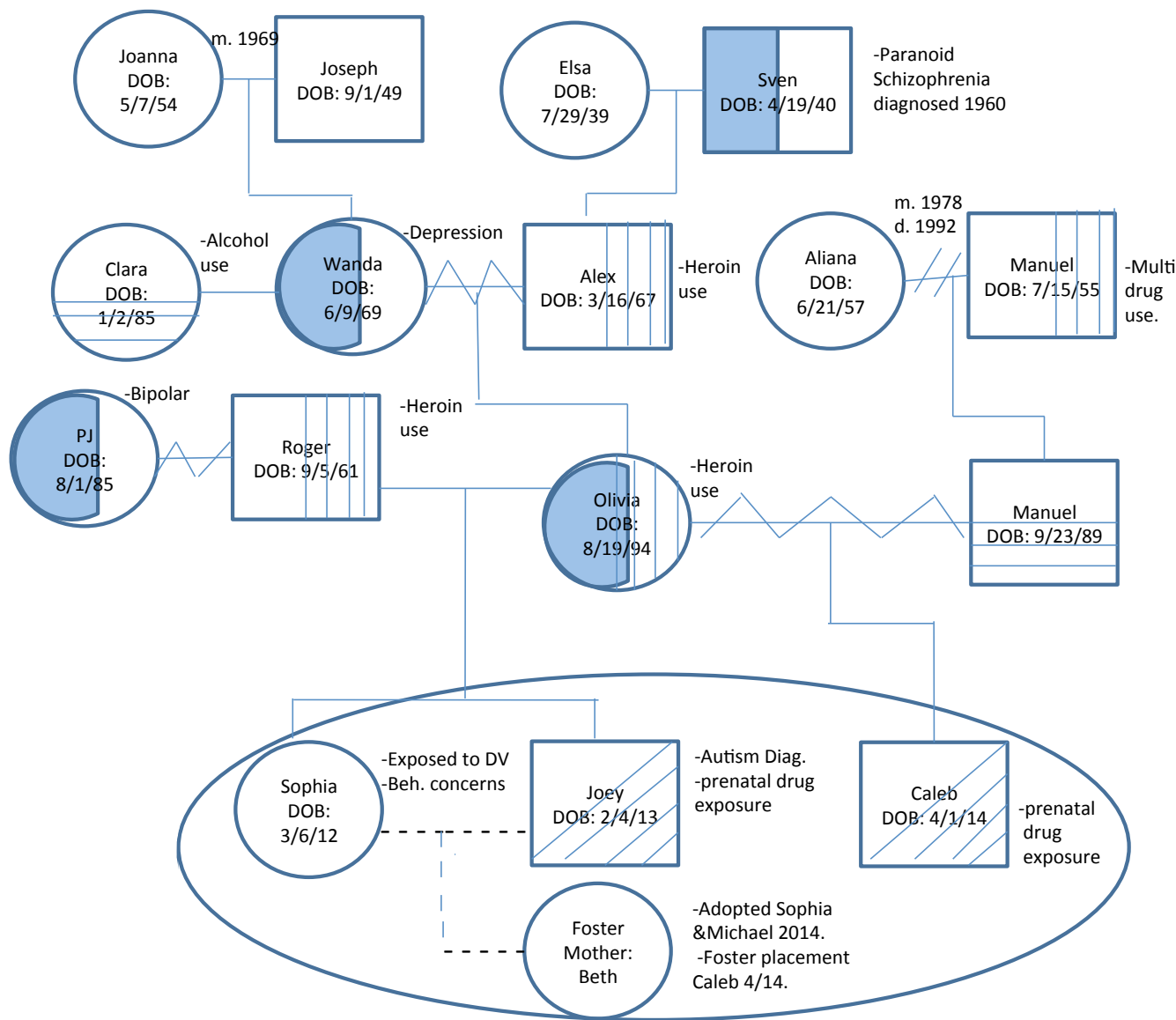


Genograms (2)

Key:

- Mental health issue=
- Substance abuse=
- Suspected SA=
- Domestic violence=
- Divorce=
- Living together=
- Devel. Delay=
- Adoption=

Sample Family Genogram



FAST FACTS

Home Visits



Maternal and Postpartum Depression AKA Perinatal Mood Complications

WHAT IS IT?

A serious medical condition that limits capacity for everyday activities. Mothers experience persistent moderate to severe symptoms that interfere with sleep, appetite and energy level. May manifest in loss of interest in usually enjoyable activities and feelings of anxiety, depression, worthlessness or guilt. Disrupts the capacity to form nurturing caregiving relationships with infants and children of all ages. 1 in 11 infants are affected in the first year of life; rates are higher for teen mothers, mothers with depression history and those experiencing poverty and multiple other stressors. A less threatening way to describe this condition is “postpartum emotional difficulties.”

IMPACT ON CHILDREN:

Intensive interventions
focused on mother-child

Can cause lasting deficits in brain architecture, stress response and immune systems

Maternal care may be intrusive/irritable or withdrawn, impacting “serve and return” interactions needed for brain building and secure attachments

Children from disadvantaged backgrounds are at higher risk for poor outcomes

Children are at higher risk for later mental health and health problems

Perform lower (on average) on cognitive, emotional and behavioral assessments

At higher risk for social adjustment difficulties and school problems

WHAT TO DO?

Support, educate, encourage and normalize. Provide hope: this is common and treatable. Refer mother and child for support and therapeutic services: MotherWoman/local perinatal support coalition has support groups and lists of clinical resources. Refer child under 3 to Early Intervention, over 3 to public school for evaluation and follow-up services.

Messages for mothers:

Mothering is hard for everyone.
Having a hard time is normal and it's OK to ask for help and focus on self-care

It's important to get help because your emotional health has an impact on your baby/child's development

Activate your support system:
partner, parents, friends, neighbors,
religious community will want to help

Messages for Mom
and other caregivers

Messages for partners, other supporters:

Mom and baby/child both need your support right now

Making extra time to interact with the child and respond to her cues is very important for her brain development

Find ways to increase responsive care for the child:
high quality child care, more time with relatives and friends, etc.

Mom can heal with support and therapy

FAST FACTS

Home Visits



Building Protective Factors in Families with Young Children

WHAT IS IT?

“Protective factors are conditions or attributes of individuals, families, communities or the larger society that mitigate risk and promote healthy development and well-being. They are the strengths that help to buffer and support families at risk.”

—Protective Factors Approaches in Child Welfare, Child Welfare Information Gateway , Issue Brief, February 2014

TYPES:

Individual Protective Factors (apply to children and adults)

Self regulation—ability to identify, manage and control emotions and behaviors

Relational and communication skills—ability to form positive bonds and connections with others and to communicate effectively with them about needs and interests; non-violent relational problem solving skills such as conflict resolution; self-efficacy in conflict situations

Social connections and positive activities—opportunities for socialization with peers and adults, e.g. support groups, playgroups, etc.

Relational Protective Factors (apply to children and adults)

Caring adults and peers—extended family, supportive friends that model positive norms, mentors, home visitors, faith-based community

Parental resilience—capacity of parents to maintain stability, remain calm, provide nurturing support despite challenging circumstances

Parenting competencies—positive parent-child interactions, responsive parenting, nurturing, knowledge of parenting/child development

Social-emotional competence of children—caregivers are able to nurture and support children’s developing social-emotional skills

Concrete supports in times of need—supports and services (e.g. housing, food, transportation) that address needs and minimize stress

Community and Societal Protective Factors

Positive community—safe neighborhoods with jobs, effective schools, faith communities, positive norms and activities for families

Community services/supports—that partner to create a safety net for families and advocate for family and child well-being initiatives

Policies and norms—that encourage investment in safe, stable and nurturing relationships and environments for every child and family

Educational opportunities—for parents and children, e.g. accessible high quality adult education/job training, early education/child care programs and positive school environments with family support services/programming available in schools

WHAT TO DO?

Identify and build upon existing child/family strengths, relationships, resources. Locate and refer to community resources that help parents and children increase protective factors, e.g. home visiting, therapy, early education, emergency supports, family centers, parenting workshops, support groups. Use the “warm handoff” for referrals—find a supportive person and personally introduce that person to the family.

Toolkit Section 6 provides information about locating and referring to supportive community resources.

FAST FACTS

Home Visits



Transitions and Out-of-Home Placements

WHAT IS IT?

Sometimes placement changes are unavoidable. When a child needs to be removed from biological family or needs to change foster care placements, thoughtful and paced transitions can help lessen the trauma for the child. Ideally: 'One Child, One Home.' When this is not possible, minimize placement changes and make referrals to help the child adjust.

Before placement DCF should:

Assess temperamental, relational and environmental goodness-of-fit of child and new caregiver.

Is the caregiver willing to be a concurrent home?

Ages/issues of other children in the home?

Is this a safe, appropriate placement for an infant/toddler/preschooler?

Disclose a detailed history of child to caregiver.

For a suggested format for providing child's history to staff or caregivers, refer to Toolkit Section 5-, "Helping Children Thrive in Child Care/Early Education."

A few things to keep in mind during a transition:

Routines:

Learn details about the child's current routine and convey to staff. Bath time, feeding, nap, bed time; these intimate moments can be moments of stress or comfort. Staff needs to know how best to comfort the child and structure routines. Strongly advocate that the child continue in the same child care setting during a transition.

Smells:

For the youngest, smells are often a source of comfort and continuity. Using the same detergent, lotion, and soap for the baby is helpful.

Foods:

Another basic, but important, source of comfort. Same bottles, formula, snacks, and solid foods are less disruptive and more familiar to infants and toddlers. Coordinate gradual introduction of new foods with caregivers.

Continued Contact:

Just as gradual introduction of a new caregiver is important, maintaining contact with the previous caregiver will help the child develop a healthy view of relationships. Explore options to support this continuity.

Timing:

Each transition should be tailored to the child's needs and responses, ranging from a week to multiple weeks. Not too short, but not too long. Avoid changes in the early education setting during placement transitions.

Communicate:

Make sure that key staff are aware of the child's transition. Encourage them to convey that the move is not their fault. **Advocate for NO pre-placement overnights for infants and toddlers!**

FAST FACTS



Home Visits

Successful Visitation for Infants and Toddlers

WHAT IS IT?

Visits are particularly important for infants and toddlers when placed out-of-home. They are unable to 'hold' their parents with them during separations and therefore need frequent visits to maintain/develop a strong attachment. Frequent visitation is the best indicator of successful reunification. VISITS SHOULD BE FUN!

INFANTS

Look for feeding, eye contact, talking, singing, reading, peek-a-boo, encouragement of safe exploration, rocking and soothing. Encourage parent(s) to converse with the non-verbal infant. Help parent(s) respond to infant's cues if they are becoming overstimulated.

TODDLERS

Look for fun, playful interactions while playing together, reading, pretend play and developmentally appropriate games, providing structure and rules, drawing together, feeding, cuddling (if the child is interested). Be aware of the child's cues and how they are coping during the visit.

WHAT TO DO?

For infants and toddlers, frequent and regular visitation is critical. Ideally, infants would visit daily, or at a minimum twice a week.

Ideally visits will take place in a home environment (i.e. supervised at the parent's or foster parent's home or in a familiar and comfortable community location).

Some early education programs allow parents to visit on site.

This option needs to be coordinated with the family and their DCF Social Worker.

Visitation should never be used as reward or punishment.

Visits also allow the opportunity to observe caregiver/child interactions, to assess the child's social-emotional well-being, and to model appropriate engagement.

When a parent or child is struggling during visits, it may be helpful to refer to a dyadic therapist who could help facilitate healthy relationship building between the parent and child during visits.

Provide toddler/older infant with a picture of parent (if appropriate) to hold between visits.

Reassure child of future visits. Acknowledge that leaving visits can be very hard on both child and parent.

4

Building Relationships with Young Children

- 4-A Getting to Know the Preschool Child | Coloring Book
- 4-B What's Going On? (School-Aged Child) | Coloring Book
- 4-C Fast Facts | Building Trust with Young Children
- 4-D Tools for Involving Children
- 4-E Child-Friendly Communication

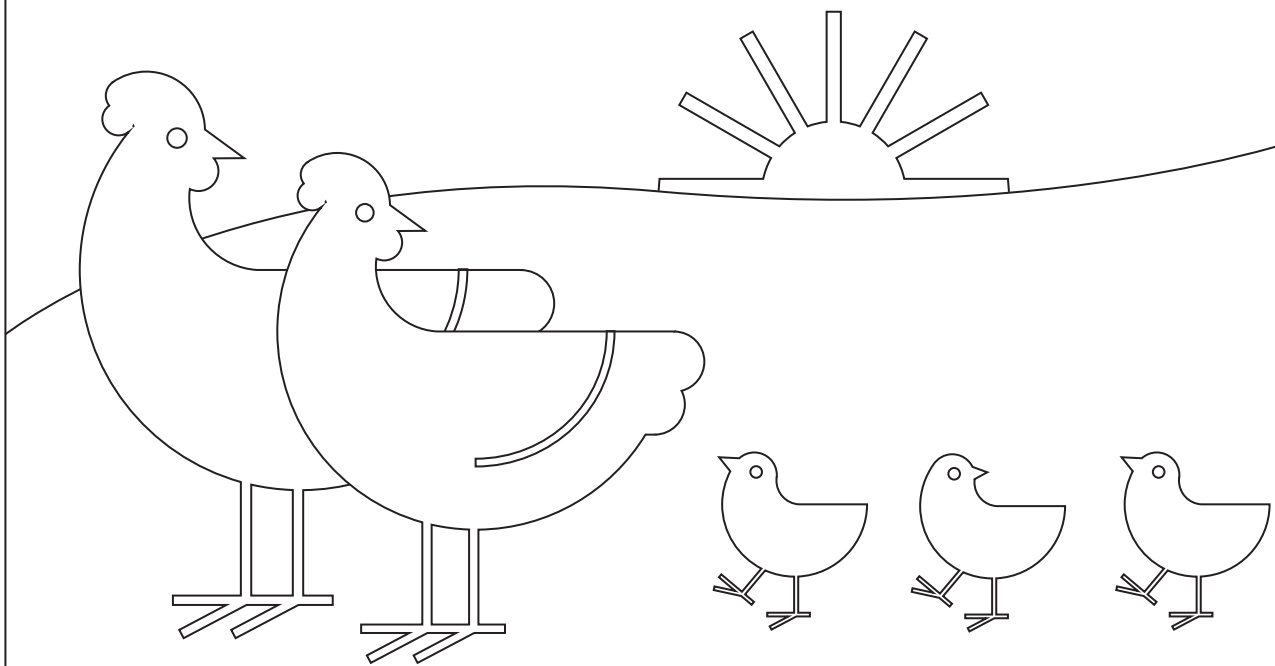
CHILD WELFARE
TOOLKIT



FOR EARLY CHILDHOOD PROFESSIONALS



A Book About Me and My Family

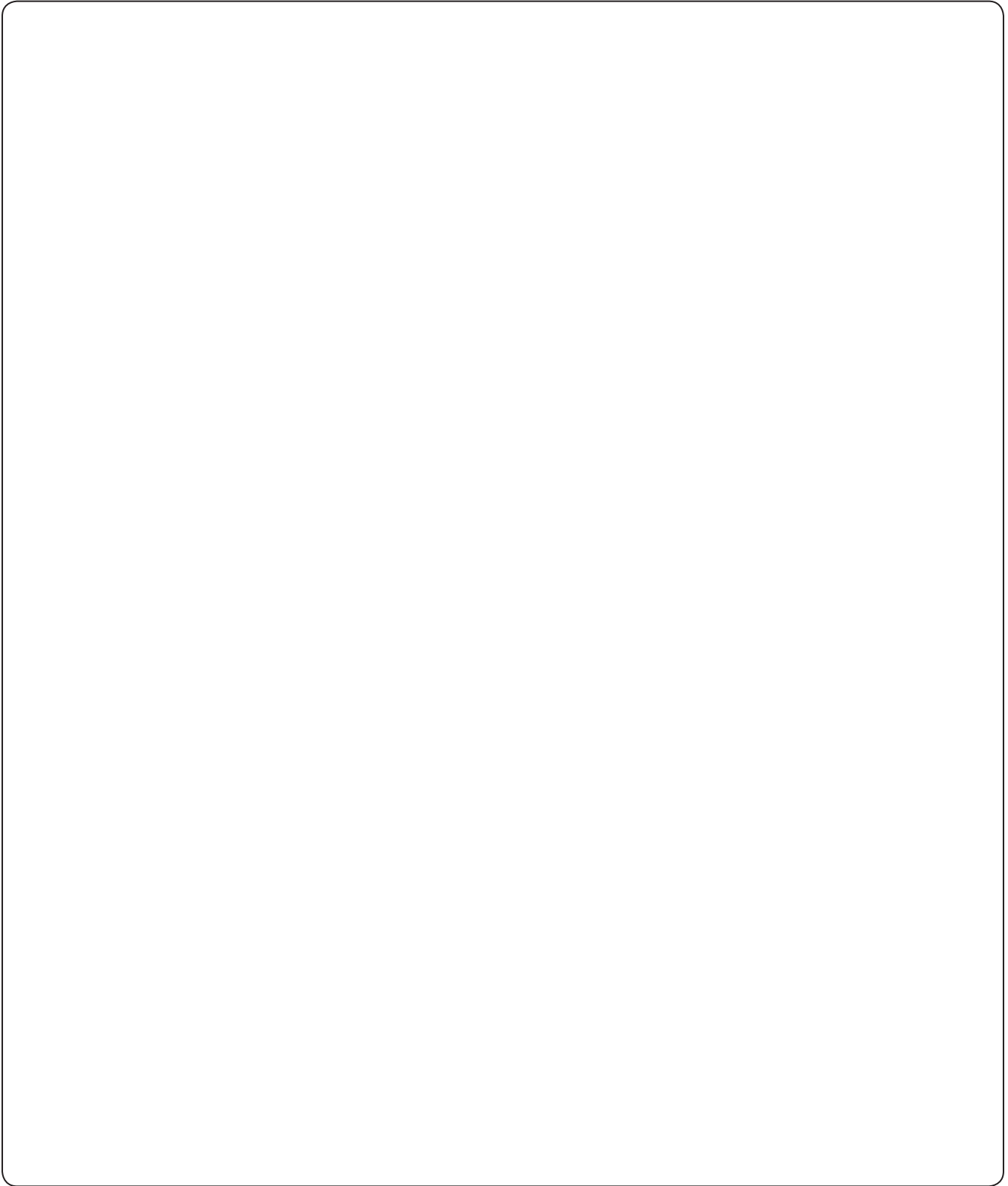


Getting to Know the Preschool Child

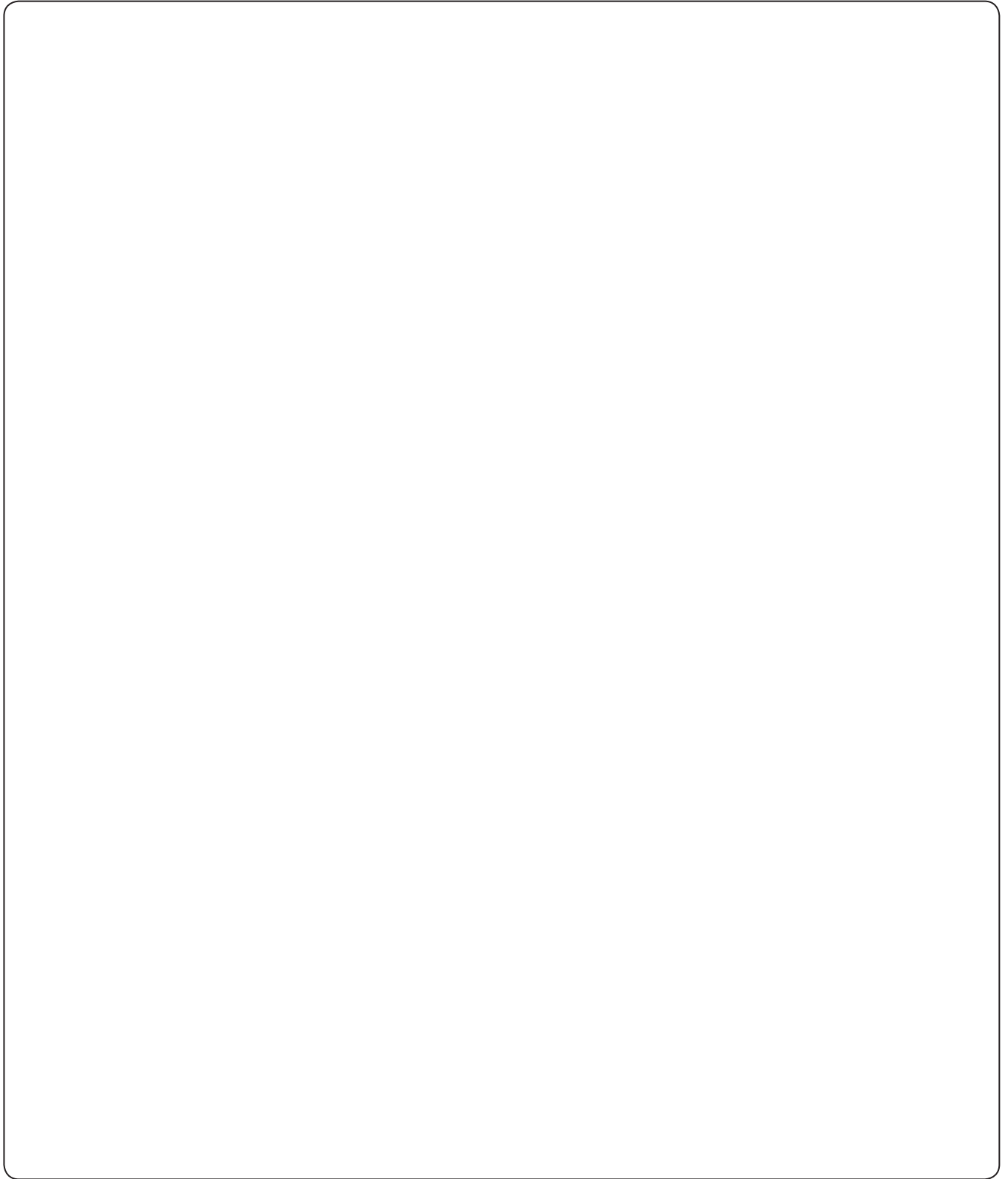


EARLY CHILDHOOD
TOOLKIT





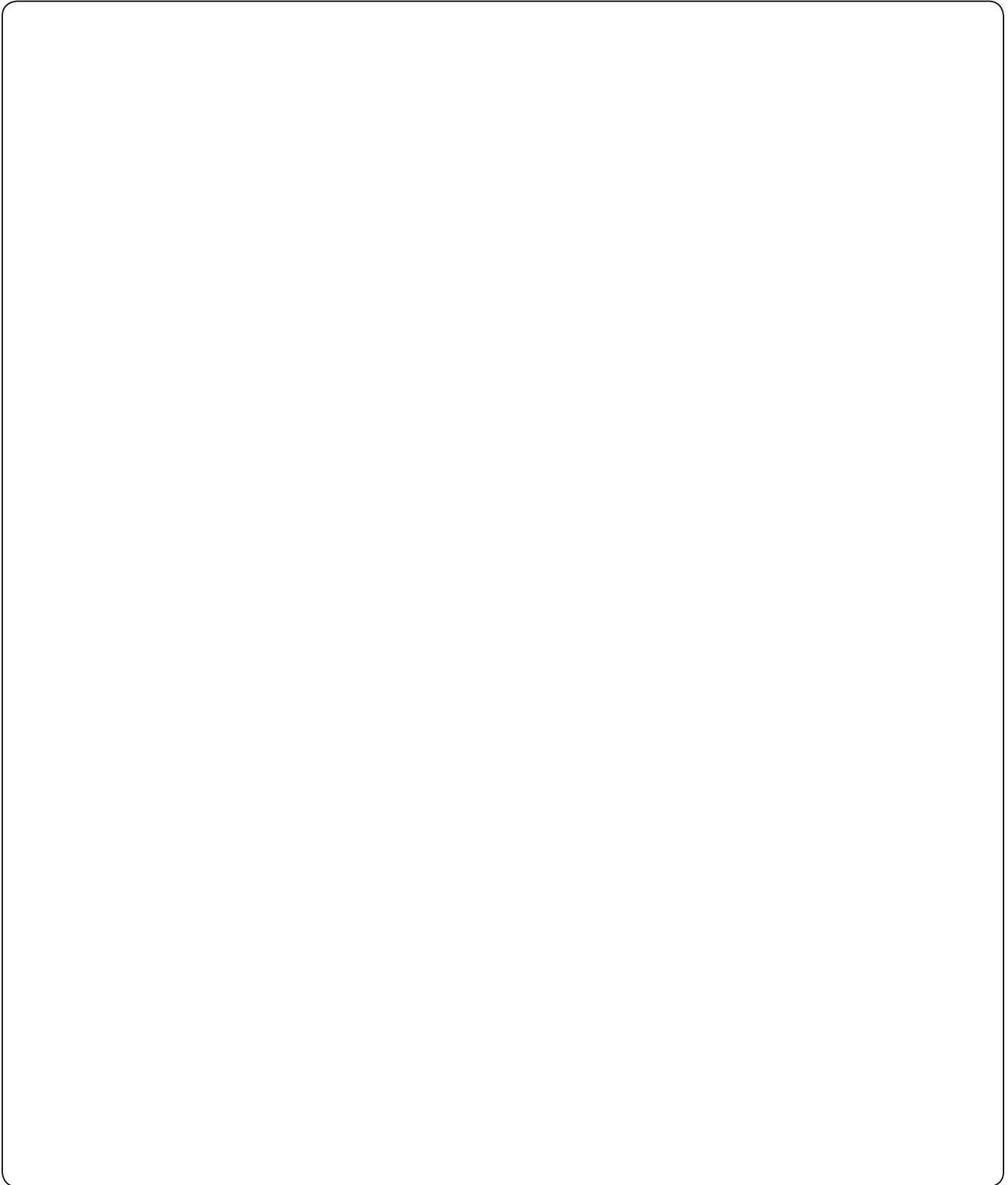
1. This is a drawing of me. I am _____ years old.



2. This is a drawing of some of the people in my family.

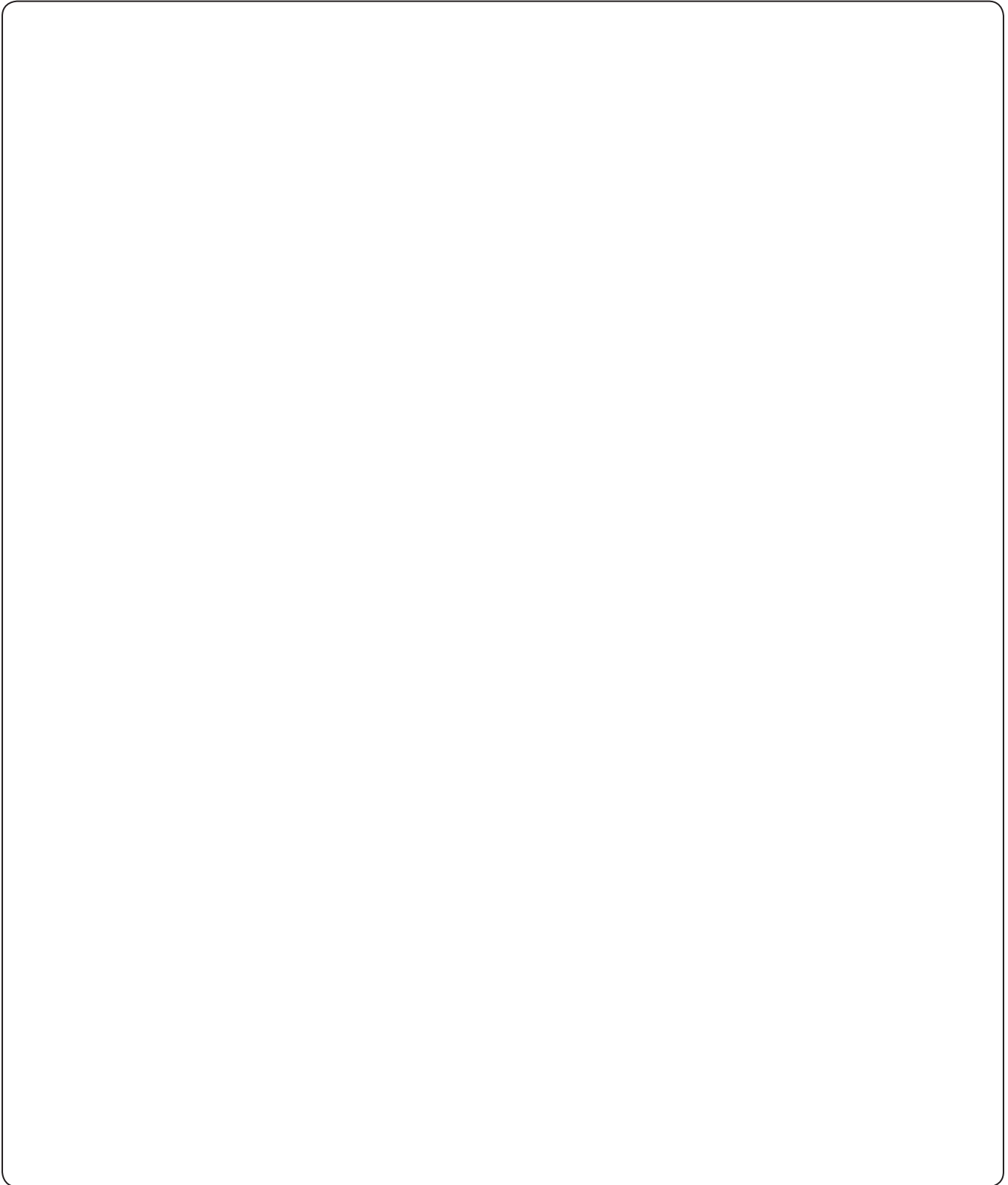
The people in my picture are _____

_____.



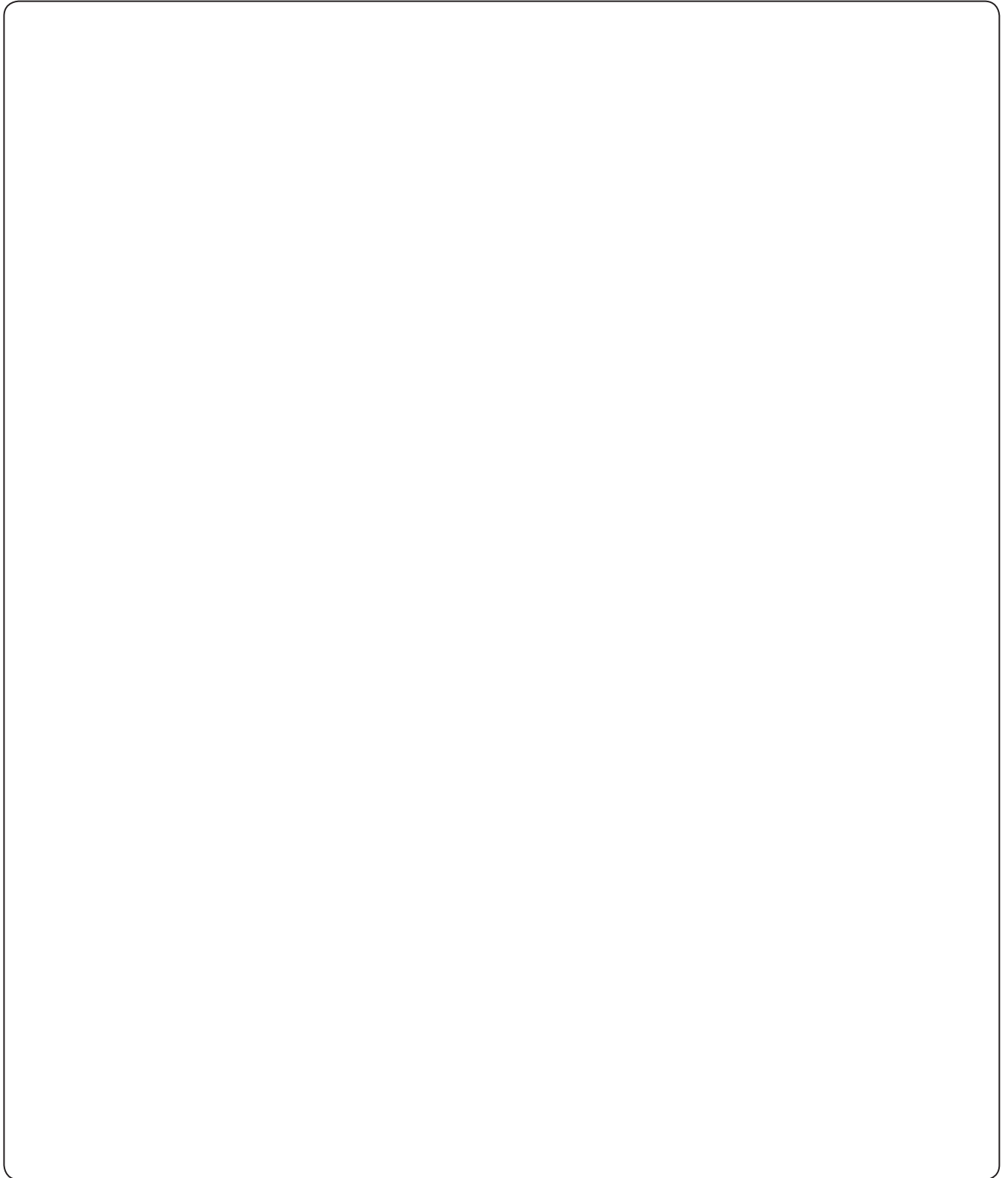
- 3.** This is a drawing of my pet or a pet I would like to have someday.
My pet's name is _____.

- 4.** This is where I live now.
This is where I used to live.



5. This is a drawing of me playing.

When I play, I like to _____.



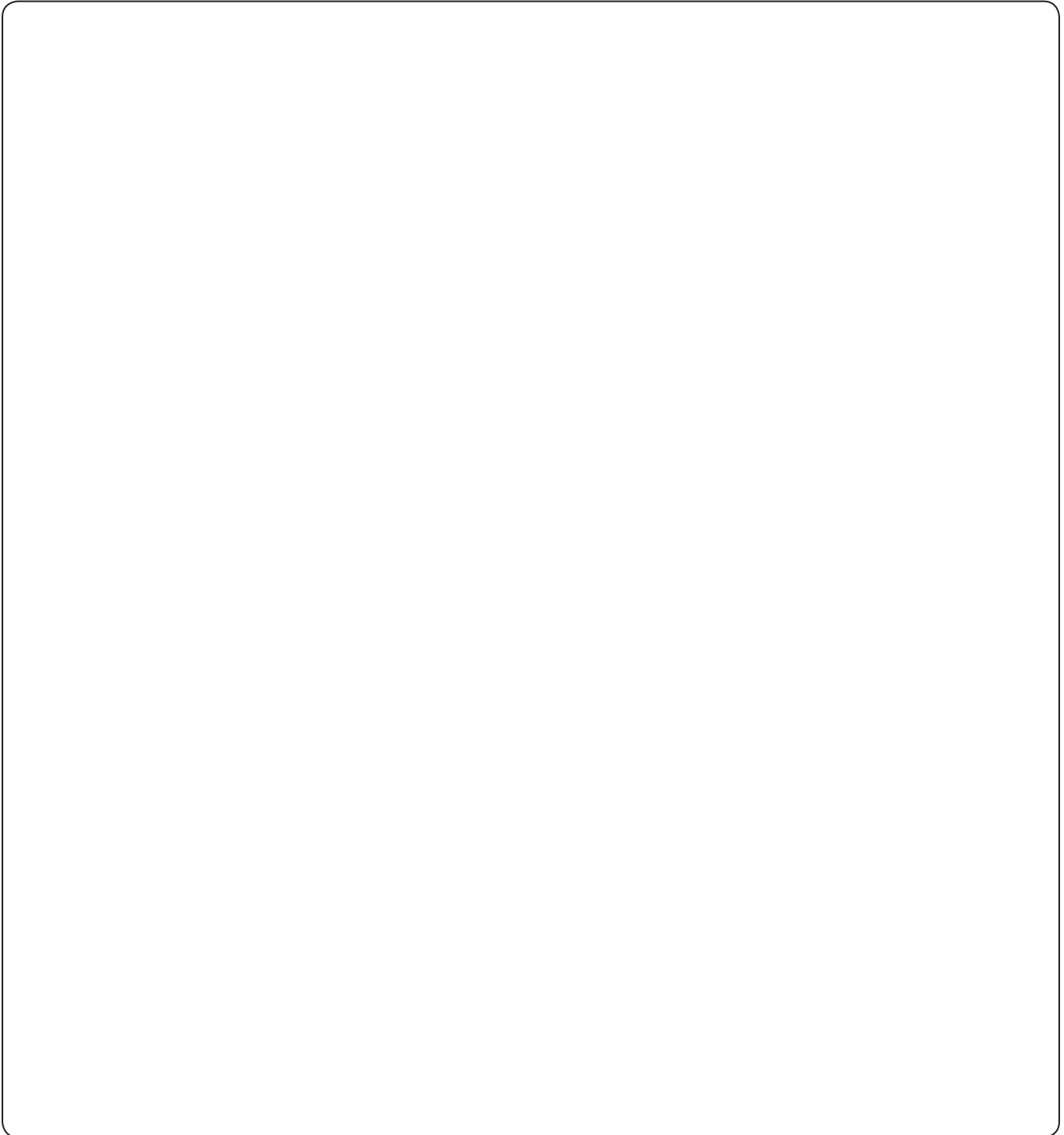
6. This is a drawing of some foods I like to eat.

A large, empty rectangular box with rounded corners, intended for a drawing. The box is white and occupies the upper two-thirds of the page.

7. This is a drawing of something that makes me feel sad.

A large, empty rectangular box with rounded corners, intended for a drawing. The box is white and occupies the upper two-thirds of the page.

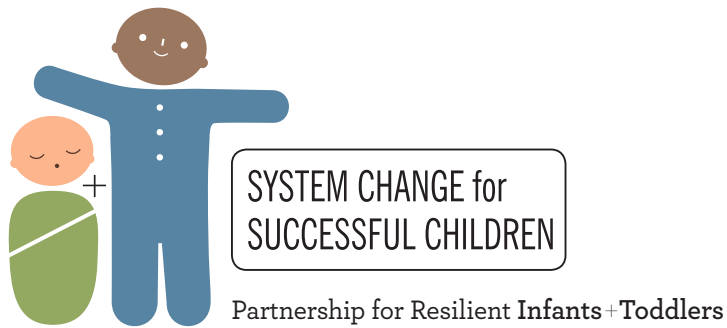
8. This is a drawing of something that makes me feel happy.



- 9.** My Social Worker is someone who helps me and my family. My Social Worker makes sure I am safe and that I have grown-ups who help me and take good care of me. If I have questions, I can ask my Social Worker. My Social Worker's name is _____.
- This is a drawing of me and my Social Worker.

A large, empty rectangular box with rounded corners, intended for a drawing. The box is white and occupies the upper two-thirds of the page.

10. This is a drawing of something I wish would happen.



SCSC is funded by a federal grant to the Collaborative for Educational Services from the Children's Bureau of the Administration of Children and Families

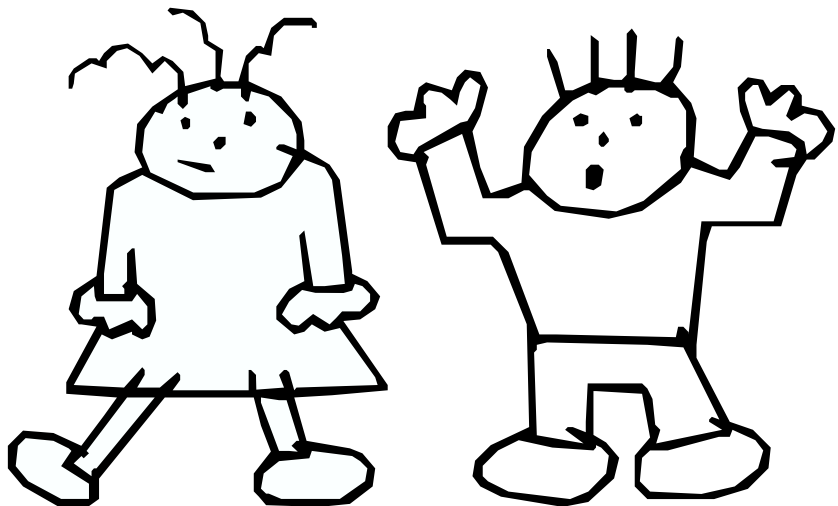


Collaborative for Educational Services
Early Childhood Programs
97 Hawley Street, Northampton, MA 01060
413.586.4998
earlychildhood@collaborative.org

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What's Going On?

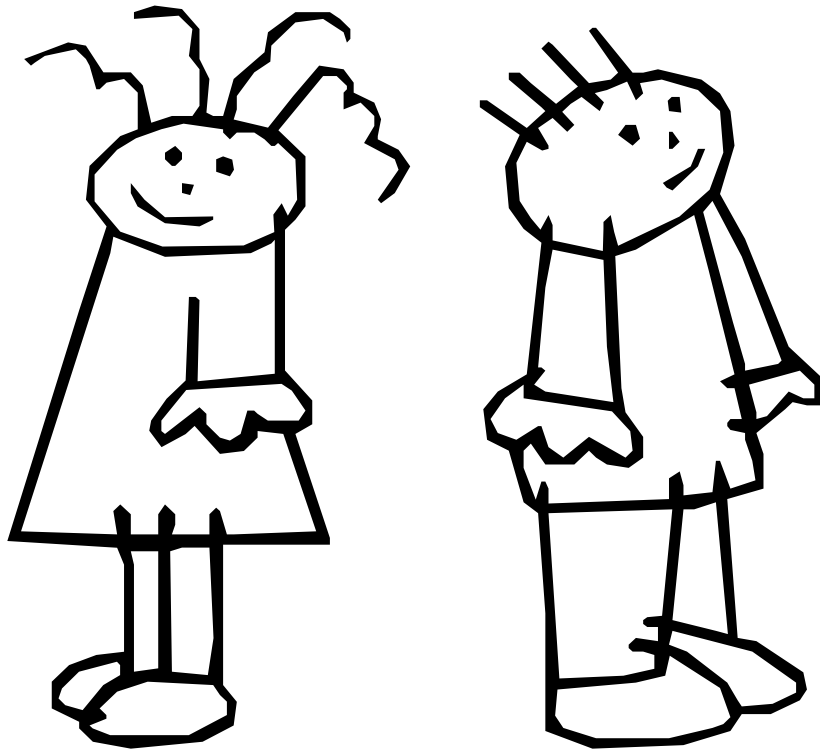
A Coloring
Booklet for
Children in
Foster Care



Source: Shaening and Associates, Inc. and The New Mexico Supreme Court's Court Improvement Project Task Force

All families have problems. Sometimes those problems mean children cannot live at home. They may have to live with a relative or in a foster home for a while.

If you live in a foster home, this booklet is for you. It tells you about the court and about foster care. It also tells you about the people who will help you and your family.



This booklet talks about serious things. You may want someone to read it with you. That's OK. You can read this booklet out loud, write in it, color in it, and talk to someone else about it - like your Mom or your sister or your Social Worker or your teacher. That's OK, too. This is your booklet.

First, let's find out about you!

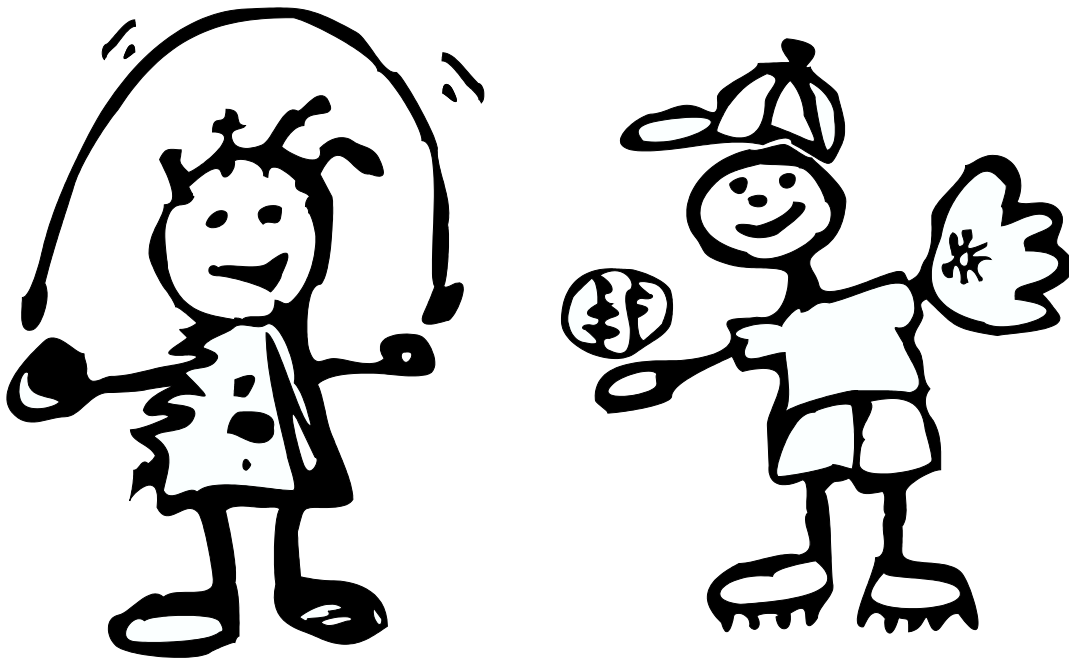
What is your name? _____

How old are you? _____

What school do you go to? _____

What are some of your favorite subjects?

What are some of your favorite things to do?



What are your Mom's and Dad's names?

What are your brothers' or sisters' names?

Who else is in your family?

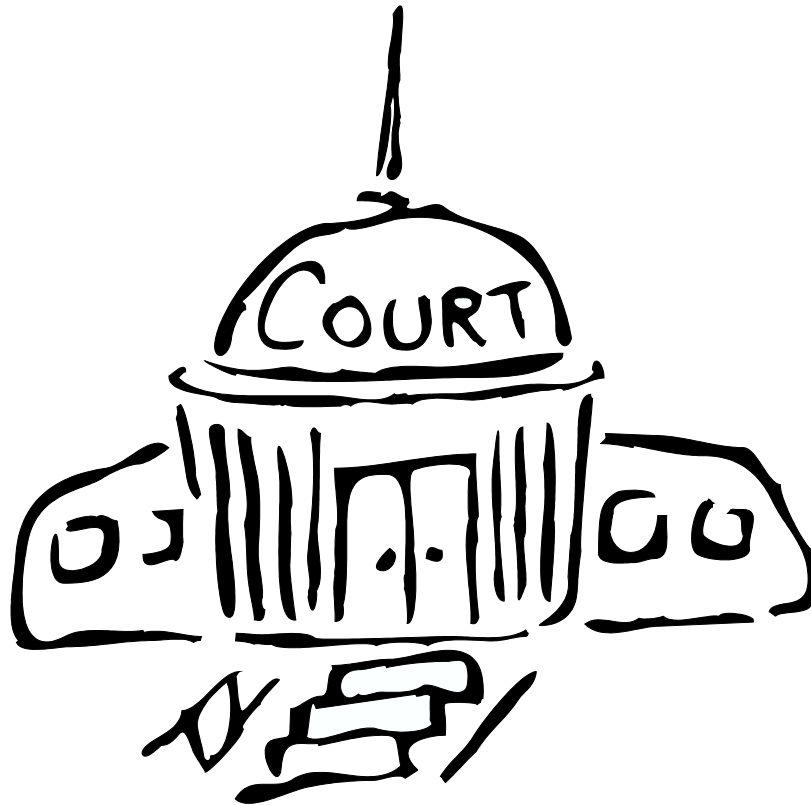
Do you have any pets? What are their names?

Can you draw a picture of your family?



GOING TO COURT

Lots of different families have to go to court. Some have a lot of children, and some have only one or two. But all these families have problems. At court, the judge and other people try to help your family work on its problems.



The JUDGE is in charge of the court. The Judge listens to people talk about what is happening with your family. The Judge decides how to make sure you will be safe. And the Judge decides how to make sure your family gets the help they need.

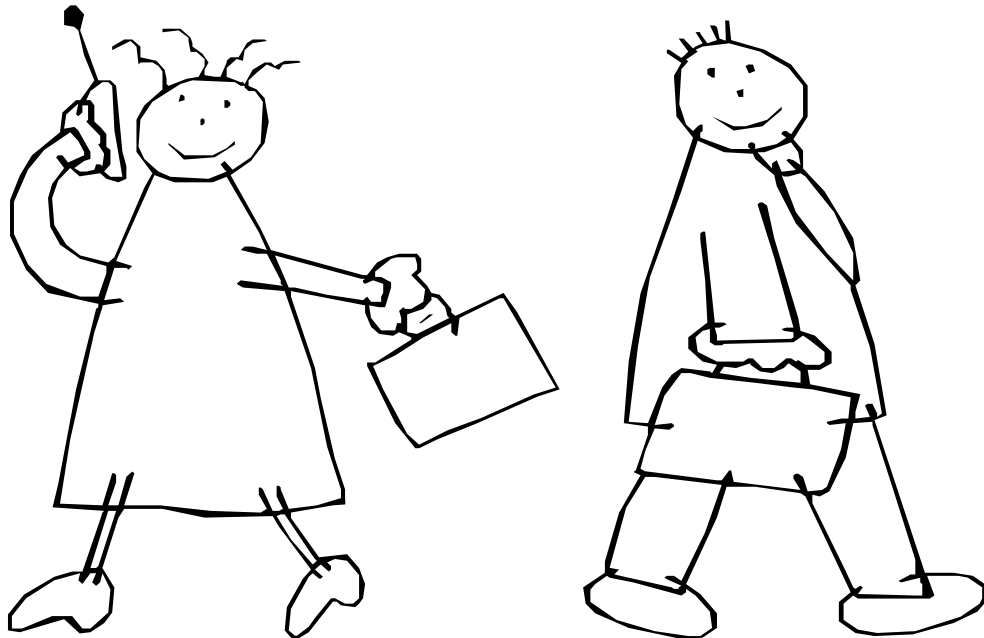
PEOPLE WHO CAN HELP

There are a lot of people who can help you right now. Did you know that you have your very own lawyer? You might also have a *CASA*, and you have a Social Worker.

Your lawyer is called a *GAL*. Your *GAL* is there to help you. Your *GAL* will probably want to talk to you alone. That way your *GAL* can get to know you and tell the Judge about you.

What is your *GAL*'s name?

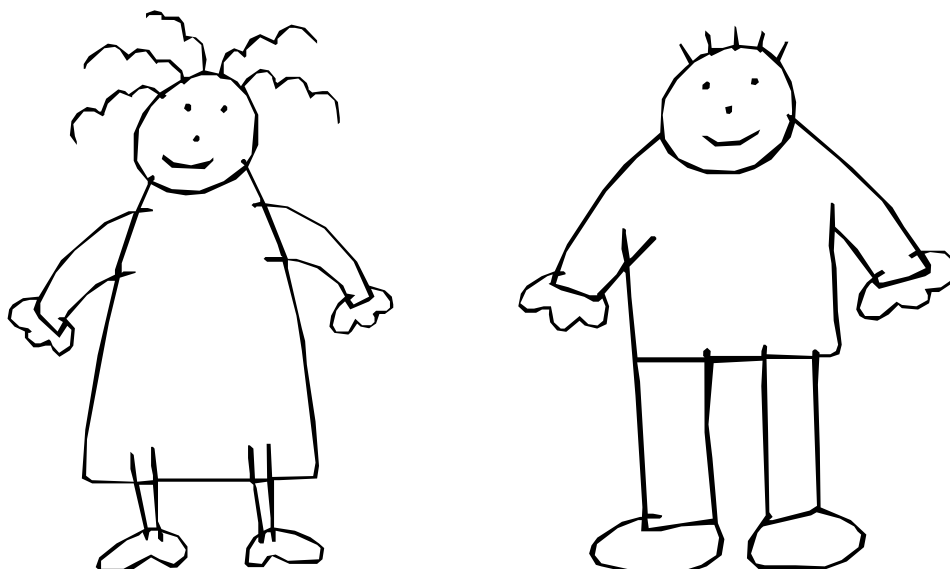
What is your *GAL*'s phone number?



You might also have a *CASA*. Your *CASA* is someone who will talk to you and your family. Your *CASA* will let the Judge know what is best for you.

What is your *CASA*'s name?

What is your *CASA*'s phone number?

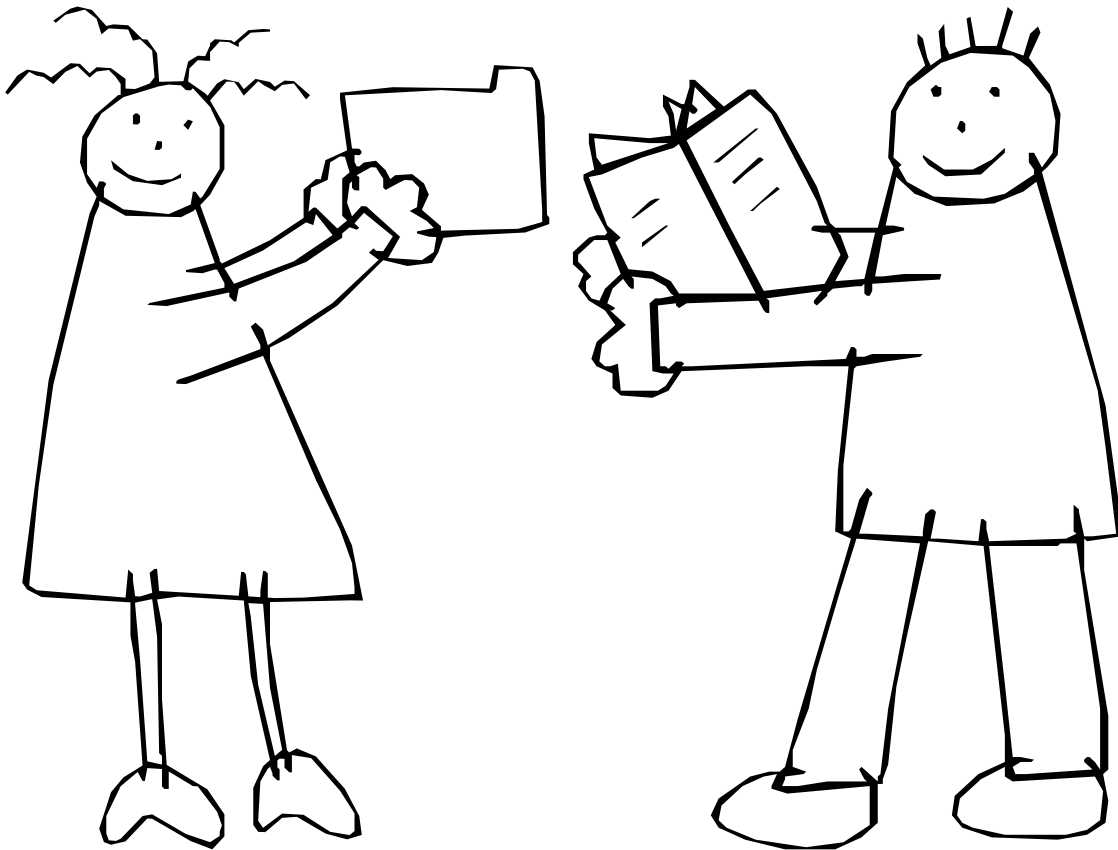


Are there some things you would like to talk to your *GAL* or your *CASA* about? You can write them down here.

YOUR SOCIAL WORKER

Your Social Worker is someone else who will help you. Your Social Worker will spend time with you and with your parents. Your Social Worker will help your family.

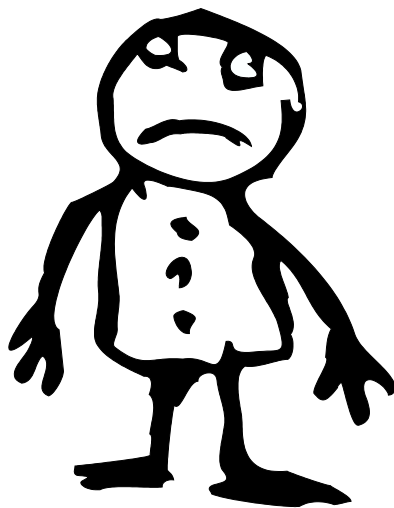
Your Social Worker is a good person to talk to if you have questions. You can also talk to your Social Worker about how you are feeling.



What is your Social Worker's name?

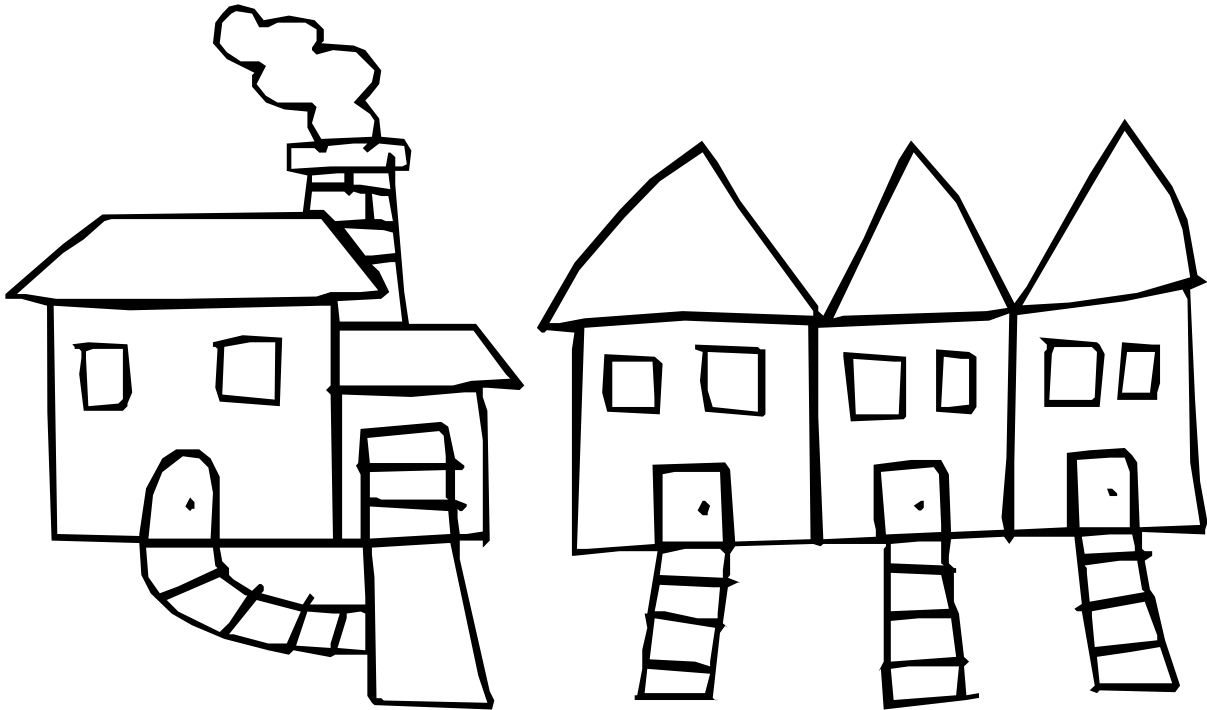
What is your Social Worker's phone number?

Are there some things you would like to talk to your Social Worker about?



WHY DO I HAVE TO GO TO A FOSTER HOME?

Your Social Worker, your GAL, and the Judge all think that it would be better for you to live with a foster family for a while. You will stay there until the judge and others decide it is safe for you to go home again.



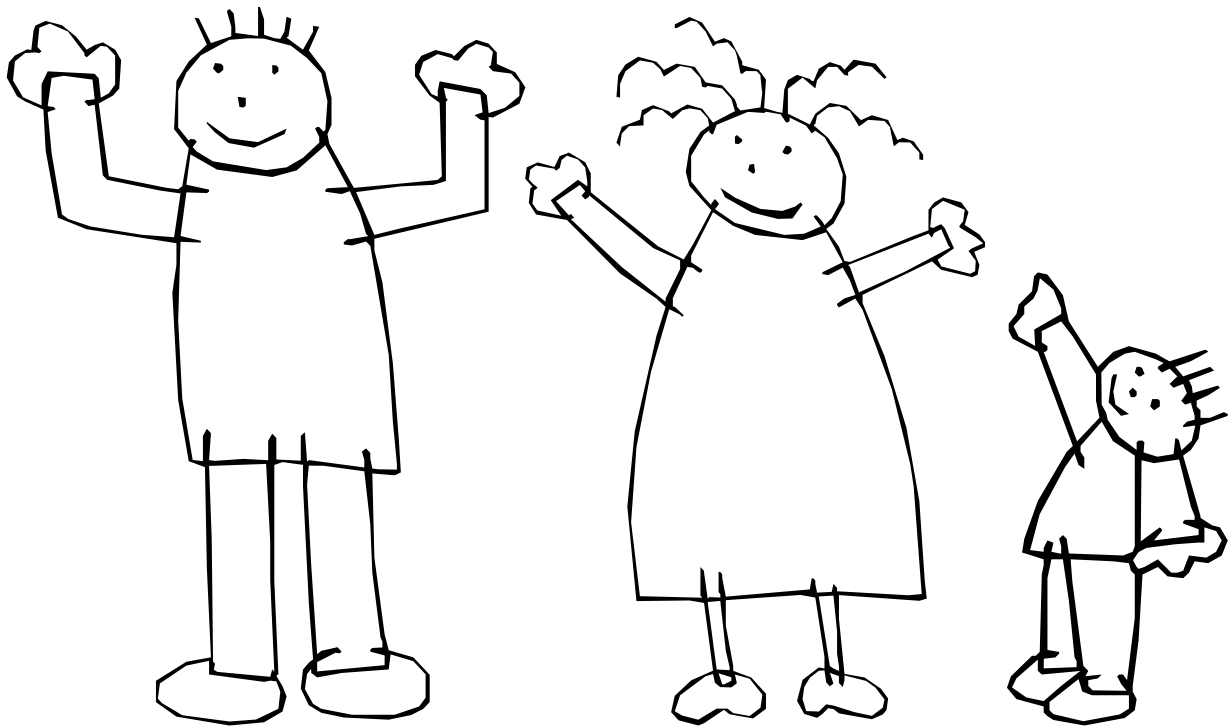
What is your address at your foster home?

What is your phone number?

YOUR FOSTER PARENTS

Your foster parents are there to help you. Remember, it wasn't their idea for you to have to live away from your home right now. But they are happy you live with them. They want to make sure you are safe. They will take care of you until you can go back home.

What are your foster parents' names?

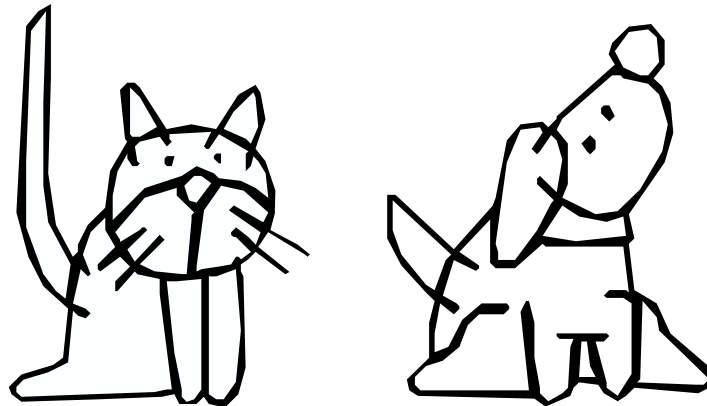


GETTING USED TO YOUR FOSTER HOME

It might take you a little while to get used to all the new things in your foster home. Maybe your foster parents have rules you are not used to. Maybe there are other children living in your foster home with you.

What other children live in your foster home?

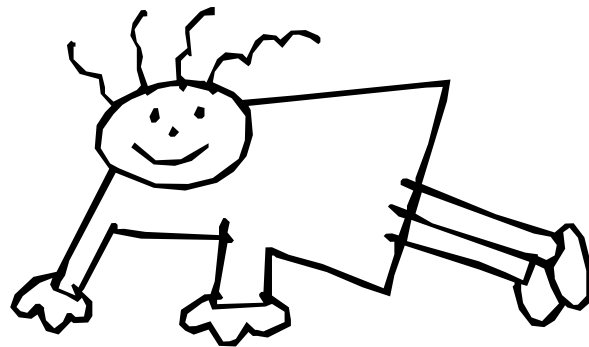
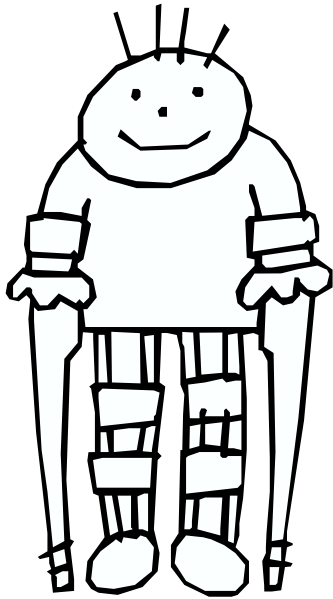
Are there any pets? What are their names?



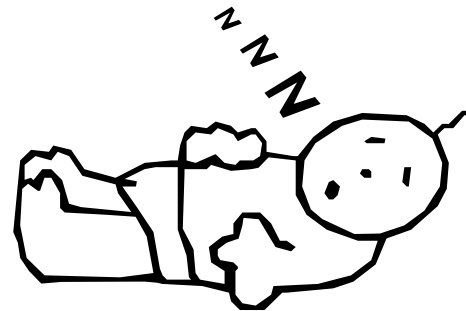
You may feel scared or shy about going to live in a new place with a foster family. It's OK to feel scared or shy or sad. If anyone in your foster home does something to you that you don't like, you should talk to your Social Worker right away about how you feel.

WHAT ABOUT MY BROTHERS AND SISTERS?

Your Social Worker will try to make sure your brothers and sisters live in the same foster home as you. But sometimes they may have to live in a different place.



If your brothers or sisters don't live with you, you probably miss them a lot. Ask your Social Worker if you can visit them or call them.

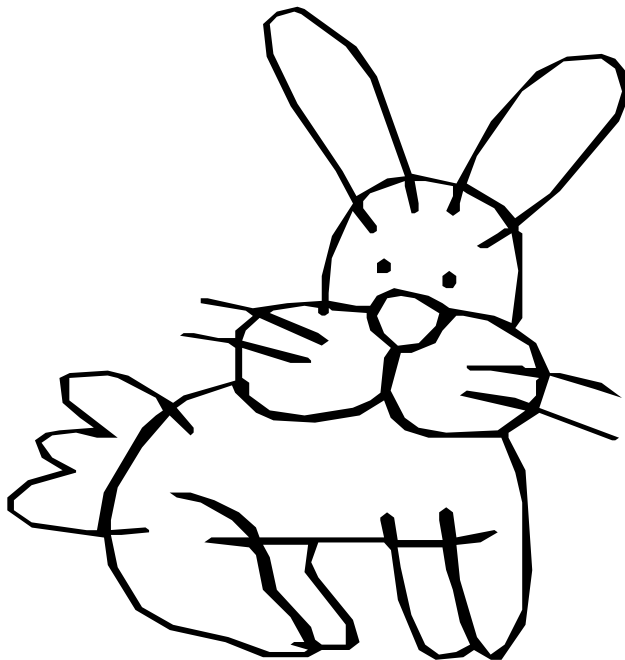


What is the phone number where your brothers or sisters live?

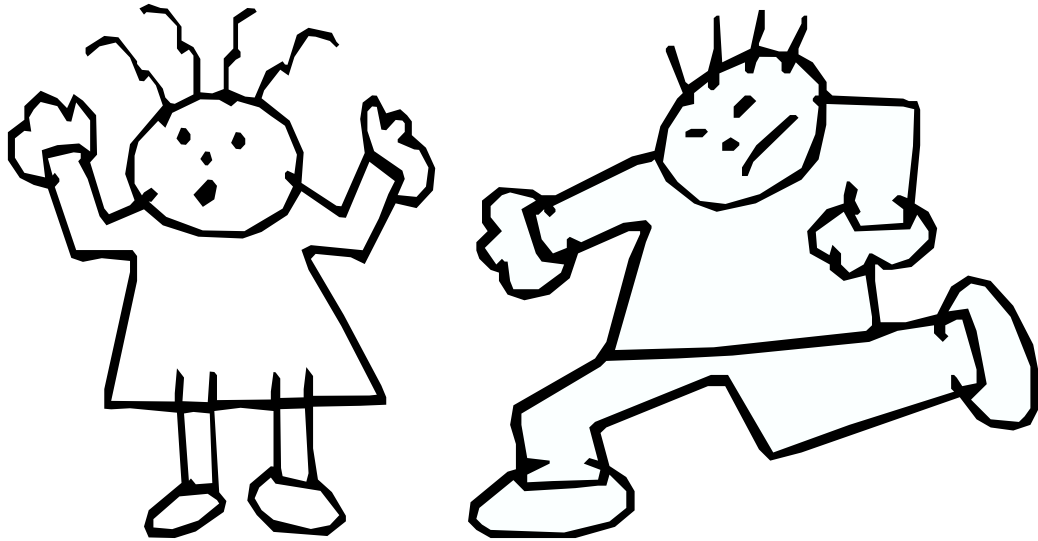
WHAT'S HAPPENING TO MY MOM AND DAD?

You probably really miss your Mom and Dad. And they miss you, too. Probably the hardest thing about being in foster care is that you can't see your Mom or Dad whenever you want to.

Ask your Social Worker if you can call your Mom or Dad when you miss them. Or maybe you could write them a letter. If it's OK for you to write them, what is the address where you could write?



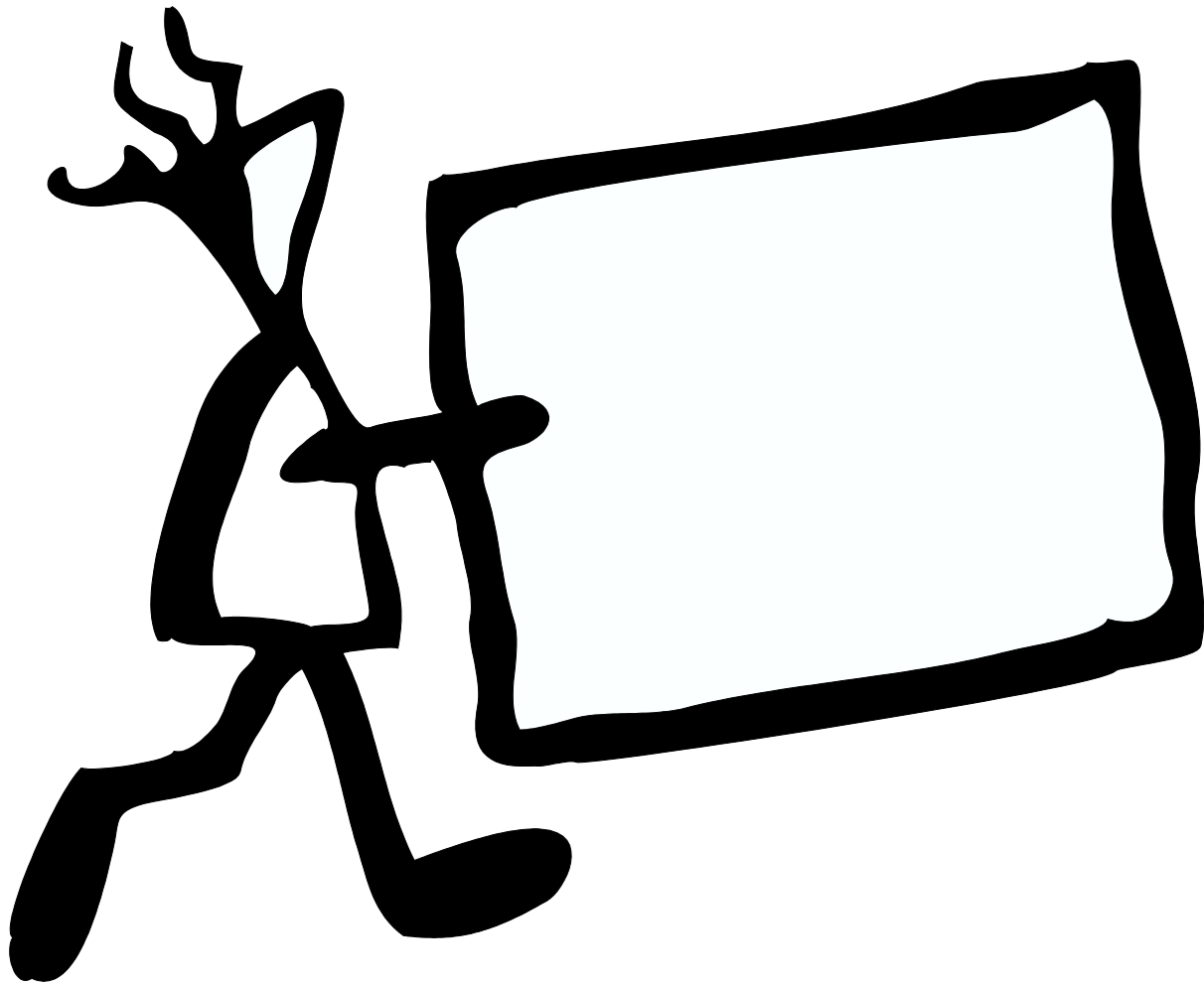
Going to live in a foster home and being apart from your family probably makes you feel mixed up. Maybe you feel sad or scared, or maybe you feel confused. Maybe you even feel really mad.



Remember:

- This is NOT YOUR FAULT. It is NEVER a child's fault when children cannot live at home.
- If you have questions or need to talk to someone, talk to your foster parents, your Social Worker, or your GAL. They want to help you.
- Is there anyone else you could talk to? Write their name and phone number here.

This Is My Booklet:



**PREPARED BY SHAENING AND ASSOCIATES, INC. AND
THE NEW MEXICO SUPREME COURT'S COURT IMPROVEMENT PROJECT TASK FORCE**

**Funding provided by the U.S. Department of Health and Human Services - Administration
for Children and Families, the New Mexico Children, Youth & Families Department - Children's
Justice Advisory Act Group, and the State of New Mexico- Administrative Office of the Courts**

Source: Shaening and Associates, Inc. and The New Mexico Supreme Court's Court Improvement Project Task Force

FAST FACTS



Building
Relationships
with Young
Children

Building Trust with Young Children

WHAT IS IT?

Explaining difficult events to young children can be challenging, especially if there has been an attachment disruption. It is important for the Social Worker to gain the child's trust and be viewed as a dependable adult who is there to help.

Helpful Tips for Social Workers to Keep in Mind:

Explain who you are and that you are one of the grown-ups whose job is to help children. Offer reassuring words and explain who the other adults are who will help them (e.g. foster parents, therapists, attorneys). "What's Going On? A Coloring Book for Children in Foster Care" in Toolkit Section 4c may be used to help the school-aged child understand recent events.

Get to know the child by talking about things that are not directly related to the child's situation, i.e. favorite food, favorite animal, what the child likes to do, who they like to play with. "Getting to Know the Preschool Child—A Book About Me and My Family" in Toolkit Section 4-A may help you to get to know the child better.

Think ahead about what you will say to the child. Try to anticipate what the child will be concerned about. Be prepared.

Keep it simple; start where the child is. Be honest, but remember that children do not need adult level detail.

If the child has questions, respond with direct, honest answers geared to their developmental level.

Try to respond to unspoken worries by naming them for the child and offering reassurance.

Normalize the child's experience by explaining that you know other children like them who have had similar experiences.

Explain that some children think the problems in their family are their fault, but that's never true. It is the job of grow-ups to take care of children and to work on making things better when a family is having problems.

To make sure that a child understands what you have said, ask the child to repeat it back to you in his or her own words.

Tools for Involving Children

The Signs of Safety
Child Protection Practice Framework
September 2011, 2nd Edition
Government of Western Australia, Department for Child Protection
www.childprotection.wa.gov.au

18 The Signs of Safety Child Protection Practice Framework

- **An underlying assumption that the assessment is a work in progress rather than a definitive set piece.**

Signs of Safety always seeks to create assessments drawing from a professional stance of inquiry and humility about what the professionals think they know rather than a paternalistic professional stance that asserts, 'this is the way it is'.

The disciplines and principles underlying the use of the *Signs of Safety* assessment and planning are more fully described in Turnell and Edwards 1999, and Turnell and Essex 2006.

8. Involving children

A considerable body of research indicates that many children and young people caught up in the child protection system feel like they are 'pawns in big people's games' and that they have little say or contribution in what happens to them (Butler and Williamson 1994; Cashmore 2002; Gilligan 2000; Westcott 1995; Westcott and Davies 1996). Particularly disturbing is the fact that many children in care tell researchers that they do not understand why they are in care. Visiting CREATE's⁶ website www.create.org.au or listening to any of the young people who speak publicly through this organisation about their living in care experience tells the same message.

There is considerable talk in the child protection field about privileging the voice of the child, but this is more often talked about than operationalised. A primary reason practitioners fail to involve children is the fact that they are rarely provided with straight forward tools and practical guidance that equips them to involve children in a context where they fear that involving children can create more problems than it solves.

Since 2004 one of the key growing edges of *Signs of Safety* has been the development with practitioners of tools and processes designed to more actively involve children in child protection assessment, in understanding why professionals are intervening in their lives and in safety planning. These include:

- Three Houses Tool
- Fairy/Wizard Tool
- Words and Pictures Explanations
- Words and Pictures Safety Plans

These four tools can involve children and young people throughout the life of the child protection case.

⁶ CREATE is a uniquely Australian organization, which provides support and a direct voice for young people in the Australian care system so they can influence governments and professionals.

8.1 Three Houses tool and the Fairy/Wizard tool

8.1.1 Three Houses tool

The Three Houses tool was first created by Nicki Weld and Maggie Greening from Child Youth and Family, New Zealand and is a practical method of undertaking child protection assessments with children and young people (Weld, 2008). The Three Houses method takes the three key assessment questions of *Signs of Safety* assessment and planning - what are we worried about; what's working well and what needs to happen - and locates them in three houses to make the issues more accessible for children.



Steps for using the Three Houses tool include:

1. Wherever possible, inform the parents or carers of the need to interview the children, explain the three houses process to them and obtain permission to interview the children.
2. Make a decision whether to work with the child with/without parents or carers present.
3. Explain the three houses to the child using one sheet of paper per house.
4. Use words and drawings as appropriate and anything else useful to engage child in the process.
5. Often start with 'house of good things' particularly where the child is anxious or uncertain.
6. Once finished, obtain permission of the child to show to others - parents, extended family, professionals. Address any safety issues for the child in presenting to others.
7. Present the finished three houses assessment to the parents/caregivers, usually beginning with 'house of good things'.

The following is an anonymous example of the Three Houses tool, created by Princess Margaret Hospital Child Protection Social Worker Sonja Parker with an eight-year-old girl 'Tia' who was brought into the hospital by her grandparents. The assessment speaks to the power of locating children in the centre of the assessment process.

Tia's Three - Houses

House of Worries	House of Good Things	House of Wishes/Dreams
<ul style="list-style-type: none"> <input type="checkbox"/> Mum's health. (She has been sick. She sometimes goes to hospital). <input type="checkbox"/> Mum talks to herself and the walls and looks at herself in the mirror. <input type="checkbox"/> Mum sometimes yells at night and she wakes us up and Michael starts crying. I get scared. <input type="checkbox"/> Michael – he is sometimes alone with mum. <input type="checkbox"/> Sometimes mum wakes us up and drives us around at night. She goes to all sorts of places. <input type="checkbox"/> Sometimes people break into the house and steal our clothes and our things. <input type="checkbox"/> One man got drunk and came to the house and smashed the window. <input type="checkbox"/> Sometimes I worry that the windows are going to get smashed again. <input type="checkbox"/> Sometimes mum gets really mad and hits Michael and myself on the arms and legs and bottom. <input type="checkbox"/> Sometimes when mum drives us late at night and she doesn't get up in the morning and I have to do my hair and try to make my uniform okay and get my breakfast. <input type="checkbox"/> Sometimes other people are around and our things get stolen like my PSP and then I get a smack. <input type="checkbox"/> Sometimes my mum comes to my Nana's house and she demands that I go with her and I feel scared – I'm sometimes scared to go with her. <input type="checkbox"/> One night Mum held some tablets to her mouth and she told Michael and I that she was going to take them. <input type="checkbox"/> Sometimes I have to lie to my Nana when my Mum is around. <input type="checkbox"/> Sometimes my Mum swears and spits in my uncle's face (at my Nana's house). I have to lock myself in my room. <input type="checkbox"/> Sometimes Mum and her friends hit each other. Once Melissa punched Mum on the nose and Mum had a blood nose. <input type="checkbox"/> Sometimes Mum goes out and leaves me and Michael alone at night. Our phone is broken and I can't call Nana. <input type="checkbox"/> Sometimes we have to walk in the park at night time to my Nana Rhonda's to ask for a smoke. Then we walk back. <input type="checkbox"/> Now we have takeaway 3-4 times a week (I miss the yummy food mum used to cook). 	<ul style="list-style-type: none"> <input type="checkbox"/> Mum used to cook me food and she sometimes still does now. <input type="checkbox"/> Mum used to take us to the park sometimes or out to Fremantle or to AQUA (last term). <input type="checkbox"/> She sometimes goes to my Nana's and stays with her. <input type="checkbox"/> Sometimes we used to all go out together – Mum and Nana & us. <input type="checkbox"/> Staying with my Nana and having fun there – with my Auntie and Uncle. Michael really likes going to my uncle's. <input type="checkbox"/> We get to do lots of good fun with my uncle and auntie, like at Hilary's beach. <input type="checkbox"/> When we go to dinners with the family like tonight - I get excited. <input type="checkbox"/> School is good. <input type="checkbox"/> I like being with my Nana & Jake, my grandpa & Carole and with my mum when she's good. 	<ul style="list-style-type: none"> <input type="checkbox"/> I want to go live with my Nana, Auntie, me and my brother. <input type="checkbox"/> I want a happy family. <input type="checkbox"/> For Michael and me to be happy. <input type="checkbox"/> For my mum to be better and well. <input type="checkbox"/> For my mum to have fun with us. <input type="checkbox"/> To be with my mum more when she's better. <input type="checkbox"/> For Mum not to get sick anymore. <input type="checkbox"/> For mum not to drive us around late at night. <input type="checkbox"/> For us to move out of that house because it's scary now with all the windows being smashed. <input type="checkbox"/> For people not to come in and out and steal our things. <input type="checkbox"/> For me & Michael to be happy. <input type="checkbox"/> For my Mum to stop hating my Nana, my auntie and my Pa <input type="checkbox"/> For my dad not to go to jail anymore. <input type="checkbox"/> To go and visit my dad sometimes.

Case of Sonja Parker, Perth, West Australia

Source: The Signs of Safety—Child Protection Practice Framework | www.childprotection.wa.gov.au

8.1.2 The Fairy/Wizard tool

Child protection professionals around the world have found that the Three Houses tool, because it focuses directly on the child's experience and voice, time and again creates this sort of breakthrough opportunity with parents who are 'resisting' professional perspectives and interventions.

Vania Da Paz of DCP, was involved in the 1996 *Signs of Safety* six-month development project (refer to a practice example in the *Signs of Safety* book, Turnell and Edwards 1999, p.81). Da Paz has always been determined to find ways to involve children and young people in her child protection practice and following the initial training in *Signs of Safety* she developed a very similar tool that serves the same purpose as the Three Houses tool but with different graphic representation. Rather than Three Houses, Da Paz explores the same three questions using a drawing of a fairy with a magic wand (for girls) or a Wizard figure (for boys) as follows:



Fairy and Wizard Outlines, drawn by Vania Da Paz

Da Paz uses the Fairy's/Wizard's clothes (which represent what can/should be changed – just as we change our clothes) to explore and write down, together with the child, the problems/worries from the child's perspective – or 'what needs to be changed'. The Fairy's wings and the Wizard's cape represent the good things in the child's life, since the wings enable the Fairy to 'fly away' or 'escape' her problems; and the cape 'protects' the young Wizard and 'makes his problems invisible for a little while'. On the star of the Fairy's wand, and in the spell bubble at the end of the Wizard's wand, the worker and the child record the child's wishes, and vision of their life, the way they would want it to be with all the problems solved; the wands represent 'wishes coming true' and explores hope for the future.

A comprehensive exploration of the Three Houses and Wizard and Fairy tools is available in Brennan and Robson (2010) and Turnell, (In Press a).

8.2 Words and pictures explanation

Turnell and Essex (2006) describe a 'Words and Pictures' explanation process for informing children and young people about serious child protection concerns that both involves and directly speaks to children. The following illustration is an example excerpted from Turnell and Essex (2006). The example is presented to give a feel for age-appropriate explanations that locate children in the middle of the practice picture and do this without trivialising or minimising the seriousness of the child protection concerns.

Words and Pictures Story in an Injured Infant Case

Who's Worried?



What Are They Worried About?



Sharon was sick and very badly hurt and had to go to hospital. Sharon had very big hurts all over her body. The doctors were very worried, they said Sharon had been hurt while Mummy and Daddy were looking after her. Mummy and Daddy said they didn't hurt Sharon but the doctors and the social worker were still worried and said they had to make sure Sharon would be safe before she could come home.

What Happened Then?



After this the social worker said Sharon couldn't live with Mummy and Daddy. Nan and Pop wanted to help so Sharon went to live with them after she got out of hospital. Sharon has lived with Nan and Pop for more than two years since then.

What Are We Doing?



Mummy and Daddy are working very hard with Andrew and Karen (the social worker) to show everyone that Sharon will be safe when she comes home.

Artwork by Dan Glamorgan

The 'Words and Pictures' method also offers a powerful method of creating a meaningful explanation for children in care and young people who are typically very confused or uncertain as to why they have come into the care system. One example of this adaptation of the words and pictures method can found in Turnell and Essex (2006, pp 94-101).

Child Friendly Communication:

Reassuring Messages for Young Children

Talking about challenging topics with young children is never a one-time discussion. Their ability to understand will grow with time, and they'll need to ask some questions many times as they struggle to understand or because they need continued reassurance. Without pressuring the child, continue to provide open-ended opportunities to discuss the subject and remind him/her that you are available to answer questions.

Generic Reassurance

- “It’s not your fault. You didn’t do anything to cause this to happen.” This message will need to be repeated many times. Many children feel responsible for the problems in their family.
- “It’s OK to have all kinds of feelings. Sometimes your feelings change and that’s OK, too.”
- Normalize: “You are not alone. _____ happens to a lot of kids and families and there are people who can help the kids and grownups when _____ happens in their family.” Help the child list the helpers for their family.
- Keep it simple, true and age appropriate. Tell even young children the truth, but share only as much as the child can understand and use language appropriate to the child’s developmental stage. Even young children will pick up on inconsistencies and feel betrayed when they realize an adult didn’t tell them the truth. Also, the truth is often easier than what children are imagining.
- Ask children to repeat back what you’ve told them to be sure they’ve understood.

Identifying and Explaining Helpers

- “It’s the job of certain grownups to make sure that kids are safe. Some of these grownups work as teachers, like me, some are called social workers and some work in the courts. It is their job to help kids and their families when they are having problems.” Help child identify grownup helpers they can talk to about how they’re feeling: relatives, social workers, teachers, home visitors, clergy, family friends, etc.
- “You can always ask me any questions. If I don’t know the answers, I will do my best to find out. I will always tell you the truth.”

Child Friendly Communication (2)

Placement/Separation from Parents

- “Your _____ love(s) you and want(s) to be with you, but the judge has decided that he/she/they need some help to learn how to keep you safe/take good care of you before you can go home.”
- Anticipate, understand and address loyalty conflicts: “You can like/love people in your foster family and still love and miss your parents.”
- Kids 5 and under who have been separated from a parent/primary caregiver need to know where they are, when they will see them again, and when they are coming home. They also need reassurance that their parents are OK. If some of this information is unknown, it is better to admit you don’t know than to make up an answer, but reassure the child that you’ll do your best to find out and give them answers as soon as you know more. Alert the social worker if you think the child is confused or needs more information or reassurance.
- During separations from parents, helping children maintain contact with friends and relatives through visits, phone calls, sending drawings, letters, etc. whenever possible will help. Alert the social worker if the child seems to need more contact with a particular person.
- If at all possible, keeping children placed out of the home in the same child care program or school will provide much-needed continuity and routine. Explain to the social worker and caregivers that the benefits to the child are significant and help them find ways to minimize or deal with the inconvenience this may cause.

Family Violence

- “When your parents argue and fight, it’s not your fault and it’s not your job to stop them.”
- “This happens in other families, too, and there are people who can help parents who have trouble getting along and sometimes hurt each other.”
- “Kids who have seen and heard their parents fighting have a lot of different feelings and are sometimes confused about what they’re feeling. Sometimes they worry about their Mom or Dad and sometimes they get mad or sad.”
- “Your social worker’s job is to make sure that you are safe and also to help your Mom and Dad get the help they need to solve their problems so everyone in your family can be safe and not be hurt.”

Parent in Prison

- “Everyone makes mistakes and we can all try to do better the next time. Just because an adult made a mistake or did a bad thing, it doesn’t mean they’re a bad person. Even when kids get mad or are sad about their grownups, it’s always OK to still love their _____ (Mom, Dad, Grandpa, etc.).”
- Adaptation of placement message for prison: “Your _____ needs to go to a place called jail as a punishment and to learn not to break the rules anymore before he/she can come home.” Substitute “steal,” “use/sell drugs,” “hurt people,” but only if these are concepts the child can understand.
- “Jail is kind of like a long time out for grownups.” Refer to time frames kids can relate to, if not completely understand: after your birthday, 3 more birthdays, after a holiday like Halloween or Christmas, when it gets warm again after the wintertime, etc. If it is decided that they will visit at the prison, explain when and who will be with them.

Child Friendly Communication (3)

Talking about Death

- Below the age of 5 or 6, children do not have the ability to understand that death is final, permanent and happens to everyone and every living thing.
- Explain death in simple terms, like “_____ died. That means his/her body doesn’t work anymore. He/she can’t see or move or talk anymore.”
- Answer children’s questions honestly, avoiding euphemisms like “went away, passed away, went to sleep.” Young children may develop fears based on these euphemisms, like being afraid to go to sleep or being afraid when family members leave them.
- Young children will need to ask the same questions repeatedly. Help staff and caregivers to be patient and consistent in answering questions over and over again.
- Young children sense and are affected by the grieving of those around them. Caregivers should not try to hide their grief, but should share how they’re feeling in terms the child can understand: “Mommy is sad because she misses Grandma so much.”
- Children will need permission to feel whatever they are feeling and help to name how they’re feeling. It may help them to draw a picture, light a candle, etc. to remember the deceased.
- Staff and caregivers need to understand that grief in young children can take many forms and is processed in bite-sized bits over time. A child may need to play about death, or even pretend to be dead. They may have a range of feelings directed at the deceased or at other adult caregivers. They may feel responsible for the death and will need to be reassured that they did nothing to bring it about.
- If children ask where the deceased is, the simplest answer is that their body is in the cemetery. They usually aren’t asking a metaphysical question about the afterlife.
- Let caregivers know if a child seems confused or upset by the way death has been explained and help them frame their message in ways that will not confuse or frighten the child. For example, “God loved _____ so much, he wanted her with him in heaven” could result in the child wondering if she should be good so God would take her to heaven to be with the deceased or if she should be bad so that wouldn’t happen. Caregivers may not be aware of how their explanations are affecting the child.
- There are many age-appropriate books to help children understand and cope with death. Some are listed in the booklists found in Toolkit Section 5, Materials to Share with Parents. The Children’s Librarian at the local library is a good resource to find books that fit the child’s developmental stage and circumstances.

Notes

5

Collaborating with Child Welfare (DCF)

- 5-A You Are Not Alone: Guide to the DCF System in MA
- 5-B EC-DCF Collaboration Tips
- 5-C Collaboration Guide
- 5-D Fast Facts | Mandated Reporting of Suspected Abuse
- 5-E DCF Guide for Mandated Reporters
- 5-F Fast Facts | Importance of Continuity
in Early Education Programs
- 5-G Map of the Massachusetts System
of Early Care and Education
- 5-H Helping Children Thrive in Child Care

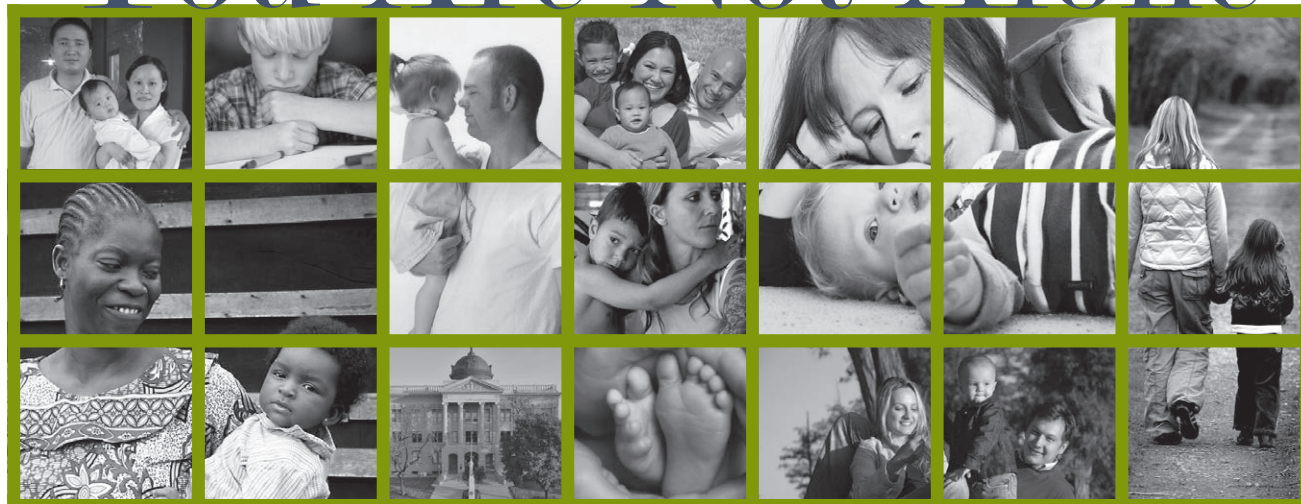
CHILD WELFARE
TOOLKIT



FOR EARLY CHILDHOOD PROFESSIONALS



You Are Not Alone



An empowering guide
for parents whose children
are in DCF* Foster Care.

Written by Parents for Parents

You Are Not Alone
An Empowering Guide for Parents Whose Children are in DCF* Foster Care
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Disclaimer:

All information in this Guide is the responsibility of the Family Nurturing Center of Massachusetts and Parents Helping Parents—The Roundtable of Support. The Department of Children and Families did not edit or approve any information or commentary provided in this Guide. No public funds were used in preparing this guide.

How do I get a copy of this Guide?

Anyone may download the most up-to-date version of the Guide at no charge from the Parents Helping Parents Website, www.parentshelpingparents.org. Parents may obtain a free copy of You Are Not Alone by emailing Parents Helping Parents (PHP) at info@parentshelpingparents.org, by calling 1.800.882.1250 x109, or by writing to PHP at 108 Water Street, Watertown, MA 02472. Copies may also be available from DCF workers, the Probation Department of the Juvenile Court, or your assigned attorney. Organizations and interested officials may order a printed copy for \$7.00 (shipping included). Discounts are available for orders of 5 copies or more.

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*The Department of Children and Families, or "DCF," is the state child protection agency for Massachusetts.
Prior to July 8, 2008, it was called the "Department of Social Services," abbreviated as "DSS."

What just happened to me?

I can't believe this!

Where are my kids?

Why did I lose my children?

Who's going to take care of them?

When can they come home?

I'm mad, scared, and confused. I have so many questions.

Yes, this is a nightmare, but, unfortunately, it won't go away when you wake up. You are going to need help dealing with this situation.

But you are not alone. Parents who have been there wrote this guide. Some of us had problems with drugs or alcohol. Some of us used to lose control. All of us love our children and all of us have had our children placed in foster care by DCF. Some of us have our children back in our care. Some of us do not. Some of us recognize that our life style and actions were hurting our children and we are grateful for the help DCF provided. Others of us are angry at DCF and believe separating us from our children was an extreme over-reaction to our situation and did far more harm than good. We came together and worked with advocates and a legal team to pull together this guide, to help other parents whose children have been removed from their homes by DCF. We hope that by sharing this information we can make your journey easier than ours was.

First things first: Find someone to talk to. Family, friend, or professional, find someone to listen, to help you think clearly, and to encourage you. Personal support from people you trust will help you get through this crisis. You're going to need a lot of help dealing with this situation.

If you cannot reach anyone you know, call the Parental Stress Line at 1-800-632-8188. You can talk to someone there 24 hours a day. The volunteer answering the hotline is trained to help you vent your frustration, get emotional support, and figure out what to do next—all anonymously. You do not have to give your name. The Parental Stress Line is run by Parents Helping Parents, a private organization. It is not part of DCF.

Right now, reach out for help. One note: Be aware that if you feel the need to make any "confessions" about abusing or neglecting your child/ren, it is in your own best interest to tell your story to your lawyer first and go on from there. Your lawyer is the only person legally obligated to keep what you say confidential.

Many parents have gone through this before. Learn from our experiences. Right now you need to find people you can trust, talk to them about how you feel, and start planning how you will get your child or children back home.

Here are some of our stories...

“Almost 13 years ago, I found myself sitting on a hospital bed and for a few fleeting minutes, I felt the biggest relief in my life. I had finally told someone about the mental and physical abuse I had been living with. What I thought was going to be so helpful turned into a parent's worst nightmare. The nurse went to get another woman who then told me that my children were not going home with me, but were going to be brought to DCF. It was one heck of a ride. I learned a lot and had a lot of hard times. I also met some incredible people who helped me. I had to reach out for help. I had to do it for myself and for my kids. It was hard, but I did it and am now a great mother to my four children who live with me.”

“My daughter was taken away from her mother when I, her dad, was in jail. I felt so helpless. Then I realized that I had to get my stuff together inside so that when I got out, I could take care of my baby. I worked hard. My DCF worker introduced me to a Nurturing Fathers Program and I owe a lot to that. It made me a better person. I am grateful for my classes. They helped me get my daughter back. In less than two months, I had my daughter back with me.”

“All of a sudden my son stopped listening to me. He started hanging out with a new set of friends. I didn't know what they were doing. I went to DCF for help with a CHINS and now my son is in DCF custody. I didn't think this could happen but it has.”

Source: The Roundtable of Support, Inc. and Family Nurturing Center of Massachusetts, Inc. | ©2010 Parents Helping Parents—www.parentshelpingparents.org

You Are Not Alone: Guide to the DCF System in MA (4)

“For several years now, I’ve been working with DCF in a good way to better my parenting skills. My mom used her hands to discipline me. I thought spanking was the only way to do it. I’m grateful that DCF came into my life. With the help and support I’ve gotten from them, I’m now able to discipline in a positive manner. I love my kids and want to keep them safe and happy. DCF helped me find who I am and who I want to be – a good mother.”

“You’ll never forget the day it happened. You’ll have endless nights not knowing where your child is. The trauma takes so long to leave and then it comes back when you least expect it. Get connected to people who can help you. You will need every bit of help you can get.”

We’ve been there, and some of us are still there—dealing with DCF and trying to reunite our families.

If you need immediate help, here are resources that many of us found helpful:

General Help

Parental Stress Line/Parents Helping Parents: 1-800-632-8188; 24 hours; translation service available.

Safe Link: 1-877-785-2020 or 1-800-992-2600; domestic violence helpline and shelter openings; 24 hours; multilingual.

The Samaritans: 1-866-912-4673; suicide and depression; 24 hours; English only.

Crisis Information Hotline: 1-800-254-7568; Spanish.

Legal Help

Legal Advocacy Center: 1-800-342-5297 or 617-742-9179; housing problems, bankruptcy, concerns about DCF, Social Security collection, and unemployment benefits; Monday to Friday, 9:00 a.m.–3:30 p.m. (closes Wednesdays at 12:30 p.m.).

National Lawyers Guild: 617-227-7008; lawyer referral service for low-income clients; Monday to Friday, 9:00 a.m.–3:00 p.m.; English and Spanish.

State Agency Help

DCF Ombudsman’s Office (to register complaints): 617-748-2444.

Office of the Child Advocate: 617-979-8360; for concerns about the services your child is receiving from a state agency.

Department of Children and Families, Central Office: 617-748-2000; 8:45 a.m.–5:00 p.m.

You’ll find many more resource listings on the Statewide Resource List at the back of this guide.

Keep your cool as best you can, learn along the way, listen to the experience of those who have already traveled this path, and it will be easier.

Good luck.

Rose Charrier	Michael Rhodes
Robin J. Clemens	Isabel Rosado
Sandra Cochran	Sabrina (Wright) Sharkey
Michael Davis	Leontyne (Leah) Smith
Tim Hairston	Marcia Winfrey
Jose Plazo	

Note: If you have filed a Child in Need of Services (“CHINS”) petition, then some of the information in this guide will not apply. A good resource for working with DCF on a CHINS case is Kids and the Law: A User’s Guide to the Court System, a booklet available from Adolescent Consultation Services, 189 Cambridge Street, Cambridge, MA 02141, 617-494-0135. The guide is also available in Spanish and Khmer.

Acknowledgments

This guide was written by parents who have had children placed in foster care by the Department of Children and Families. The purpose of the guide is to provide information and support to other parents whose children have been removed from their care. The parents/authors were recruited to this project by the Family Nurturing Center (www.familynurturing.org) and Parents Helping Parents (www.parentshelpingparents.org), two nonprofit organizations and advocates who oversaw the project and helped to shape it. A committee of parents with involvement in the Massachusetts child protective system will continue to update the guide and promote its use.

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This guide is not meant to serve as legal advice, but rather, as a source of information to help you be a strong advocate for yourself and your child/ren. If you do not understand something in the guide or have difficulty keeping notes or a journal of your meetings and appointments, speak to your attorney or ask someone you trust to help you or call The Parental Stress Line at 1-800-632-8188.

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* The Department of Children and Families, or "DCF," is the state child protection agency for Massachusetts. Prior to July 8, 2009, it was called the "Department of Social Services," abbreviated as "DSS."

1: Answering First Questions

“Yes, it is true that the Commonwealth of Massachusetts has the right to take your child from your house, from his or her school, or from a hospital! When it happened to me, I was in shock. When you lose your child, you feel like you’ve lost everything. You wonder who is taking care of your child. I was so confused and so angry! Those were the worst nights of my life. I screamed for what seemed like days. I couldn’t hear anyone.”

What is the Department of Children and Families?

The Massachusetts Department of Children and Families (“DCF”), formerly known as the Department of Social Services, is the state’s child protection agency. Its mission is to protect children from abuse and neglect and to strengthen families. For more information about DCF’s work and the various resources it provides for families and children, visit its website. Go to www.mass.gov and enter “Department of Children and Families” in the search box at the top right of the screen.

We hope this guide will help you work with DCF so that you can create the best outcomes for your child/ren and family.

What do I do right now?

This is a scary time. Your child has just been taken from you. You may not understand why your child was removed from your home. You may not agree with DCF’s reason for taking your child.

Where do you start?

- First, take care of yourself. Find someone you trust, someone with whom you can share your feelings.
- Second, contact a lawyer. Hire a private lawyer if you can afford one, or speak to your court-appointed lawyer if the court has given you one. (For more information on this, see Chapter 7 “Understanding the Legal System” page 24.)
- Third, you have a lot to learn about yourself, about DCF and the courts, and about the people who will be trying to help you. Start by reading this guide.

You are beginning a difficult journey in parenting, and you will need help. You are being asked to meet new people, listen to new information, and find new ways to act. Get calm, stay focused, and learn. Knowledge is the key to your success.

Why did DCF remove my child from my house?

“Do not expect that all the people who are involved in this case will see things the same way you do.”

DCF took your child away from you because DCF received a report that your child was being abused or neglected or was in danger of being abused or neglected. After investigating the report, a DCF worker and his or her supervisor decided that there was a significant chance that your child would continue to be abused or neglected and needed to be placed in foster care.

In addition to serious bodily harm and emotional abuse, “Abuse or Neglect” includes allowing a child to live in unhealthy and/or dirty conditions or to live without adequate food, clothing, heat, or medical care. DCF also considers taking drugs in the presence of a child, failing to supervise a child properly, failing to keep the child safe from other people who may abuse the child, or failing to require a child who is under sixteen to attend school to be neglect. Neglect is also allowing a child to see or hear domestic violence.

You have the right to see the reports the DCF workers have written about you. To get copies, send a letter of request to Commissioner Angelo McClain, Massachusetts Dept. of Children and Families, 24 Farnsworth Street, Boston, MA 02210.

DCF does not need to go to court before removing children from their homes. In an emergency, DCF can remove a child right away if it believes it needs to protect the child from further abuse or neglect. The department then must file a “care and protection” petition in court on the next business day. If DCF removes a child on a Friday, it does not need to file a care and protection petition until the following Monday.

Where is my child?

“I found myself saying that I couldn’t be angry with these people because they had my child.”

When DCF removes children from a family, they can place the children anywhere the DCF worker thinks is appropriate. You have very little to say about where your child is placed. DCF is unlikely to tell you exactly where your child is placed, to prevent you (or someone else) from trying to make unauthorized contact. The most common placement is a foster home. Other arrangements include kinship care (with a family member or friend), group homes, medical care settings (including medical foster homes), and residential treatment programs. When someone says that a child has been “placed in foster care,” the “foster” child could be placed in any of these types of settings. Your child may be placed with the other parent if that parent doesn’t live with you.

You Are Not Alone: Guide to the DCF System in MA (8)

If you have more than one child, your children may or may not be placed together, depending on the individual needs of each child and the available foster home space.

In the “Resources and Tools” section at the back of this guide, Section H “Information About My Child” page 47, there is a form you can complete and give to DCF. It provides important information about each of your children, which will help to ensure that each child receives as appropriate a placement as possible.

Kinship Care or Kinship Placements

DCF first tries to place children with their kin or relatives (grandparents, aunts, uncles, cousins, and others), or with family friends, because this often makes things easier for the children. *If you have a relative or family friend with whom you would like your child placed, give the DCF worker the person's name, address, and phone number right away.* If you need to check with your relative or friend first, do so as quickly as possible and then let your DCF worker know. Tell your worker what your kin is willing to do -- even if the relative or friend is not in a position to take care of your child/ren for a long time.

Because these families have not been trained by DCF to be foster parents, they must fill out paperwork and get approved by DCF. Before placing a child with a relative, DCF will do a background check, including CORIs (Criminal Offender Record Information) on all household members over age fourteen. DCF also will complete a home study (looking at the condition and safety of the home) before placing the child with the friend or family member. Sometimes relatives or friends are paid a stipend to help with the cost of caring for your child.

Foster Care

If there is no relative or friend available or DCF does not think that the relative or friend would be an appropriate placement for the child, DCF will place the child in a foster home. Foster homes are private homes of families who have agreed to take care of children. These families are called “foster families” or “foster parents.” Foster parents are screened by DCF and must complete a twelve-week training program. In most cases, they are caring individuals who are opening their homes to others. They receive a small monthly stipend from DCF for each child placed in their home. A DCF worker is required to make a monthly visit to the foster home to see the child. Children placed in foster homes will usually attend the local public school where the foster home is located.

“My child was put in foster care twice. The first time—the foster mother was willing to talk with me and let me talk to my child. The second time, the foster parents were really mean to my daughter and me.”

Specialized Foster Care

“Specialized Foster Care” or “Intensive Foster Care” both describe a foster home where the foster parents have received special training to take care of children who have special medical or emotional needs or need extra care. If your child has special medical or mental health needs, you should tell the DCF worker immediately so that your child will be placed where s/he can receive the appropriate specialized care.

Group Homes

If a child needs more structure or supervision than a foster home can give, or if there are no available foster homes, the child may be placed in a group home. Group homes can host six, ten, or even more children, either single sex or mixed. Children placed in group homes are almost always at least ten years old. Group home staff cares for them. The children will usually attend the local public school in the area where the group home is located.

Residential Treatment Programs

Residential treatment programs are larger than group homes, hosting up to 25 children. They take care of children with more serious problems. These programs have more staff than group homes, including doctors, nurses, and social workers. If your child has special emotional needs, DCF may place him or her first in a residential program in order to observe your child and then determine what your child's needs are and where your child should be placed later.



Image courtesy of Rise Magazine and Karolina Zaniesienko.

Some residential programs, called “Hospital Diversion Programs,” have extra services so that a child doesn't have to be hospitalized. These programs are also called “Acute Residential Treatment” (“A-R-T” for short) or “short-term diagnostic.” Children are not supposed to stay in these programs for more than 45 days, although they sometimes stay longer.

Most residential treatment programs include a school with certified teachers, although some children in residential treatment programs on a long-term basis may attend the local public school.

“My daughter has been in and out of residential programs. Some are better than others. But it's hard because a lot of them are co-ed and that means my daughter is living with boys and some are older than her. She's learning about stuff that I would never want her to know about.”

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Emergency Placement

Some foster homes, group homes, and residential programs are prepared to take children on an emergency basis. When DCF places a child in an “emergency placement,” the child will usually stay there for a short time until DCF finds a long-term placement for the child.

The staff members working in emergency placement programs are responsible for keeping children safe and providing them with food. In some cases, they, rather than the DCF worker, are responsible for the child’s medications and for setting up doctors’ appointments.

When can I see my child?

We know that you will want to see your child as soon as possible. You will want to know that s/he is okay. You will want your child to know that you love him/her and that things will work out.

You may ask DCF to see your child as soon as possible, but you should know that when DCF has legal custody of children, DCF decides when visits will take place, where they will take place, and how long they will last. Make sure that the visitation schedule and rules are written into your service plan so that you know when and how visits will be coordinated.

If your child remains in DCF’s custody after the 72-hour hearing (read to find out what this is), visits will usually take place once each week. DCF is required to give you “regular and frequent” visits with your children. If DCF does not, let your lawyer know immediately.

You should call and confirm all visits ahead of time, and you should attend all visits. If you do not, this will hurt you in court. Most important, go to all your visits because your child needs to see you whenever possible. If you have a scheduling conflict, document all the related calls you make to your worker and lawyer.



Image courtesy of Rise Magazine and haynia Waldron.

“It’s important to communicate clearly with your worker and, if you can, with the Foster Family/Group Home. I had a lot of visits canceled at the last minute. This became a problem with my job since I had been requesting the time off to go and see my son.”

When can I call my child?

If DCF allows phone contact, it will most likely limit the number of phone calls you can have, when you can call, how long your calls can be, and what you can or can’t say to your child. DCF may require another adult, such as the foster parent or a group home staff member, to listen to your conversations.

Keep the conversation simple at first and ask your child about his or her day and activities. Has s/he learned any new games? Is s/he meeting new friends at the new school? Let your child know that you love him or her, and that you’re always thinking about him or her. You don’t need to ask questions all the time. Children want to share what is going on and how they are feeling.

If DCF allows you to contact the foster family, speak with the foster parent first when you place calls to your child. Inquire about how your child is adapting to the foster home, about your child’s emotional state, about your child’s physical well-being, about school, and other subjects that will help you converse with your child and also show respect for the foster parents’ care.

Relaxed conversation with your child will likely be difficult in the beginning. If the conversation is awkward, you can ask your child if s/he feels comfortable talking at that point. If the answer is “No,” ask your caseworker to make other arrangements so your child can speak to you when and where s/he is comfortable.

Is my child safe?

DCF will try to place your child in the right kind of foster home. Foster homes have one or two trained, certified foster parents. Some are trained by DCF; some are trained by other agencies, such as Catholic Charities or DARE.

The best way to know if your child is safe is to keep in contact with your DCF worker and your child. Be sure to come to all your visits and call your child as often as you are allowed. Ask your worker about the foster family. Tell your DCF worker about any concerns you may have about the foster family or any desires you may have to work with the foster family. If you are allowed to speak to the foster parent, this is another way of ensuring your child’s well-being.

“I was concerned about his safety. You hear about these things that happen in foster care. I needed to be in touch with my child to really know he was safe.”

Will anybody tell me how my child is doing?

You have the right to know how your child is doing. It is your job to call the DCF worker and to ask about your child.

Specific questions about your child’s education and health care are addressed in Chapter “5: Making Decisions About Your Child’s Care”.

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What if I can't get in touch with my DCF worker?

If you are not able to get the DCF worker to answer your phone calls, ask to speak to your DCF worker's supervisor. Tell your lawyer if your DCF worker or supervisor does not answer your phone calls. If you are having trouble reaching your worker or getting your calls returned, keep a journal of where and when you left messages.

You may also call the DCF Ombudsman's office at 617-748-2444 between 8:45 a.m. and 5:00 p.m. to report the problem. The Ombudsman's job is to respond, mediate, and resolve (if possible) any issues of concern to DCF clients and other concerned citizens regarding agency programs, policies, or service delivery.

Why do I need my own lawyer now?

DCF has decided that you should not be taking care of your own child, and DCF is going to court to ask a judge to agree. A lawyer is the professional who can help you get your child back or work toward whatever goal you set. A lawyer can help you have a voice in deciding what happens to your child and in shaping what your role will be as the parent. When you go to court, you will need a lawyer to speak on your behalf and to help you navigate this difficult, complicated situation.

Don't delay. You want to speak with your own lawyer before you speak to anyone at DCF regarding your case, if that is possible.

How do I get a lawyer?

You may ask the court to give you a court-appointed lawyer or you may hire your own lawyer.

“DCF told me right away that my kid had a lawyer and that I had a right to one too.”

What about a court-appointed lawyer?

Will I have to pay for a court-appointed lawyer?

Parents who are “indigent” (unable to afford a lawyer) have a right to a lawyer appointed by the court. Some courts will give you a lawyer before you get to the courthouse. You will then need to show that you are indigent after you get to court. If you are not indigent, the judge will take your lawyer off the case. Some courts will give you a lawyer only after you get to the courthouse and show that you are indigent.

Parents must complete paperwork at the courthouse about income, expenses, and home ownership. A probation officer will interview you for more details, to decide whether you are income-eligible for a court-appointed lawyer. Bring documents with you to court that show your income, debt, and expenses.

Parents who earn or have too much money for a free court-appointed lawyer may still be able to get a lawyer for a reduced fee. Those parents (known as “indigent but able to contribute”) will pay a certain hourly or monthly fee to the court for the appointed lawyer. A monthly payment plan can be arranged.

All parents must pay a one-time counsel fee of \$150, unless the judge determines that paying this fee would be a hardship to the parent.

What if the probation officer or the judge decides I make or have too much money for a court-appointed lawyer?

If you believe that the probation officer's decision is wrong, you can ask the judge to decide. If the judge also says no, you will have to hire your own lawyer.

For assistance finding a lawyer, ask the Clerk's Office in the courthouse for a list of lawyers who practice child welfare law or contact a legal service agency to ask for a lawyer. (See the listings in Chapter 10: Resources and Tools “B: Getting the Support You Need: A Statewide Resource List” page 39.)

You may also go to court without a lawyer. This is called appearing “pro se” (for yourself). It is our experience that it is very hard to represent yourself in care and protection cases because you typically need a legal background to be successful.

What if I don't like my court-appointed lawyer?

If you are unhappy with the job that your lawyer is doing, tell the lawyer why you are unhappy. Try to work out any differences. If you cannot work things out, as a last resort you may ask your lawyer to withdraw from your case. The judge will decide if your lawyer can withdraw. The judge will also decide whether to give you a different lawyer. Judges usually will not replace a lawyer unless there is a good reason. They also usually will not give you a new lawyer if you are very close to the day of the trial.



Image courtesy of Rise Magazine and Freddy Bruce.

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“My lawyer was good at first, really working with me and calling me back. Now he doesn’t. Be persistent!”

How do I work with my lawyer?

Does my lawyer work for me, for DCF, or for the judge?

Your lawyer works for you. Your lawyer does not work for DCF or the judge or your child. No matter who pays for the lawyer, the lawyer works for and represents you. Expected performance standards for court-appointed lawyers can be found at the website for the Committee for Public Counsel Services, www.publiccounsel.net, under “Assigned Counsel Manual.”

“When I entered the courtroom, I wasn’t sure who my lawyer was working for since he spent so much time talking to the DCF lawyer and my child’s lawyer. The courtroom can look very lopsided with only you and your lawyer on one side of the room and DCF, its lawyer, and your child’s lawyer on the opposite side of the room.”

How will the lawyer know what I want?

It is your job to tell your lawyer what you want to happen with your family. For instance, you may want your child returned to your home immediately, or you may want the child’s other parent to have custody, or you may want to receive services before your child comes home. You have the right to hold private, confidential conversations with your lawyer.

Once you tell your lawyer what you want, it is your lawyer’s job to work toward that goal. Your lawyer will talk to DCF, the other lawyers, and the judge about your case, but your lawyer always works for you and you alone. Your lawyer may be friendly with the other lawyers or the judge. They may have worked together in the same courtroom for years. But that does not mean that your lawyer works for anybody but you. If you have any concerns, talk to your lawyer about it.

See Chapter 7 “Understanding the Legal System” page 24, for more information on the legal process.

“I had no idea what to say to people other than that I wanted my kids back home with me.”

“My court-appointed lawyer was very good at helping me get my children back. I’m very lucky I had her on my side. I guess the court system works after all if you work hard and you accept responsibility for what happened.”

2: Helping Yourself Helps Your Child



Image courtesy of Rise Magazine and Odessa Straub.

“Make sure you know the reason why DCF is involved in your life...violence, drugs, alcohol, neglect, a mistake. Take responsibility for your part. Don’t wait for a social worker to make the first move in deciding what actions or help you need; do it yourself if possible! Not only will this save time, but also it will show DCF that you are working hard to get your child back. Get your personal life in order and take control...baby steps at first and gradually it will be easier.”

This is a very emotional time. You may be scared, frustrated, and lonely. You may feel like you don’t have anyone you can trust. Your feelings are understandable. Go home; cry, scream, curse, or do whatever gives you relief at the moment. But do not give in to stress by doing things that will only make the situation worse, such as drinking alcohol or doing drugs or screaming at DCF workers, court staff, or the judge.

There are places you can turn to for help. They will offer you emotional support and will help you sort through this traumatic situation. Reach out to family members or friends whom you know you can depend on for support. You can find a list of free resources that may be helpful in the back of this guide, see the listings in Chapter 10: Resources and Tools “B: Getting the Support You Need: A Statewide Resource List” page 39.

Keep a picture of your kids with you at all times. This will remind you of what you are working for.

“Reach out for help and find someone you can talk to. Join a Parents Helping Parents support group or find a social worker or, if you are in AA or NA, find a sponsor.”

In order to take care of your child/ren, you must be able to take care of yourself. In this chapter, you’ll read about resources that helped us to take care of ourselves.

Parenting Support

What are Parenting Groups?

There are many different types of parenting groups. There are parent support groups, parent education groups and parent groups that focus on parenting a child with specific health or education needs. The goal of each group is to provide a non-judgmental, supportive environment where parents are able to share their concerns and learn positive parenting skills that will help them have loving relationships with their children.

Can I speak freely in my parenting group?

Yes, you can speak freely in your parenting group. The people running the groups understand the stresses of being a parent and are there to help and support you. However, if you say that you are going to hurt yourself or someone else, the group leaders are required by law to report that. They must file a 51A report if you disclose that you have abused or neglected your child. In most cases, the group leader will talk with you about this and together you will determine the next steps. You can always ask the group leader how they handle situations like this.

Advocates

“The night before court, I’d be unable to sleep, thinking about it. Worrying about having to testify was nerve-wracking. The thing that helped me to get through it was having my parent advocate with me. Her presence reassured me.”

Where can I find an advocate for me as a parent or for my whole family?

Some DCF offices and some private agencies – especially mental health agencies -- have parent advocates (sometimes called Parent Partners) who can support you and advocate for you, guiding you as a parent trying to improve your parenting skills and trying to make your voice and view heard with DCF, other professionals, and the court.

It can be difficult to find a parent or family advocate, as they are not consistently available. But if you feel that this support would help you, it is worth it to check with local community-based organizations, local health centers or mental health centers, or your local school to see if they have a person who can serve as an advocate for you or your family.

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Counseling

What is counseling?

A counselor is a professional who can talk to you about your emotional well-being and help you advocate for yourself. Counseling is a chance for you to share with a trained counselor, social worker, priest/pastor/rabbi/imam, or therapist your feelings about the things you are experiencing and about events in your life. This kind of one-on-one sharing allows for opinions, advice, and support to be given to you in order to help you understand yourself and help you address specific problems or concerns you may have.

Can I speak freely to my therapist, counselor, social worker, or priest/pastor/rabbi/imam? Or will my counselor tell others what I say?

No matter what type of professional you see for counseling, most conversations with a counselor are confidential (private) by law. But remember that all types of counselors are “mandated reporters.” This means that if they learn about abuse or neglect of a child, they are required by law to report it to DCF. If they believe that you might hurt yourself or someone else, they must report it to the police, DCF, or other appropriate authorities. (There are some exceptions for religious counselors.)

In certain cases, DCF’s lawyer can go to court and get your records from a therapist or other counselor. If that happens, the judge decides whether DCF can see and use your records. It is important to talk to your lawyer and your counselor about what you should or shouldn’t discuss with a counselor.



Image courtesy of Rise Magazine and Shaun Shishido.

This law also applies to drug counselors and domestic violence counselors. Clients in batterer intervention programs do not have the same kind of confidentiality legal protections as clients in other types of counseling. Talk to your lawyer for a more complete explanation of the differences.

Anger Management Classes

How can anger management classes help me?

Anger management classes can help teach new ways to think, feel and act in stressful situations. If you think this would help you, ask your worker to find an anger management group for you.

“I went to an anger management class and it helped me a lot. I can still get really angry, but now I know better ways to act when I’m really angry. I can see the difference this has made with my daughter and me when she does something I don’t want her to do.”

Alcohol and Drug Counseling

Is there a program to help me if I have an alcohol or drug problem?

There are many types of programs to help you if you have a problem with alcohol or drugs: Inpatient treatment centers, outpatient counseling, drug therapy, and recovery programs such as Alcoholics Anonymous and Narcotics Anonymous.

You will want to create a safety plan for yourself to help you deal with the effects of alcohol and drug involvement. Your alcohol or drug counselor can help you with this.

What type of help is there for my family?

Addiction is a family disease, with each member suffering from its devastating effects; therefore, each member of the family can benefit from support during someone’s recovery process. Al-Anon and Nar-Anon are 12-step recovery programs that help family and friends of people with addiction problems.

“Part of my safety plan meant telling a friend that I was going to a party, but that I promised I would not have a drink. I knew she would ask me and I didn’t want to lie to her, so that helped me to not drink at the party.”

You’ll find additional resources in Chapter 10: Resources and Tools “B: Getting the Support You Need: A Statewide Resource List” page 39.

How can I stay safe from domestic violence?

“In order for us to create a safe place for our children, we first must create a safe place for ourselves.”

What if I have been hurt or threatened by my partner or a family member?

If you are in an unsafe situation and are being hurt or threatened, develop a safety plan. Write it down, collect all the pieces in a folder or envelope, and keep it some place where you can have easy access to it in an emergency.

A safety plan should include names and numbers of people you trust who can help you if you are in trouble. This plan should include ways to get to a safe place in an emergency. Other things that might go into your safety plan: Bank account access information, social security cards, leases, birth certificates, and other important documents. If you live with someone who sometimes makes you feel unsafe, consider moving to a friend’s home or to a shelter, if necessary.

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If you are in immediate danger, call 911 or go to your local Police Station. You may be advised to ask for a protective/restraining order, often called a "209A."



Image courtesy of Rise Magazine and Terrence Taylor.

There are several types of services and supports available to victims/survivors of domestic violence, including counseling, support groups, and advocacy services. These resources will assist you with legal matters, finding shelter, and other important community-based services. Call Safe Link toll-free at 1-877-785-2020 or 1-877-521-2601 (TTY) for help, or visit www.janedoe.org online for additional information.

If you're comfortable asking DCF for help, the Department of Children and Families' Domestic Violence Unit (617-748-2333) is a good resource for services. You may also call the police and/or a domestic violence shelter. Anyone who is a victim of domestic violence and is involved with DCF is entitled to information regarding his or her legal rights and safety options.

3: Learning Quickly: The First Days

“When DCF came and took my children, I was afraid I would never see them again. I didn’t know what would happen. I didn’t know what to expect.”

Why is the DCF investigator visiting my home?

Within the first week, as part of your case, a DCF investigator (sometimes called a “51B investigator”) will call you to schedule a visit to your home. Arrange to have your lawyer present for this visit. Reschedule if your lawyer cannot be there at that time. (If the DCF worker visits your home before DCF files your case, you will not yet have a lawyer.)

You may want to prepare for the visit by talking to your lawyer ahead of time about what you should say to the DCF investigator. It is in your best interest to present yourself as a responsible parent who loves your child and provides a loving, safe, and clean home.

The investigator will come to interview you about your family. S/he will talk with you about what happened in the situation or incident that led to the removal and explain why DCF was so concerned about your child’s safety. The investigator will also talk to you to find out if you or your family needs help or information about support services.

Before the DCF worker leaves, ask for his/her business card and contact information. Also make sure to find out when you need to appear in court and get dates, addresses, and times

When do I get to go to court to try to get my child back?

You have the right to go in front of the judge within three days after DCF removes your child. This hearing is called the “72-Hour Hearing,” because it must be held within 72 hours (three days) after removing the child. Sometimes the 72-hour hearing takes place sooner, and sometimes later. Your lawyer might ask for a delay in order to prepare more thoroughly for the hearing. Your child’s lawyer, who is appointed by the court when your child is removed from your home, might ask for a delay in order to meet with your child and decide whether to argue for the child to return home to you or to remain in DCF’s legal custody. Sometimes the judge delays the hearing because of illness or scheduling problems. If the delay is long and you do not agree to it, you should ask your lawyer to try to have the hearing held sooner.

Talk with your lawyer about the 72-hour hearing and agree on a plan for how it will be handled.

“The first time I went to court I was very nervous and I couldn’t understand anything. I wanted it to be over with. All I could think about was wanting my son home with me. It was such a fearful time.”

How does DCF get approval from a judge to keep my child?

In some courts, including the Boston Juvenile Court, DCF often brings parents and children to court when the agency first asks the judge to give it custody. This is called the “preliminary hearing.” At the preliminary hearing, you will be given a lawyer if you are indigent. You and your lawyer may be able to make a very brief argument to the judge that you should keep custody of your child. If you do not succeed, you will have to wait for the 72-hour hearing and ask then for the judge to return custody to you.



Image courtesy of Rise Magazine and Carlos Rios.

In other courts, DCF usually removes the children first, and later comes to court to ask the judge to approve the agency’s actions. In those courts, the first time a parent usually comes to court is the 72-hour hearing.

What will happen at the 72-hour hearing?

At this hearing, the lawyers will give the judge documents (mostly DCF’s records, but maybe medical or mental health records as well) and call on witnesses to testify about your case.

The lawyers will ask each witness specific questions and the witnesses will answer. Sometimes the judge will ask the witnesses questions. You may not agree with what the DCF worker or other witnesses say about you or your child. If you do not agree, tell your lawyer about it when there is a “recess” (break) in the hearing or write your lawyer a note.

You must be polite and silent when the witnesses or lawyers are speaking in the courtroom. If you shout or make faces, the judge may hold that against you. If you wish, you may take notes during the hearing. You may also ask a friend to write some notes for you if you need assistance. Ask your lawyer if you may sit next to him/her.

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How long will a 72-hour hearing last?

The 72-hour hearing may take only a few minutes if you and the other parent are not challenging DCF's removal of your children. If you are challenging the removal because you want your children returned to you immediately, or if you want your children to live with a friend or relative and DCF does not agree, your hearing could take an hour, several hours, or even several days. The judge may start the hearing on one day and continue it on another day. The next hearing date may be the next business day, or it might not be for several days or even weeks. The 72-hour hearing is like a short trial. There are witnesses, documents from DCF (and sometimes from the police or other sources), and arguments from lawyers.

Will I get to tell my side of the story?

Yes, you have a right to tell your story and to defend yourself. If you have a lawyer, your lawyer will explain to you how you will be able to do this. Telling your story in court is not like telling it to a friend or a counselor. Your lawyer will tell your story to the judge. He or she may do this directly, by asking you questions and/or by asking other people questions on the witness stand. The judge may ask you questions, too. Speaking to the judge and answering questions "under oath" (swearing to tell the truth) is called "testifying."



Image courtesy of Rise Magazine and Joshua Hecto.

What do I need to know about testifying?

Your lawyer will help you figure out what you want to say to the judge and how to say it. But once you are on the witness stand, you are on your own to answer questions as best you can. Sometimes you can bring notes with you, but most of the time you cannot. Your lawyer will explain how you should sit or stand and how you should act when you are testifying. It is important to listen carefully to the questions asked, and to answer only the question asked. If you don't understand a question, say so.

In some cases, it may not be a good idea for parents to testify. For example, it may not be a good idea to testify if you are being charged with a crime in another court or may be charged later. Your lawyer will tell you if he or she believes it is not a good idea for you to testify.

“When you are on the witness stand, your nerves have the best of you and it feels like you’re being bombarded with questions. Take deep breaths and slow yourself down with “self talk.” Think before you speak. Look at your lawyer for a cue. Listening and focusing are key. One step and one question at a time.”

Do I have to testify?

You do not have to testify. But if you do not, the judge might hold that against you. When DCF claims that you have problems caring for your child, the judge expects that you will testify and explain that what DCF says is not true, or, if it is true, that you still do a good job caring for your child. If you do not testify, the judge may decide that what DCF says about you is true. Your lawyer will explain to you why you should (or should not) testify.

Can I get other people to speak to the judge on my behalf?

You may be able to have family members, neighbors, friends, or your service providers (such as therapists, counselors or group leaders) testify on your behalf. Make sure your lawyer knows about these people as soon as possible, so that your lawyer can arrange to get them to court. It is up to the lawyer to decide whether it is a good strategy to call some or all of the witnesses in your case.

What if I don't understand what's going on?

Before the hearing, ask your lawyer to explain what will happen during the hearing. It may be hard for your lawyer to speak to the judge and explain what is happening to you at the same time. During a break, ask your lawyer to explain what has happened. Sometimes your lawyer may not be able to meet you right away during a break or after the hearing because he or she has other cases that are being called. If you wish to wait, make sure you tell your lawyer that you will be waiting in the lobby.

What if I do not understand English?

If you do not speak English well enough to understand what is happening at court, your lawyer will ask the judge to get you an interpreter. The interpreter will listen to you in your own language and then tell the judge what you said in English. The interpreter will also tell you in your own language what the other people in the courtroom are saying. The interpreter can also translate for you and your lawyer outside of the courtroom.

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What decisions can I expect the judge to make at a 72-hour hearing?

The judge will announce a decision at the end of the 72-hour hearing.

The judge may:

- Return your child home to you. If the judge does this, he or she might require you to do certain activities, such as drug testing or cooperating with DCF, in order to keep your child in your home.
- Give temporary custody of your child to someone else, such as the child's other parent, a relative, or a family friend.
- Give DCF temporary custody of your child.
- Accept an agreement negotiated, by your lawyer, between you and DCF. (See "stipulating," below.)

What is temporary custody?

When DCF has temporary custody, it generally means that the agency has custody until after the trial or until DCF decides that it wants to ask the judge to give custody back to you or to someone else. When another person (such as a friend or family member) has temporary custody, the judge can change the order at any time.

What is "stipulating"?

Your lawyer may explain to you about "settling" or "stipulating" at the 72-hour hearing. There are many ways to settle at the 72-hour hearing. A common way is that a parent agrees to give DCF temporary custody, but DCF agrees to return custody to the parent soon if the parent participates in certain services (such as counseling or drug testing) or takes certain actions (such as getting a restraining order against an abusive partner or finding proper housing). You should discuss any proposed settlement or stipulation with your lawyer. It is important that you understand it completely.

What if I don't agree with what the judge decided at the 72-hour hearing?

Discuss with your lawyer what happened at the 72-hour hearing so that you understand what the judge ordered. You may be able to appeal the results of the hearing to a higher court. This kind of appeal is very unusual. Ask your lawyer if he or she believes that an appeal would be helpful.

“The journey through the court system to reunification is like a roller coaster ride. It goes up and down, it has twists and turns that never end, and for me it has yet to come to a stop.”

Who are the other people involved in my case?

Many people will want to talk with you and get information from you. Make sure you check with your lawyer before talking to other people about your case. Keep a list of all the people who contact you and write down their phone numbers.

Who will come to my home to interview me?

“Lawyers, workers, probation officers, all these people! I already felt like the worst mom and now I felt that all these people were judging me to be the worst mom, too. It was extremely overwhelming trying to keep up.”

Many individuals will come to your home and interview you after your hearing. Each person will be looking at you and your home in order to decide whether your child should be returned to you. Therefore, you want to make a good impression. You should make sure your home is clean and tidy. You should always be respectful, even if the questions they ask or the comments they make are disturbing or suggest that you have not treated your child well. What you say and do and how your home looks will be reported back to the court, sometimes in a written report. Your conversations with these interviewers are not private or confidential. Nothing is “off the record.” Ask for your lawyer to be present if you think you need help answering questions. If you need a translator, ask your lawyer for one.

• **Probation Officer.** A probation officer is assigned in every care and protection case (situations where DCF removes your child). The probation officer, who is an employee of the court, may come to your home and write a brief report to the judge. The report usually will be about the condition of your home, but might include whether you are participating in services and programs and whatever the probation officer believes is in the best interests of your child.

• **Court Investigator.** A court investigator is assigned in every care and protection case. This person is usually a lawyer or psychologist. The court investigator works for the judge. He or she will interview you, your child, and many other people who know about your child and your family. The court investigator will write a long report to the judge (sometimes as long as 50 pages). Your lawyer should be with you when the court investigator interviews you. Be prepared for this meeting. Bring a list of

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names and phone numbers of people who will say good things about you.

- **Child's Lawyer.** If your child is living with you, your child's lawyer will come to your house. If your child is in foster care, the child's lawyer may still want to meet you and see your home. You do not have to speak to your child's lawyer. You should tell your lawyer that the child's lawyer wants to speak to you. If you agree to speak with him or her, your lawyer should be present during this interview.

- **Guardian ad Litem (GAL).** Sometimes judges will appoint a guardian ad litem, or GAL, for your child. There are different types of GALs. Some will interview you and other people you know and then report back to the judge about what they learned. Others are appointed to help the judge decide whether your child should have important medical procedures or be given certain medications. Other GALs are appointed as "next friend" for your child. A "next friend" GAL will help your child's lawyer decide whether to fight for your child to return home, to stay in foster care, or to be freed for adoption. Sometimes judges appoint GALs to help parents work with their lawyers.

- **DCF Workers.** DCF workers will come to your home. These DCF workers have different titles and different jobs. Some DCF workers investigate Section 51A reports of suspected abuse and neglect; they are called "investigators" or "51B investigators." Others conduct assessments of your family; they are called "assessment workers." Others work with the family for months or years at a time; they are called "ongoing workers." Ongoing workers usually come to your home once each month. If DCF's goal for your child is adoption, your child will be assigned an "adoption worker." Later, the adoption worker may work with you, as well.

- **Others.** Sometimes service providers and people from other agencies will come to your home. These people may be home health aides, visiting nurses, parenting coordinators, social workers, parent advocates, or family advocates. They may be from private agencies, such as Catholic Charities or Communities for People, or from state agencies, such as the Department of Mental Health.

What do I say to these people? Do I have to cooperate with them?

The court investigator's job is to write a report for the judge within about two months of the first hearing. It is important for you to have a good interview with the investigator so that you can get your side of the story to the judge. You do not have to answer questions that make you uncomfortable, but the investigator will write in the report that you did not answer certain questions. You want to make the best possible impression on the investigator, so you want to appear open and cooperative. Give the investigator names and phone numbers of people to talk to about you, but only if you are very sure that those people will say good things about you. Speak to your lawyer before you give the investigator any names and before signing any papers or releases.

You cannot speak to an investigator "off the record." Nothing you say to a court investigator, a GAL, or a probation officer is private or confidential. Everything you say may be put into a report, told to the judge, to DCF, and to the other lawyers involved in your case. The only person who will keep your conversations private is your lawyer.

“Bite your tongue and answer only what is asked in the shortest possible answer. If someone asks you something you're not sure about, don't be afraid to respond by saying, 'Let me think about that and get back to you later.'”

Your lawyer may give you specific directions about people you should (or should not) speak to, and what you should (or should not) say to them. Therefore, you must talk to your lawyer about any meeting you are going to have with a court investigator, GAL, probation officer, or DCF worker.

What if I forget to tell them important information during the interview?

If you forget to tell the investigator, a GAL, or a probation officer anything during an interview, or if you want to correct a mistake you made during the interview, explain the problem to your lawyer. Only contact the interviewer if your lawyer agrees that you should do so. Make sure that you have phone numbers for the people who interview you, just in case you need to contact them later.

Will my lawyer be there for other interviews?

Ask your lawyer to be present for all interviews and meetings. For example, when the court investigator calls you to set up an interview time, tell the investigator that you want your lawyer with you during the interview. Then make sure you tell your lawyer when the investigator is coming to your home. If your lawyer cannot be there, try to reschedule the meeting with the investigator for a time when your lawyer can attend.

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Why is my child's other parent involved?

The law requires that DCF notify both parents when it files a care and protection petition. DCF often tries to call the other parent in order to make sure that s/he knows about the case. If DCF can't reach the other parent by phone, the DCF worker may go to that parent's last known address to try to tell him or her about the case. If that does not work, DCF will send the other parent a "summons" (a notice to come to court), delivered by a sheriff or constable. If DCF does not have an address for the other parent, it may publish a notice in the local newspaper in order to find him or her.

Both parents receive notice and are allowed to take part in court hearings, even if one parent has not paid child support or has not seen the child in a long time. It does not matter if the parents are married or not.

"In my case, my child's mother (we weren't married) had a big problem and I had to learn quickly not to focus on "fixing" her. I had to remember to focus on my son and myself. So remember to focus only on yourself and on what you need to do to get your child back. If you focus on the other parent, you'll go backwards."

How do I get my child home?

Now more than ever is the time to take care of yourself, because your child needs you. You will need your emotional, mental, and physical strength to advocate effectively for your child and for yourself. Reach out to other parents who have shared similar experiences for support, advice, information, and friendship.

"Join a support group or parenting group in your area. Do this before DCF tells you to do it or before they put it on your service plan. They will always ask you what you have done on your own or whether you joined something without being told to."

Check out Rise Magazine at www.risemagazine.org. There, you can read stories about other parents who have gone through similar situations.

Follow the service plan that you and your worker have agreed upon. Review the service plan with your lawyer before you sign it. (See Chapter 8 "Creating Your Service Plan" page 30 for more about service plans.) Make sure you complete everything you are supposed to do! If you have questions about your service plan or feel that it needs to be changed over time, ask your worker for more information and/or help.

You have a choice. If you choose to do what is required of you, you are choosing to improve yourself and your life, so that your child may be returned as soon as possible.

Set your priorities straight—for yourself and for your child/ren. Don't worry about the other parent or other friends or family members. Just think about yourself and your child/ren and what you need to be healthy and strong.

"No matter how many hurdles you have to jump—and DCF will often keep adding more of them and they will get higher and higher—remember that the ultimate goal is getting your kids back."

"Doing what's in your service plan may be the only way you'll get your child back."

"I was incarcerated at the time. I wanted to know what I needed to do to get my kid back. The caseworker was cool at first and then stopped visiting me. I was asking to find out what I needed to do. As soon as I got out, I had my list of what I needed to do. Communication is key. You can get a lot done."



Image courtesy of Rise Magazine and Thaynia Waldron.

4: Visiting Your Child

“Unless you have a really good reason not to, go to the visit. Pick your battles. Is the location of the visit really important or is it more important that you get to see your child?”

DCF wants me to have visits at the DCF office. Do I have to go there?

If DCF has legal custody of your child, DCF gets to choose where the visits will be held. DCF usually wants visits between you and your child to start at the DCF office. If you really can't get to the DCF office because it is too far away, talk to your lawyer about trying to get the visits moved. DCF may agree to move them to an office closer to you.

What can I do to make sure my visits happen?

Your DCF worker usually will require you to call the day before or the morning of the visit to confirm that you are coming. If the DCF worker is not in when you call, leave a message to say that you are coming, including the date and time of the visit and the name of your child. Phone the supervisor, too, and leave a message if the supervisor does not answer the call. This confirmation call is very important. If you do not call, the DCF worker will cancel the visit.

Make sure you come to the DCF office a little bit early for the visit. Some DCF workers will cancel visits if you are more than ten minutes late. If this happens to you, speak to your worker's supervisor. You may want to ask the supervisor in advance about the visiting policies and what should happen if a parent is late. Remember, your child is waiting for you. It isn't good for you or your child if you are late.

“If you don't call to confirm that you are coming for the visit with your child, the visit might be cancelled. So make that call every time!”

What will visits be like?

DCF has special rooms where visits take place. Most rooms have a table, chairs, and a sofa. Some of the rooms have toys. The DCF worker usually supervises (watches) the visits.

When your child arrives, spend the time with your child. If the DCF worker tries to talk to you about the case during your visit time, politely tell the worker that you want to speak about the case when your visit is over. Don't talk about your case in front of your child.

Visits will likely be awkward at first because neither you nor your child knows how to act in this new situation and setting. These visits—so important to both of you—work best when you think in advance about how you will spend your time together in this unfamiliar setting.

Here are some tips:

- Confirm the appointment the day before or that morning – whichever the DCF worker requires.
- Arrive a few minutes early.
- Bring some of your child's favorite toys, books, games, crayons and paper.
- Bring healthy snacks (such as fruit, vegetables, crackers, rice cakes, cheese sticks, juice), with occasional treats.
- Plan ahead for fun activities that allow you to laugh with your child, be silly, or just enjoy the time together.
- If it is near your child's birthday, bring a special card and/or gift or a special treat if you can.
- Follow the guidelines your worker has given you about what you can and cannot say in front of your child.
- You may be sad, but put on a happy face for your child.
- Stay calm when visiting your child.
- Be honest with your child. It's okay to say, “I don't know.”
- Try your best to make the visit a good experience.
- Don't talk about the court case.

Remember that you will be watched and/or listened to during the visit. DCF reports to the judge everything you do at visits and bring to visits. If you do not follow the DCF guidelines about what you can and cannot say, this may affect your ability to have future visits.



Image courtesy of Rise Magazine and Yong Han Chen.

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“Depending on your case, you cannot bring up the court situation with your child. If you do, you may be considered “non-compliant.” This would be a bad thing. My son used to ask me about his mother and about when he’d be coming home. The first time he did, I talked with him about the case. I was then told that I was being non-compliant. So be sure to get in writing what you can and cannot do. Make sure there is justification for it and make sure that you understand it.”

Why can't I have visits at the foster home?

DCF generally does not allow visits at the foster home. Foster parents have sometimes had problems with parents harassing them, and they and their family have a right to their privacy. Many foster parents do not want the biological parents to call their house. Some foster parents don't even want the biological parents to know where they live.

Sometimes the foster parents are relatives or family friends. DCF may allow visits at the foster homes if the foster parents are willing.

What can I do if I don't like DCF's visitation schedule?

Visits are almost always on weekdays during the daytime. If you do not like the visitation schedule, tell your DCF worker and see if you can create a different schedule. Give your DCF worker a schedule of the best times for you to visit. Also, tell your lawyer right away about any problems with the schedule. Your lawyer may ask the judge to make orders about visitation, although judges rarely order visitation that is different from the schedule that DCF has set up.

If you are not able to go to a visit because of illness or another reason, be sure to notify the DCF worker immediately. Your DCF worker should be able to arrange another visit if you call well ahead of time. However, if you miss a visit without advance notification, the DCF worker does not have to “make up” that visit. Try very hard not to miss a visit or be late to a visit, as this is very difficult for the child. In addition, DCF will report this to the judge.

“I really wanted to see my daughter on Christmas day but the visitation center wasn't open that day. That was really hard.”

What information should I get from my DCF worker at each visit?

- At each visit, ask the worker if there are any upcoming court dates or meetings. Write down the date, time, and location on your schedule.
- At each visit with your child, also check with the DCF worker about the date, time, and location for your next planned visit. You can look forward to your next time together if you know when it will be.

“Just knowing I would see my children again at the next visit was all I had to hold on to.”

5: Making Decisions About Your Child's Care

“It was very tough for me having someone else making decisions for my children. It is as if your values as a parent no longer matter.”

What if I don't like the way the foster parent dresses my child or fixes her hair?

If you don't like the way foster parents are caring for your child, let the DCF worker know, but do not do this in front of your child. You may have to tolerate “style” differences until your child is returned. Remember to pick your battles carefully. If you think the child is not being given proper medical treatment, let the DCF worker and your lawyer know immediately.

What about my child's education?

Will I be able to talk to people at my child's school?

When a child is in DCF custody, each situation is different. In some cases, you may not know the town where your child is living or going to school. In other situations, DCF will tell you. You may be permitted to talk to people at your child's school about your child's progress. You may be notified about meetings regarding your child.

If DCF gives you contact information for your child's new school, call your child's teacher and guidance counselor at the school to let them know that you want to be involved in your child's education and that you want to know of any problems. If the people at the school refuse to talk to you, call your DCF worker or your lawyer for help.

If your child stays in the same school after removal from your house, contact your child's current school/teachers and set up times to speak with them. It's a good idea to stay involved with your child's school, assuming that you find the school staff to be supportive of you as a parent. Participate in activities at the school (PTO or PTA meetings, volunteering, etc.).

Before you visit the school or volunteer there, check with your lawyer to see if you are allowed to see or talk to your child at these activities, as each situation is different. School personnel may ask you to get permission from DCF before they will speak to you. Ask your DCF worker about this. If the DCF worker won't cooperate, talk with your lawyer or call the DCF Ombudsman's office at 617-748-2444.

If staff members at your child's school are not supportive of you and the goals you are working toward for your family, you may not want to talk with them, as they will not help your situation. If the school perceives you as bothering them, this may make your case worse. It could be held against you in court.

Who makes educational decisions about my child?

While your child is in DCF's custody, DCF makes all educational decisions except those involving special education. If your child has special education needs, the foster parent may be the educational decision-maker. If your child is in a residential placement, a “parent surrogate” must be appointed by the Department of Education or by the Juvenile Court. This person may contact you about any important school decisions that are going to be made about your child. Typically, parents do not have the right to attend IEP meetings if their child is in DCF custody, but each case is unique so it is best to consult your lawyer about this. If you don't like the educational plan for your child, you have the right to bring the issue to the judge.

Who will be in charge of my child's medical care?

Will my child have the same doctors?

Your child probably will not have the same doctors unless the kinship or foster parent lives in the same area as you. Contact your child's doctor and dentist to get a copy of your child's records. Pass these along to DCF to give to the new pediatrician and dentist.

If DCF requires you to make an appointment for a check-up for your child, or if you have a concern about your child's health, ask your DCF worker which pediatrician you should call.

If your child has an illness and it is important to maintain care with a certain doctor, or if a medical specialist is caring for your child, be sure to let DCF and your lawyer know.

Will I be able to talk to my child's pediatrician?

You will need to ask DCF's permission to talk to your child's pediatrician. DCF may have to sign a release for the doctor to speak with you. Doctors' offices and hospitals have very strict rules about talking to people, even parents, about their patients. If DCF does not give you permission to speak to your child's doctors, tell your lawyer immediately. Your lawyer may be able to help you either by negotiating with DCF or by asking the judge.



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Who makes medical decisions about my child?

DCF can make some medical decisions about your child, such as having your child see the doctor for check-ups or a dentist for cleanings. DCF may approve simple medical procedures. DCF also can make decisions about having your child take certain medications. However, for any larger decisions, like surgery, DCF must go to the judge for permission. The judge must hold a hearing about major medical decisions for children in DCF custody. You can take part in this hearing with your lawyer's help. The judge must also decide if your child should be put on certain medications to help your child's mental health.

“My son needed minor surgery and although physical custody had been returned to me, DCF still had legal so they needed to do the paperwork for the hospital. Come the day of surgery, no paperwork. I was frustrated that my child had to wait hours for his surgery because of poor communication.”

In a medical emergency, your child will be treated immediately. In emergencies, doctors and hospitals may act to save a person's life or to prevent serious harm without permission from a parent or guardian. Later, depending upon the treatment used, DCF may go to the judge to explain what happened and to ask for permission to continue treating your child.

DCF should tell you as soon as possible about any medical emergencies your child may have, and you should be able to see your child in the hospital. If DCF does not let you visit your child in the hospital, make sure your lawyer knows. Your lawyer can ask the judge for help.

Will my child still go to my church or a house of worship that practices my child's faith and culture?

There is no guarantee that DCF will place your child in a home where your religion is practiced. DCF must keep your child safe and well cared for, but it is not required to continue your child's religious faith. At the same time, DCF will not try to “convert” your child and should not allow foster parents to do so. If you or your child are really unhappy with the religious practices in the foster home, you should talk to the DCF worker and to your lawyer about it. The child's lawyer may also be helpful.

“This can be a big deal. My cousin, who had custody of my kids, tried to convert my children to her religion. I was furious. I documented this and successfully went to court on this.”

There may be aspects of the foster home that are unfamiliar to your child, such as ethnicity of the family or the kinds of food they eat. Try to take a common sense approach to these differences. Discuss them with your lawyer if they present a problem.



Image courtesy of Rise Magazine and Patricia Battles.

6: Managing Your Case

“There are things that will be said that aren’t true, some will be half true, and some will be completely true. You need to listen to—not agree with—it all. You can also respectfully correct the other person’s errors.”

Where do I start with DCF?

1. Ask for the name, contact information, and “duty day” (office day) of your DCF worker. Request your worker’s business card so that you know whom to contact if there is a problem with a schedule.
2. Ask for the name and number of your DCF worker’s supervisor in case you cannot reach your own worker directly.
3. Get a copy of the 51A report filed on you and the 51B investigator’s report. Request, in writing, copies from your worker or his/her Area Director. You also can write a letter, or ask someone to help you write a letter, to Commissioner Angelo McClain, Massachusetts Department of Children and Families, 24 Farnsworth Street, Boston, MA 02210, to request that copies of the reports and any related information be mailed to you immediately.

How can I communicate most effectively?

The tips and strategies in this section come from those of us who have been through the system and from people who have helped us. You may not have a lawyer right away after DCF removes your children from your care. You can do these things with or without your lawyer.

How can my emotions affect my child’s situation?

First, get a hold of your emotions the best that you can. Try to think calmly. Anger is understandable, but not helpful. It can set a bad tone for your work ahead with DCF. What you are feeling makes total sense, but take it from us who have been (and still are) in your shoes; it only hurts your case if you can’t control your anger. Don’t lash out at others.

Can DCF help me?

The workers at DCF believe that you need help or else they wouldn’t be in your life and you wouldn’t be in this mess. You need to keep your cool and think about how you can work with DCF so that you can get your child or children back as soon as possible. Think about what might be helpful to you or your children and tell DCF.

“The best part of my experience with DCF was the Family Stabilization Team services I received through Enable. This helped my family stay together while we worked with the social workers, as a family, on issues that we weren’t able to deal with on our own.”

Is documenting my case really necessary?

“Write down everything you do! I have a notebook that I still use to write down conversations and times and dates. People lie and try to confuse you and make you think that you didn’t do what you should have done. If you have everything written down, you can use this when you’re talking with people about what happened and when.”



Image courtesy of Rise Magazine and Dayton Town.

It’s all so complicated. How can I remember it all?

Get a notebook just for keeping track of your DCF case. Keep your notebook and pen with you at all times.

Divide your notebook into four sections:

1. “Phone Calls Made and Received”
2. “Action Taken”
3. “Questions”
4. “Contacts”

Then get a folder that will go with your notebook so that you can keep important documents organized in one place. Attach an envelope or paper clip for business cards.

How do I prove that I made a phone call?

Write down every call you make, including the name of the person you were calling, the phone number, the time and date you called, the name of the person you spoke with, what was said, and who agreed to do what during the call. If you have to leave a message, give your name and phone number and what time you can be reached at that number. Get the name of the person who took the message if it wasn’t voicemail. You can use copies of the form in Chapter 10: Resources and Tools “E: Documenting My DCF Case” page 42 to log all your calls.



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What about emails?

Do the same with e-mails. Record the details about each communication in your notebook and save the e-mail.

No one calls me back!

Make sure you know what day of the week your worker is in the office ("duty day"). Your worker will be at DCF that day, so that is the best day to reach him or her. If you are not getting phone calls returned from your worker (or from anyone else involved with your case), phone the person every day, leave a message, and record each call in your notebook. Then, call the person's supervisor about the problem and ask the supervisor your questions.

I want to be polite, but I can't remember names—let alone how to spell them.

Ask for a business card from every person you meet or talk to about your case. Keep these in one envelope. If someone doesn't have a business card, get his or her name, title, address, and phone number and write it down in your notebook.

I am going to groups, but how do I prove I was there?

Your DCF worker can give you a form for your group leaders to sign every time you go to a session. In the "Action" section of your notebook, write down all the classes, meetings, or workshops you attend. For example, if you attend a Common Purpose or Emerge meeting, have the group leader sign your form at the end. The sample log in Chapter 10: Resources and Tools "F. My Services Plan Log: Recording Proof of Cooperation" page 44 shows what information you should track for every group meeting you attend.

Do I really need to save all these letters and papers?

When you mail people letters, always take the letters to the post office to send via certified mail. The postal worker will hand you a receipt proving that the letter was mailed. For a small additional fee, you can request a signature confirmation. This is a postcard that is mailed back to you with the name of the person who accepted the letter as well as the time and date it arrived. Put these receipts in your folder. Also put copies of any e-mails or letters you send or receive into your folder. Keeping a paper trail may be helpful later for proving your side of the story. It shows that you are doing your part.

How can I make a difference in my case by planning ahead?

Think about how you can help your case. Do you need documents? Snacks and games for your child? Transportation? Child care arrangements? Have you returned all your phone calls? Do you have a record of all your meetings and conversations? Are you completing what you have agreed to in your service plan? Are you preparing for court and for other meetings?

Preparing also means asking questions when you do not understand words, ideas, or actions.

What am I responsible for preparing?

In addition to the actions that your service plan requires, these steps will help you to stay on top of your case and demonstrate how responsible you can be:

- Do your homework.
- Know your rights and the specific issues about your case.
- Schedule enough time for attending meetings. Think about travel time and any arrangements you might need to make with work or other children in your care.
- If you cannot keep an appointment, call and reschedule it right away. Leave a message if necessary.
- Ask your support network of professionals to write letters for your lawyer.
- Ask each time: What do I do next?

I need to confirm what I am supposed to do next....every time?

Make sure you come out of meetings with a clear understanding of what is expected of you. This will affect how long it will be before your child is returned to you. Repeat back what you heard to make sure you heard the information correctly. Write it in your notebook. Now you are prepared to do what you need to do next.

What are letters from my support network?

Ask each of the professionals who support you to write a letter certifying your participation in groups. When you go to court, give your lawyer these letters.

“Think ahead. If you plan for what you can do next to help your case, you’ll make quicker progress and hopefully get your children back home sooner.”



7: Understanding the Legal System

“When it comes right down to it, it’s important to remember that the judge is the one who makes all the important decisions, not DCF.”

How do I work with my lawyer?

How do I get in touch with my lawyer?

You can get the name and phone number of your lawyer from a clerk at the Juvenile Court Clerk’s Office. You can call the clerk or visit the Clerk’s Office in person. You will need to tell the clerk your name and the name of your child or children.

What should I tell my lawyer?

Your lawyer must know as much about you and your case as possible. It can be very bad for your case if other people tell the judge things that your lawyer does not know. Your lawyer can’t do a good job representing you unless he or she has all of the information. Don’t keep secrets from your lawyer. If you have any “skeletons” in your closet or information you have not told others about your behavior or about your family, it is important that your lawyer know these things prior to going to court.

“Don’t delay! And don’t keep secrets from your lawyer!”

Can I speak freely to my lawyer, or will my lawyer tell other people what I said?

Everything you say to your lawyer is “confidential.” This means that your lawyer can’t tell other people what you say without your permission. There is one important exception: Your lawyer may tell other people what you say if your lawyer believes that it is necessary to stop a crime that will lead to someone’s death or injury.

Why should I listen to my lawyer?

Your court-appointed lawyer is trained to represent parents and children in cases like yours. Your lawyer knows how to negotiate with DCF and speak for you in court. Your lawyer has experience working with DCF and juvenile court judges. Your lawyer will give you advice and talk to you about the different options you have. You should make sure that you understand your lawyer’s advice so that you can make the best decisions for you and your family.

Will my lawyer listen to me?

It is very important that your lawyer listens to you. Your lawyer will need a lot of information from you in order to help you. He or she will need to know what you want to happen in your case. Your lawyer will also need to know about your family and why DCF got involved with you and your children.

If you want someone else with you for support when you meet with your lawyer, talk to your lawyer about bringing a friend to your meetings. Remember, though, that if other people are present, the things you say are not protected by the rules of lawyer confidentiality.

If your lawyer doesn’t listen to you, you can ask the judge for a different lawyer. You can also file a complaint with the Committee for Public Counsel Services at 617-482-6212.

“My lawyer was great. I have no complaints. I know that isn’t always the case.”

Why does it sound like a foreign language to me when the professionals talk?

Lawyers and the court system use specialized words that most people outside the courts do not know. Use the glossary in the back of this booklet to find out what unfamiliar words mean, or ask. It’s important that you understand what is happening and that you ask your lawyer questions when you don’t understand.

How do I talk to my lawyer if I don’t speak English well?

You will need to talk with your lawyer often. You will meet with your lawyer in court and out of court. If you do not speak English well and if your lawyer does not speak your language, your lawyer will arrange for you to get the help of an interpreter at no charge. When you are in court, there may be a court interpreter available to help you, again, at no charge to you. Record in your notebook whether you were given an interpreter at each meeting.

If you have a family member or friend who speaks English, ask that person to help you when you call your lawyer to schedule meetings or if there is an emergency.

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Image courtesy of Rise Magazine and Shaun Shishido.

Who else gets a lawyer in these cases?

All children get court-appointed lawyers. If you have more than one child, one lawyer will represent all of your children unless the children want different things. For example, if one child wants to go home and another child wants to remain in foster care or live with a relative, the judge will appoint different lawyers for those children.

DCF has its own lawyers.

Grandparents and other relatives usually do not get lawyers unless they were the child's legal guardians when DCF took custody of the child.

Should I talk to my child's lawyer?

Keep on good terms with your child's lawyer, as you should with any professional involved in your case. If your lawyer tells you to do so (and your child's lawyer agrees), keep in touch with your child's lawyer on a regular basis. However, never call or talk to another lawyer unless your lawyer has okayed it.

You must remember that your child's lawyer is not your lawyer. Don't let your guard down with your child's lawyer. S/he is advocating to help your child, not you.

What if my lawyer doesn't call me or doesn't return my calls?

If you can't contact your court-appointed lawyer or your lawyer does not return your calls, call the Committee for Public Counsel Services, Children and Family Law Division, at 617-482-6212, for help.

How should I get to court?

I have to work. What do I do about getting to court?

It is your responsibility to get to court for the 72-hour hearing and all other court hearings. You should ask your employer for time off. If you cannot come to court on the date of the 72-hour hearing but you can come on another day, you should ask your lawyer to see if the court will change the hearing date. If the court will not change the hearing date, you must go on the date scheduled. If you do not go, the court will hold the hearing without you and you will likely lose.

I have other children at home. Can I bring them to court?

Yes, but you must arrange to have someone watch them in the lobby when you are in the courtroom. Children are generally not allowed in the courtroom. If you do not have someone with you who can watch the children in the courthouse, do not bring them.

Everyone who goes to court with you will have to walk through a metal detector. Be careful and plan ahead.

How will I get to court?

It is your responsibility to get to the courthouse. If you do not have a car and there is no public transportation to the court, you will have to get a ride from a friend or relative. If you are having transportation problems, or if you are too ill to get to court, let your lawyer know. He or she can explain these problems to the judge.

Do I have to go to court?

It is **very important** for you to be there. You show the judge and DCF that you care about what is going on for your family and that you love your children by being there. If you do not come to court and you do not have a good excuse (such as serious illness), the judge may think that you do not care enough about your child/ren to come to court. The judge may decide that you have "waived" (given up) your right to have a 72-hour hearing. The judge may also take away your court-appointed lawyer if you do not go to court.

If you cannot make it to court, call your lawyer and/or DCF worker immediately to let them know, even at the last minute. See Chapter 10: Resources and Tools "D. Massachusetts Juvenile Court Phone Numbers" page 41 for courthouse phone numbers.

“You should definitely go to your 72-hour hearing!”

What should I wear to court?

Dress respectfully, modestly, and neatly. A professional or "Sunday best" look is one way to show that you are taking the proceedings seriously. Leave the "flash" and the athletic wear at home. Empty your pockets so that they don't jingle when you are sitting in the courtroom. Most professionals in the courtrooms wear suits or uniforms with jackets. You might want to bring a sweater or jacket along so you don't get cold.

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“Such an emphasis was put on what to wear. Nobody stopped to think that I might not have a dress or skirt or that when I fled for my life it was with the clothes on my back. I’m a single mom... any money goes to feeding and clothing my children. But to prove I’m a good mother I had to have good clothes.”

What should I bring to court?

You should come to the courthouse well prepared, with any paperwork you may need, a snack in case you have to wait a long while, and your wallet with identification. Remember that everyone who enters a courthouse must pass through a metal detector, so plan ahead for that.

What happens inside the courthouse?

Will I see my child at court?

Probably not. At some point, the DCF worker will bring your child to the courthouse to meet the judge, but this rarely occurs at the same time as the hearing.

At Boston Juvenile Court, DCF may ask you to bring your child to court with you before removal. If the judge then gives custody of your child to DCF, try to remain calm, especially when saying good-bye to your child. This makes things easier for your child, and shows the judge and the DCF workers that you are able to put your child’s needs ahead of your own frustration and anger.

My case is scheduled for 9:00 a.m. When should I get to the courthouse?

Early! You should get to the courthouse well before 9:00 a.m. so that you can meet with your lawyer first. Your lawyer may tell you to meet him or her at a specific time. If you are late and your case is called without you present, you may not have a chance to go before the judge. This is very serious. It may cause you to lose temporary custody of your child. The judge may even remove your court-appointed lawyer.

Leave extra time for heavy traffic or a late bus. It may also take longer than you expect to go through security and find the right courtroom. Be sure to get to the courtroom on time!

If there is a recess (break) during the day for lunch or for any other reason, make sure to be back in the courtroom at the correct time.

How long will I have to wait before my case is called?

It is hard to say how long you will have to wait for your case to be called. If your case is scheduled for 9:00 a.m., you may be called into the courtroom right at 9:00 a.m. or you may have to wait several hours. The court clerks decide the order that cases are called into the courtroom. The clerks usually start with cases that take less time. Trials and 72-hour hearings take more time, so these cases are often the last to be called into the courtroom. Try to make good use of the waiting time by talking to your lawyer. You could also bring a magazine or book to read. If you need to leave the courthouse for any reason, be sure to let your lawyer know where you are going and when you will be back.

Can I have friends and family with me while I wait?

Yes, you can have friends and family with you at the courthouse. They may not be allowed into the courtroom when your case is called, but they can wait with you in the lobby. Your friends and family will have to pass through the metal detector in order to get into the courthouse. Be sure to tell your lawyer who the people are who have come with you to the courthouse.

What should I expect in the courtroom?

What does the courtroom look like?

Every Juvenile Court courtroom is different, but they share some common elements. Each courtroom has a raised platform and table where the judge sits (called a “bench”). The clerk often sits at a table a few feet in front of the judge. The lawyers sit at tables in front of the bench, facing the judge. Parents and other lawyers (who are not involved in your case) sit on chairs or benches behind the tables, in the back of the courtroom. Probation officers and other court staff sit at tables on either side of the bench. Witnesses sit in the empty chair near the judge while they are testifying. Ask your lawyer if he or she can take you to see the courtroom before the judge comes in.

Where do I sit?

Parents generally sit behind the lawyers’ tables, but your lawyer may ask you to sit at the table, right next to him or her. If you like, you can ask your lawyer if you can sit at the lawyer’s table.

What are the rules of the courtroom and how should I act while I’m there?

There are many rules of the courtroom to learn. When the judge comes in, a court officer says, “All rise.” Everyone must stand, including the court staff and the lawyers. When the judge sits, the court officer says, “You may be seated,” and everyone sits.

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You will need to take your hat off inside the courtroom. You should not chew gum or bring food into the courtroom. You cannot read a newspaper. Turn off cell phones and pagers; you may not use them inside the courtroom.

The judge may ask you a question, or your lawyer may ask you to tell the judge something. Always stand when speaking to the judge and address the judge by saying "Your Honor." Otherwise, you should only speak if your lawyer asks you a question or you have a question for your lawyer. In that case, please speak quietly, so that only your lawyer can hear you.

Here are some helpful tips:

- The judge will evaluate you in part by the way you act in and around the courtroom, so be sure to be on your best behavior.
- Don't raise your voice or use foul language.
- Sit upright while testifying.
- Be polite to the lawyers on both sides of the case.
- Show respect to all of the courtroom officials. Be particularly attentive when the judge is speaking.
- Dress in your "Sunday best." Avoid large jewelry or bright clothing that would be distracting. Avoid carrying items in your pockets that jingle (keys, coins, earrings, etc.)



Image courtesy of Rise Magazine and Shaun Shishido.

Who are the people in the courtroom?

The **judge** listens to the lawyers and decides the case. The **clerk** helps the judge write information into the case file and organize the case. The clerk makes sure the lawyers are in court and ready to speak to the judge. The clerk will also look at the judge's calendar and help the lawyers pick out dates for the next hearing. There may be many clerks in the courtroom at the same time, filing papers and helping the judge get organized. The **probation officer** files a report for the judge at most hearings and may come to your home in order to tell the judge how you are doing. The **DCF lawyer** and **worker** will be there. Your **lawyer**, your **child's lawyer**, and the **other parent's lawyer** will be there. There may be other lawyers in the courtroom as well who are not involved in your case. They are generally waiting for other cases to be called.

Why is there a probation officer?

The Juvenile Court probation officers investigate cases and write reports for the judge. Sometimes they run criminal records (CORI) checks on parents, witnesses, or people who are asking the judge to give them custody of a child.

You must remember that these cases are not criminal cases. You are not "on probation" just because there is a probation officer on your case. If you have a probation officer for a criminal offense you have committed, the Juvenile Court probation officer may speak to your probation officer and report that conversation to the judge, but the Juvenile Court probation officer will not take over your criminal case.

Is there a jury?

No. A judge decides all care and protection cases without a jury. There may be a jury box in your courtroom with many empty seats, but that is because the same judge may also hear cases that include a jury in the same room.

What if I want to ask my lawyer something while my case is in front of the judge?

You may quietly ask your lawyer questions while the case is in front of the judge, but not while the judge is speaking. Your lawyer may tell you to wait for a few moments before he or she can answer you. If you do not speak English well and you are having trouble understanding the judge or the lawyers, let your lawyer know right away. Your lawyer will then ask the judge to get an interpreter for you.

Are there more court hearings?

When do I go back to court after the 72-hour hearing?

If your child is still in DCF custody after the 72-hour hearing (and sometimes even if your child is returned to you), the judge and the lawyers will schedule another court date, usually about three months later. In the meantime, the judge will assign a "court investigator" (see Glossary) to interview you and write a report for the judge. You may come to court when this report is filed. You also may come to court for a "status" hearing (for the judge to find out how everything is going). Sometimes there are other hearings that come quickly after the 72-hour hearing. You should find out from your lawyer what the next hearing will be about and when it will happen, and then write down the date, time, and location on your schedule.

What happens in court later in the case?

There may be many "status" hearings and one or more "pre-trial conferences," followed by a trial that can last for many days. At later hearings but before trial, the DCF lawyer will tell the judge how the child is doing and DCF's version of the progress you are making toward getting your child back. Your lawyer will tell the judge your story of how you are doing. The child's lawyer will tell

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the judge about the case, too. Your lawyer may ask the judge to order DCF to give you more visits or more services, depending upon the situation.

Do I have to go to these hearings?

You must go to all hearings, unless your lawyer and the judge say that you should not. If you do not attend a hearing, the judge may believe that you don't care and may hold it against you. If you know that it will be difficult for you to get to a hearing, let your lawyer know ahead of time so that he or she can explain this to the judge.

Will there be a trial?

Unless you and DCF agree on what should happen, there will be a trial. The trial may take place six months or even a year or more after your children are removed by DCF. For more information about the trial and timing, see Chapter 10: Resources and Tools "C. Care and Protection Time Frame" page 40.

How do I prepare for trial with my lawyer?

What will my lawyer do to get ready for trial?

Your lawyer will look at the entire DCF case file, interview witnesses, and file motions. Your lawyer will talk with you many times and help you get ready for trial. You may be called as a witness by DCF, by your child's lawyer, or by your own lawyer. Your lawyer will help prepare you to testify. Your lawyer may also have meetings with the other lawyers involved in the case in order to make sure that everyone is ready for trial and that they have all the necessary paperwork.

How can I help my lawyer get ready for trial?

You can help your lawyer get ready for trial by keeping in regular contact with him or her. If you move at any time, make sure your lawyer knows how to reach you. You can also help by making sure that your lawyer has the names, addresses, and phone numbers of your counselor, other professionals, or other witnesses who will say good things about you and your parenting. Tell any counselors you're working with about court hearings. Your lawyer may want the professionals who have been working with you to come to court to vouch for you.

Be sure to tell your lawyer about any changes in your life that may be important to your case (for example, your partner has moved in or out, you have relapsed, you recently obtained a restraining order, etc.).

Tell your lawyer about any fears or concerns you have before going to court. He or she can help answer your questions as well as help you understand what to expect from the court experience.

What is DCF doing to get ready for trial?

DCF workers prepare for trial by talking about the case with their supervisors and by reading their case notes (also known as "dictation") and the DCF records. The DCF lawyer, like your own lawyer, will be reviewing DCF's records, talking to the worker, and talking to other witnesses.

What is my child's lawyer doing to get ready for trial?

Your child's lawyer is doing exactly what your lawyer is doing. He or she is also meeting with your child to make a final decision about your child's position at trial. Talk to your own lawyer about whether (or how) you should be cooperating with your child's lawyer.

What if I have other legal charges pending?

If the probation officer looks at your CORI and finds a "default" or "warrant" for your arrest, the probation officer will inform the judge. The judge may then ask a court employee to keep you at the courthouse (perhaps even overnight) until arrangements can be made for you to be brought to the court that issued the default or warrant, or the judge may let you go to that court on your own, based on your promise to go to that court quickly. If you have an outstanding warrant, you should try to go to that court and have it taken care of in advance.

"Hearing on the Merits"? Is this the trial?

The trial, sometimes called "Hearing on the Merits," is the time for DCF, your lawyer, and your child's lawyer to present information to the judge so that the judge can determine what will happen to your child and your parental rights.

What is happening at the trial?

At the beginning of the trial, some judges allow the lawyers to give "opening statements." These are brief speeches by the lawyers on what your case is about. Some judges do not allow this, and start their trials by having DCF call its first witness. In almost all trials, DCF presents its case first, followed by the parents' lawyers, and then the child's lawyer. The lawyers will present many witnesses and give



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the judge many documents. It is like a 72-hour hearing (see Chapter “2: Helping Yourself Helps Your Child” page 10), but longer and more complex.

At the trial, the judge will decide many questions, including where your child will live. The judge may also decide about whether your parental rights should be “terminated” (ended) and your child freed for adoption.

At the end of the trial, most judges allow the lawyers to give “closing arguments.” These are brief speeches by the lawyers that summarize what your case is all about. The DCF closing arguments will present the case from DCF’s perspective; your lawyer’s closing arguments will present the case from your perspective, and your child’s lawyer’s closing arguments will be from your child’s perspective.

The judge may make a decision right at the end of the trial. The judge also may “take the case under advisement,” meaning that he or she will think about it for a while and make a decision later. Your lawyer will tell you what the judge decides as soon as the lawyer finds out.

Will I have a chance to speak to the judge?

Yes. It is your right to testify in your care and protection trial. You do not have a right to stand up and give a speech about your case, your family, or your DCF experience, but you have the right to take the witness stand and answer questions asked by your lawyer. “Taking the witness stand” means going to the front of the courtroom, swearing to tell the truth, and responding honestly to the questions asked of you. If you take the witness stand, however, you may be cross-examined (questioned) by the DCF lawyer and the other lawyers in the case. They may ask questions that you don’t want to answer, but you must.

Will my lawyer be able to call witnesses?

Yes. Your lawyer is allowed to call witnesses to testify for your side. You should make sure your lawyer knows well in advance who your witnesses are and how to reach them.

Your lawyer may decide that some of your potential witnesses would not be helpful to your case, so all of your witnesses may not be called. That is a strategic decision for your lawyer to make after discussing it with you.

Will my lawyer be able to give the judge important papers about me and my child?

Yes. Your lawyer is allowed to give “evidence” (Chapter 10: Resources and Tools “A. Speaking of Words: A Glossary” page 35 to the judge, including important papers. Make sure that your lawyer has all of the paperwork that you would like the judge to see.

How long will the trial last?

Care and protection trials can last an hour, many days or even months. Discuss the trial schedule with your lawyer; he or she will have the best idea of how long the trial will last.

When the trial is over, what decisions can the judge make?

The judge has a number of options at the end of a trial. He or she can return your child to you; give custody to another person, such as your child’s other parent or another relative; give DCF temporary custody or permanent custody (until the child turns eighteen); or terminate your parental rights and free the child for adoption. In some circumstances, the judge can give guardianship of your child to another person. If the judge terminates parental rights, he or she may order that parent-child visits continue until or even after the child is adopted.

If my rights are terminated, can I ever see my child again?

An order terminating parental rights ends all legal parent-child relations. The parent does not even have the right to have the judge review the decision later. Sometimes DCF allows parents to visit with children after a termination order. Sometimes the judge orders visits. But often there are no further visits, or only a “farewell” or “termination” visit between the parent and child. DCF is more likely to allow visits after termination, and the judge is more likely to order it, if the child is not placed in a home seeking to adopt the child (a “pre-adoptive home”) and the parent has regularly visited before termination.

Can I appeal?

If I’m not happy with what the judge ordered, can I get another court to change it?

Parents and children have a right to appeal (or challenge) an order by the judge after a trial. You have only 30 days to start an appeal so talk to your lawyer right away about whether this is a good idea and what you need to do.



8: Working with DCF

“Our first DCF worker was caring and sensitive to my daughters and used a supportive tone even when I was feeling upset or overwhelmed. She treated us with genuine respect and concern.”

Who will DCF assign to work with me?

What is the role of the DCF worker?

Your DCF worker can go by a number of titles: caseworker, DCF worker, on-going worker, and social worker.

This is the person who will be working with you on a regular basis. The DCF worker's job is to help you with whatever problems brought your family to DCF's attention. Your DCF worker will arrange visits with your children, keep you in contact with your children, and work with you to develop a service plan. S/he will also be reporting to all the other people involved in your case about your progress.

Do I have to work with a DCF worker?

Yes, if you want to have your child returned to you as quickly as possible. It is in your best interest to work with the DCF caseworker assigned to your family.

How do I work with the DCF worker?

What can I do to build the best possible working relationship with my DCF worker?

This is what we found helpful in dealing with DCF workers:

- Get your worker's address and phone number at DCF. Also, find out if your worker has an assigned day at the office (or “duty day”), because this will be the easiest day to reach the worker by phone.
- If you are having trouble reaching your worker or getting your calls returned, keep a record of where and when you left messages.
- If you cannot reach your DCF worker, call his/her supervisor.
- Share with your worker important information about your child (routines, medical history, school, etc.) See Chapter 10: Resources and Tools “H. Information About My Child” page 47 for a form to complete about each of your children.
- Participate in creating your service plan.
- Give your DCF worker proof that you are participating in services offered to you.
- Make sure that your worker is getting counseling for your child.
- If something is required of you that is unrealistic, ask the worker to make another plan.
- Keep all appointments that you have made.
- If you are unable to get to an appointment or unable to get there on time, be sure to call your worker or the worker's supervisor. Leave a message if they are not in.
- Provide DCF with information regarding your progress if your lawyer tells you to.
- Ask how visitation with your child will happen and participate in visitation. Always confirm your visits in advance.
- Advocate for visits, supervised or unsupervised.
- Tell your lawyer if your DCF worker or supervisor does not answer your phone calls or if any other problems come up.

Your DCF worker can become an advocate for your family, especially if you establish a good working relationship with your worker. DCF workers focus primarily on supporting your child, so when you can work together with your DCF worker on behalf of your child, the most difficult of situations can be easier.

“A lot of DCF workers aren't parents, so they don't have the same life experience that I do. This made it really hard for me to listen to them tell me how to parent my son.”

“Your DCF worker shouldn't be the enemy, but it is true that she is on the other side of the courtroom.”



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What if I don't speak or understand English very well?

If English is not your first language, you should request translation services for every DCF meeting and court hearing. It is very important that you understand what is happening and how to get help. Keep track in your notebook whether you were given an interpreter.

What can I expect from my DCF worker?

At all times, you should expect to be treated with respect by DCF staff. If you feel that your DCF worker or any DCF staff person is not respectful or is in any way being unfair, call the DCF Ombudsman's office at 617-748-2444 to report your situation and ask if there is a DCF family advocate in your area to work with you. Family Advocates are not always available, but you always have the right to ask for one.

Helping your child is your DCF worker's main responsibility. Your worker can also be a good resource for you as a parent trying to create a stronger family. Your DCF worker can give you information about housing, domestic violence, substance abuse, parenting, employment, or whatever else you may need. Your worker can also refer you to a variety of groups and programs, some of which may not even be on your service plan. Ask! Helping you is another way for both of you to help your child.

“My social worker was a hard worker who put his heart and soul into the job.”

Can I speak freely to my DCF worker?

Your DCF worker will **not** keep what you say private and confidential from other people at DCF or from the judge. S/he may repeat what you have said.

However, your DCF worker cannot talk about you and your family to people outside of DCF and the court without written permission (a “release”) from you. You may want to sign releases so that DCF can speak to your counselors or other providers, but you should speak to your lawyer about this. If DCF has custody of your child, the DCF worker may talk to your child's doctors and other providers in order to learn about your care of the child. **Never** sign any release without talking to your lawyer first. Be aware of what you are signing and if you have questions, ask your lawyer!

What is the best way to speak to people at DCF?

Throughout your work with DCF, keep these suggestions in mind.

- Take time to think and focus before you respond to anyone's questions.
- Don't be afraid to say, “Let me think about that and get back to you later.”
- Stay as calm as you can. Show them that you are a responsible and mature parent.
- Make eye contact when appropriate and be aware of your tone of voice and body language. Don't yell or look uninterested.
- Ask to be excused (or to go use the bathroom) if you feel the conversation is getting out of hand. It is okay to take a break, and it is better to do that before you lose your cool.
- Know that it is okay to disagree with someone else. Just acknowledge that you disagree respectfully. Don't lash out in anger.
- Take control over the situation and get your questions answered. You don't have to roll over and play dead.
- Try to stay positive even if you don't agree with something you hear. You can agree to disagree and then follow up later.
- Use specific examples of behavior or language when you are describing a situation or problem.

What are my options if I run into problems with my worker?

What if my DCF worker says I have a problem, but I don't think I do?

If you and your DCF worker disagree about the problems you and your family are dealing with, talk to your lawyer. You may need to find other professionals who can help you convince the DCF worker or the judge about your situation. For example, your DCF worker may believe that you have a substance abuse problem. If you disagree, you should talk to your lawyer. The lawyer may arrange for you to be interviewed by a psychologist or social worker who specializes in substance abuse. This person will then, with your lawyer's knowledge and approval, explain your situation to the DCF worker or to the judge.

What if I have a problem with my DCF worker or I just don't like my DCF worker?

DCF workers are people, too. Some you will like and others you may not. (At the same time, some DCF workers will like you, and some will not.) Remember that the DCF worker is a very important person in your case. Even if you have conflicts with your DCF worker, you don't get along, or you do not agree with some of your worker's decisions, always be polite and respectful toward the DCF worker. Try to be honest with yourself about why you don't like your worker. Try to talk to your worker and, if possible, to work out your differences. If that doesn't work, try talking to your worker's supervisor. S/he is part of the team to help your family.

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If you honestly feel that you cannot resolve your differences, you can request a new worker. However, changing your DCF worker can cause a delay in your case and you should not count on getting a new one. It is very difficult to get a different DCF worker assigned to a case.

Always tell your lawyer about problems with your worker.

Whom do I call at DCF if I have a major complaints or concerns not being addressed by my worker?

If your worker and supervisor do not respond to you or you have serious concerns about the services being delivered to you, talk to them and talk to your lawyer. In addition, you can call the DCF Ombudsman's office at 617-748-2444 between 8:45 a.m. and 5:00 p.m. to report problems. The Ombudsman's job is to respond, mediate, and resolve (if possible) any issues of concern to DCF clients and other concerned citizens regarding agency programs, policies, or service delivery.

“Some workers were truly caring, dedicated to helping us to reunification, to helping me protect my children. Other workers failed miserably. This was where learning to self-advocate helped so much.”

9: Creating Your Service Plan

“The quicker you do what’s on your plan, the better off you are.”

What is a service plan?

A service plan is a list of “tasks” or services that DCF wants you and your family members to do. You should work with your DCF worker to decide which services would most help your family. Be sure to discuss your service plan with your lawyer. The service plan may also include tasks for DCF, the foster parent, or residential program staff. Some service plans include special services for parents, such as respite care or free summer camps.

What is expected of me?

What am I expected to do?

Each parent gets separate service plan tasks. For example, a mother with substance abuse issues may have the tasks of doing regular urine testing, attending AA meetings, and attending substance abuse counseling. A father with mental health issues may have service plan tasks of attending therapy and regularly taking all prescribed medications. Older children may have their own tasks, such as attending school and following the rules of the program or foster home.

What if I can’t read the service plan?

If you do not read English, make sure that DCF gives you a service plan in your own language. If you cannot read, make sure that DCF reads the document to you and that you have a complete understanding of what is required of you.

If you’re getting help reading this and/or your service plan, make sure that someone you trust translates items for you and that you clearly understand what you need to do on your plan.

Will someone remind me?

No! DCF won’t push you to do the things on your service plan. You need to take responsibility for completing the service plan on your own.

Do I have to do all the tasks listed on the service plan?

Review the service plan carefully and decide if you can do all of the tasks assigned to you by DCF. If there are tasks you cannot do, speak with your worker or your lawyer about negotiating with DCF to assign different tasks. Speak to your worker about adding flexibility around the scheduling of meetings and appointments if the times are a problem for you.

You have a better chance of having your child/ren returned to you if you do all the tasks assigned to you than if you do not. But sometimes just doing the tasks is not enough. Talk to your lawyer and to the DCF worker about what DCF expects of you.

Should I sign my service plan?

Service plans are supposed to be agreements that parents help to create. Make sure you understand the plan and all of the tasks. Be sure to review the service plan with your lawyer before you sign it. It is your right to show it to your lawyer rather than signing it right away at the meeting.

If you agree with the plan and believe that you really can do what is required of you, you should sign it. If you feel that a goal is unrealistic, discuss this with your worker. Make suggestions about changes that you think would be helpful. If you continue to disagree with some parts of the plan, you may still sign it; however, write your concerns or disagreements right on the plan. This shows that you have read and discussed the plan and are trying to work on it.

Can I add to my service plan?

Yes. If there are tasks that you would like to do, or that you think would help you, but they are not on your service plan, talk to your worker or lawyer about having them added.

Is adding on a good idea?

DCF looks favorably at tasks that you add to your service plan. So if you can think of something that is realistic, add it on. It will work to your advantage.



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What are Permanency Goals?

There are several possible permanency goals but the most common are: 1) Return Home and 2) Adoption. (See Chapter 10: Resources and Tools “A. Speaking of Words: A Glossary” page 35 for more information about Permanency Goals.) When DCF places a child in foster care, almost always the goal is “Return Home”. (If you have been involved with DCF in the past, on rare occasions DCF may select “adoption” or another goal.)

The permanency goal is very important because it tells you what DCF thinks the long-term plan will be for your child. DCF can change the permanency goal any time but usually it gets changed at the Foster Care Review (see below) or after DCF has a Permanency Planning Conference (see below). It is very important that you understand what the goal is and why DCF has chosen a particular goal. If you don't understand, ask your DCF worker. If you disagree with the permanency goal, as calmly as you can you should tell your DCF worker. You may want to object officially to the goal. You should discuss this with your lawyer.

“I feel my worker gave me pertinent information about my case and helped me with decisions regarding custody and permanency goals.”

The Foster Care Review: How Am I Doing?

What is a “Foster Care Review”?

A Foster Care Review (FCR) is a review at the DCF office of how well you, DCF, and, sometimes, your child, have been doing at completing your service plans tasks. It is also a chance to change your service plan. A Foster Care Review is scheduled every six months for as long as the child is in foster care. The purpose of the FCR is to review progress toward the permanency goal identified in the service plan.

Who attends a Foster Care Review?

The FCR meeting usually includes your DCF worker, other DCF staff, the foster parents caring for your children, and representatives of any other agencies working with you and your family. You can request that a therapist, teacher, advocate, or other important person in your life or in your child's life be invited to the FCR. A DCF staff person chairs the FCR meeting. A volunteer, who helps the reviewer, will also be present. Sometimes another DCF staff person attends, too. You can ask your lawyer to come to the FCR if you want to, but he or she is not required to be there. FCRs are scheduled without consulting the lawyers, so they may not be able to attend.

What happens at a Foster Care Review?

Your DCF worker will be asked to give his/her opinion of the progress of your case. You may or may not agree with your worker, but you will also be given a chance to express your opinions as to how the case is going. It can be stressful to participate in this meeting, but the reviewer really wants to hear from you. Remember to try to stay calm and focused. This is a great opportunity to advocate for yourself with all of the key players there. Bring to the Foster Care Review copies of any documentation that you feel would be helpful to your case.

Before attending your Foster Care Review, you might want to review the suggestions in this guide for working with DCF (see Chapter “6: Managing Your Case” page 22).

What is a Permanency Planning Conference?

If your child is still in foster care after nine months, DCF will have an internal meeting called a “Permanency Planning Conference” to decide whether the permanency goal (usually “Return Home”) is still the best goal or whether adoption or something else should be the goal. You and your lawyer will NOT be invited to this meeting. However, you do have a right to know the result of the meeting and why DCF decided to continue or to change the permanency goal.

“The first time I got involved with DCF was right after my first baby was born. My doctor told me I had post-partum depression. He suggested that I go to DCF for help. I was honest with my caseworker about how I was feeling and the help I needed. The DCF worker was wonderful. She signed me up for anger management, parenting, and self-esteem classes. My hard work paid off in the end. I really got into the “Mommy” role and my daughter came home after four months. This experience taught me the importance of how taking care of myself is in the best interest of my baby's well-being.”



10: Resources and Tools

A. Speaking of Words: A Glossary

B. Getting the Support You Need: A Statewide Resource List

C. Care and Protection Time Frame

D. Massachusetts Juvenile Court Phone Numbers

E. Documenting My Case

F. My Service Plan Log: Recording Proof of Cooperation

G. Contact Information: How To Get In Touch

H. Information about My Child

A. Speaking of Words: A Glossary

DCF and the legal system have their own “jargon” or vocabulary. Look here to find definitions of terms you don’t know.

Abuse. The non-accidental commission of any act by a caretaker upon a child under age 18 that either (a) causes or creates a substantial risk of physical or emotional injury or (b) constitutes a sexual offense under the laws of the Commonwealth, or any sexual contact between a caretaker and a person under the care of that individual.

Abuse of Discretion Hearing. A court hearing where a parent or child asks the judge to review DCF’s decisions about visitation, where a child will live, or what services DCF is giving the parent or child.

Adoption. When someone other than the birth parent becomes the legal parent of the child.

Affidavit. A written document that a person signs, under oath, about what she or he did or what she or he has seen.

Allegations. What someone (in this case, DCF) says you did or did not do.

Appeal/Appellate. A request that a higher court review the decision of the Juvenile Court judge.

Best Interests of the Child. What the judge must think about when making many decisions about your child. A “best interests” hearing is a hearing for the judge to decide what should happen to your child after a parent has been found unfit at trial.

Bonding. The strength of the relationship between a parent (or other important adult) and a child.

Care and Protection. The type of case that DCF files in the Juvenile Court when it takes custody away from a parent or when DCF is thinking about taking custody away.

CASA. A Court-Appointed Special Advocate. CASAs are volunteers who wish to help children in Juvenile Court cases. They meet with the child, interview people familiar with the child, and either write a report for the judge or tell the judge about what they think is in the child’s best interests. See also GALs.

CHINS. Child in Need of Services. If a child doesn’t go to school, misbehaves at school, refuses to follow parents’ rules, or runs away from home, the judge may find the child “in need of services.” The judge cannot order the child to attend school or stop disobeying rules, but the judge can put the child in DCF’s custody if they do not do what the judge orders. Children have a right to a lawyer in CHINS cases. If the judge is being asked to consider giving custody of a child to DCF, indigent parents have a right to a lawyer, too.

Clerk. A person who works for the judge in the courthouse. The clerks do many things. They call the cases, assign lawyers to parents and children, and make sure that papers get placed in the proper files.

Colloquy (pronounced, “kol-uh-kwee”). When parents decide to give up their right to a trial, the judge asks them questions about whether they have spoken to their lawyer and whether they understand the rights they are giving up. The parent’s answers are given under oath. This question-and-answer session between the judge and the parent is the “colloquy.”

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Confidential/Confidentiality. Something that is private and cannot be disclosed to other people, such as your conversations with your lawyer.

CORI. Criminal Offender Record Information. This is a computer record of all of a person's criminal charges and how they were resolved. The CORI also contains a person's restraining order record.

Court Clinic. Most Juvenile Courts have one or more psychologists and other mental health professionals who work in the court clinic. They perform testing and evaluations. They do not work for parents or children or for their lawyers. They work for the judge, and they give their test results and reports to the judge.

Court Investigator. The judge in every care and protection case must appoint a Court Investigator. This person is usually a lawyer or a mental health professional. The Court Investigator interviews parents, children, and others who know the parents and children. Then the Court Investigator writes a report, which he or she gives to the judge. Sometimes this report contains recommendations about where the child should live and what services the family needs.

Court Officer. Court security guards.

Custody. The judge can give a parent, another person, or DCF "legal custody" of a child. "Legal custody" is the power to decide what happens to a child, including where the child lives, who visits the child, and what kind of medical care the child receives. "Physical custody"—where the child lives—is a part of Probate and Family Court divorce practice, but it has no real meaning in care and protection cases. If a child is in DCF's legal custody, DCF chooses where to "place" the child, and where the child lives is called a "placement." DCF may "place" the child in a foster home, a group home, or with a parent, but that placement resource does not have any form of "custody."

The Department/DCF/The Department of Children and Families. This is the state agency responsible for the protection of children and for providing services to families.

Evidence. Witness testimony and anything that is given to the judge to read or see so that the judge can decide what to do in the case. There are many rules that control what kind of writings and other things the judge can consider.

Ex parte hearing. A hearing where only one party is present because it is an emergency and there is no time to tell the other parties.

Experts. Usually medical, mental health, or other professionals who help the judge decide what to do in the case. They may work for your lawyer, the child's lawyer, DCF, or the judge (such as psychologists in the court clinic). Some experts testify in court, while others only help explain information to the lawyers. There are many rules that control who can be an expert and what that expert can say to the judge if the expert is testifying in court.

Fair Hearing. An appeal within DCF of a decision that you do not like. For example, if DCF supports a 51A (see below), you may appeal (seek review of) that decision before a Fair Hearing Officer. The Fair Hearing is like a mini-trial, with relaxed rules of evidence. The judge can review other decisions by DCF. You should talk to your lawyer about what decisions can be appealed to the judge and what decisions must go to a Fair Hearing.

51A. From a statute, Massachusetts General Laws chapter 119, Section 51A, it refers to a report of suspected abuse or neglect of a child. Some professionals, such as doctors, teachers, daycare workers, and social workers, are "mandated reporters." This means that they must report suspected abuse or neglect to DCF. Everyone else—friends, neighbors, relatives—may report but does not have to. Lawyers are not "mandated reporters."

51B. From a statute, Massachusetts General Laws chapter 119 Section 51B, it refers to DCF's investigation of a report of suspected abuse or neglect under Section 51A. The investigation is usually written up in a report by a DCF worker (the "51B investigator"). If DCF "supports" the 51A after a 51B investigation (that is, decides that the report is true), you may be able to appeal this decision in a "Fair Hearing."

Findings. The facts, as the judge sees them, usually in writing. The judge uses his or her findings to support whatever decision he or she makes.

Foster Care. Where DCF places a child in its legal custody. There are many types of foster care, including foster homes, group homes, and residential housing.

Foster Home. A specially-trained private home where DCF places a child in its legal custody to live. The foster parents may be strangers to you and your child. They may care for more than one child. Alternatively, they may be your friends or relatives who are allowed to care just for your child (a "child-specific foster home").

Group Home. A group home is a living situation where many children, usually teenagers, live. Group homes are staffed with many adults who supervise the children, educate them, and make sure that their needs are being met.



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Guardian ad Litem (pronounced, “add light-em”). A person appointed by the judge to help the judge make certain decisions about the case (also known as a “GAL”). “Investigator” GALs interview parents, children, and other people who know the family and report what they have learned to the judge. “Evaluator” GALs write reports to the judge about a particular issue, such as whether there is a strong bond between you and your child, or whether visitation is good for your child. “Next friend” GALs help a lawyer decide what his or her client wants to do. A “Rogers” GAL makes a recommendation to the judge about whether a child in DCF’s custody should receive extraordinary medical care (such as non-emergency surgery or anti-psychotic medication). Sometimes judges give GALs other roles, such as helping children get proper educational services.

Guardianship. A type of legal custody of a child by someone other than a parent or DCF. Temporary guardianship may expire after a certain number of days or may be changed by the court after a short hearing. Permanent guardianship lasts until the child turns 18.

Hearing. An event at court in front of the judge.

Hearing on the Merits. A care and protection trial.

Indigent/Indigence. Parents are indigent if they cannot afford to pay for a lawyer or for the costs of a legal case. Indigence is measured in many ways: Parents are considered indigent if they are receiving public assistance, including food stamps or Supplemental Security Income (SSI); are in jail or a correctional facility and have no money; are living in a hospital or certain other types of residential facilities; or have an after-tax income of less than 125% of the “poverty threshold.” The court has forms that explain the income limits. Parent may be “indigent but able to contribute” if they have an after-tax income of between 125% and 250% of the “poverty threshold.” A probation officer makes the first decision about whether a parent is indigent, but a judge can review that decision if the parent disagrees with it.

Interpreter. If a parent or child does not speak English, an interpreter will help him or her to speak to his or her lawyer and the judge. The interpreter will also help the parent or child understand what is being said in court.

Interstate Compact. The Interstate Compact on the Placement of Children, or ICPC, is a set of rules that DCF and the judge must follow in order to send a child to live in another state. A child cannot be sent to another state (except for short visits) unless that other state’s child protection agency does a “home study” and approves the home. This out-of-state approval process often takes many months.

Judge. The person who decides the important issues in a case, such as who has custody of a child, whether a case is dismissed, and whether parental rights are terminated.

Kinship Placement. Placement of a child in DCF’s custody with that child’s relative.

Motion. A request by a party (see below) for a judge to take some action in the case. Some motions are oral (spoken requests), but most are made in writing. Examples of motions include motions for the judge to order more visitation, motions for the judge to order DCF to give the lawyers certain documents, and motions to bring an incarcerated parent into the court.

Neglect. Failure, by a caretaker, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition.

Open Adoption Agreement. An agreement between a birth parent and an adoptive parent about visitation, or some other kind of contact, with a child who is to be adopted. Open adoption agreements must be signed by the birth parent, the adoptive parent, DCF, and the lawyer for the child. These agreements are also called “post-adoption contact agreements.”

Party. A person who is participating in a legal case. Parents, children, and DCF are parties to a care and protection case.

Paternity. A legal case about whether a particular man is a child’s biological father. A paternity action is sometimes filed in Juvenile Court during a care and protection case, but more often it is filed in the Probate and Family Court. The man who is claiming to be the child’s father usually must agree to blood or other testing in order to prove that he is the father of the child.

Permanent Custody. Legal custody of a child until that child turns eighteen.

Permanency Goal. This is the long-term placement plan for your child. There are six possible goals: Return Home, Reunification with another parent, Adoption, Guardianship (usually with another relative such as grandparent), Supportive Living (usually for disabled children), and Living Independently (usually for older teenagers).

Permanency Hearing. A hearing at which DCF presents its permanency goal for the child to the judge. The judge must approve or deny DCF’s plan. Parents and children have the opportunity to object to DCF’s plan in front of the judge.



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Petition. The written request by DCF (and very rarely by someone else) to start a care and protection case. The petition is filed along with an affidavit of a DCF worker that explains why DCF believes the child is in need of care and protection.

Post-adoption Visitation. The judge may order visits, or the exchange of letters and photographs, between a birth parent and child after the child has been adopted. Judges can only do this if post-adoption visits or contact is in the child's best interests.

Privilege. Legal protection for things you say to your lawyer or therapist so that no one can force them to share your conversations with others (even the judge).

Probation Officer. A court employee with many responsibilities in the Juvenile Court. Probation Officers recommend whether a parent can have a court-appointed lawyer because he or she is indigent. They produce a parent's or witness's criminal offender records (CORIs) for the judge. They do an investigation and report to the judge about whether parents are participating in services and how children are doing at home or in foster care. They also supervise children in CHINS cases (see above). If a CHINS case goes to trial, the Probation Officer presents the case to the judge.

Pro bono. For free.

Pro se (pronounced, "pro say"). Without a lawyer. To "appear pro se" is to participate in a hearing without a lawyer. This is not usually a good idea in these types of cases.

Residential Program. A program for children who need a larger facility with more structure and a variety of staff. Children in residential programs frequently need many medical, psychological, and behavioral services.

Reunification. The return home of a child to his or her parent. Sometimes DCF also uses this term for the placement of a child with a previously non-custodial parent. The reunification may take place right away, or it may take many weeks, with gradually increasing visitation. A "goal" of reunification means that DCF is working toward reunifying a child with his or her parent, but it does not mean that the reunification will happen on any set date.

72-Hour Hearing. After DCF removes children from a parent, the judge must hold a hearing within 72 hours. At this hearing, parents and children can ask the judge to return the children or to give custody to someone other than DCF. A 72-hour hearing may include witnesses and exhibits. If a parent "waives" the 72-hour hearing, it means that the parent is not going to fight the removal by DCF and is not going to ask the judge to give custody to someone else at that time.

Stipulation. An agreement. The lawyers may agree (stipulate) that certain evidence can be presented to the judge. A stipulation for judgment is an agreement by the parties to a particular decision, such as a decision that a child is in need of care and protection. Taking the witness stand. A person who sits in the witness's chair and swears to tell the truth under oath "takes the witness stand" or "takes the stand."

Temporary Custody. Custody until the next court hearing, or until the hearing on the merits (trial). The court can give DCF, a parent, or another person temporary custody.

Termination of Parental Rights. After a care and protection trial, the judge can do many things, including terminating parental rights (TPR). If parental rights are terminated (ended), a parent loses all rights to that child, including visitation. Terminating parental rights frees the child to be adopted by another person. Even if the child is not adopted after a parent's rights are terminated, the parent cannot ask the court to review the case and get another chance for reunification.

Testimony. A witness who answers questions on the witness stand under oath (swearing to tell the truth) gives "testimony."

Unfitness. At a care and protection trial, DCF must prove by clear and convincing evidence that a parent is "unfit" before the judge can give DCF permanent custody of a child or terminate parental rights. Unfitness generally means a serious problem—such as drug or alcohol abuse, untreated mental illness, physical or sexual abuse, or exposure to domestic violence—which a parent cannot solve before trial. A parent can also be unfit if he or she cannot meet the needs of a particular child. For example, a parent with none of the problems listed above who is stretched to the breaking point by caring for four other children may be unfit to care for a fifth child who has serious medical or mental health problems.

Visitation. When DCF has legal custody of a child, it has the power to control visits with the child. See Chapter "4: Visiting Your Child" page 18, for more information.

Waive/Waiver. To give up a right. To waive counsel means giving up the right to a lawyer. To waive a 72-hour hearing means giving up the right to have the hearing.



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Witness. A person who answers questions on the witness stand under oath (swearing to tell the truth).

B. Getting the Support You Need: A Statewide Resource List

The Commonwealth of Massachusetts has many agencies and nonprofits whose goal is to help you. Take advantage of their resources and assistance.

24 Hour Telephone Hotlines

Parental Stress Line, 1-800-632-8188. A 24-hour-a-day helpline for parents/caregivers operated by Parents Helping Parents. Information available about weekly Parent Support Groups. www.parentshelpingparents.org. Translation service available.

Safe Link, 1-877-785-2020. A 24-hour domestic abuse hotline and referral services operated by Casa Myrna Vasquez. Information available about shelter openings. Multilingual.

Suicide Prevention, 617-247-0220. A 24-hour hotline for adults who are depressed and expressing suicidal feelings operated by Samaritans of Greater Massachusetts. English only.

Crisis Information – Spanish, 1-800-254-7568.

Rape Abuse and Incest National Network, 1-800-656-4673 (1-800-656-HOPE). A 24-hour hotline providing confidential advice and referrals to local community services agencies. Secure online hotline available. www.rainn.org. English and Spanish.

National Runaway Switchboard, 1-800-786-2929 (1-800-RUNAWAY). A 24-hour crisis hotline for youth and families, with referrals to local (social service) agencies. Translating services available.

Crisis Hotline, 1-800-448-3000; TTY 1-800-448-1833. A 24-hour crisis hotline for youths and families to help address suicide prevention, drug problems, child abuse, and many other issues/problems operated by Boys Town. www.boystown.org. Multilingual.

Legal Services

Legal Advocacy and Resource Center, 1-800-342-5297 or 617-742-9179. Free legal information, advice, and referrals for low-income Massachusetts residents. Monday, Thursday, Friday, 9:00 a.m.–3:30 p.m.; Tuesday, 9:00 a.m.–3:30 p.m. and 4:00–7:30 p.m.; Wednesday, 9:00 a.m.–12:30 p.m. www.larcma.org.

National Lawyers Guild, 1-617-227-7008. Lawyer referral service for low-income clients. Monday–Friday, 9:00 a.m.–3:00 p.m. (No walk-ins.) 14 Beacon St., Suite 404, Boston, MA 02108. www.nlgmass.org/lrs. English and Spanish.

National Alliance for Family Court Justice, 1-978-388-0463. An international group of volunteers dedicated to addressing failures in the court and social services systems. Contact Massachusetts State Director Robin Weisenstein, robinw_01854@yahoo.com. www.nafcj.net.

Drug and Alcohol Prevention and Treatment

Al-Anon/Alateen and Family Groups, 1-508-366-0556. Support groups for family members/friends affected by another's alcoholism. 57 East Main St., Suite 109, Westborough MA 01581-1457; LDCofMa@aol.com; www.ma-al-anon-alateen.org.

Alanon Family Groups of MA., 1-508-366-0556. 57 East Main St. Suite 109, Westborough, MA 01581-1457; LDCofMa@aol.com; <http://al-anon-alateen.org>.

Alcoholics Anonymous, 617-426-9444. A group of men and women helping themselves and others to recover from the disease of alcoholism. 12 Channel Street #604, Marine Industrial Park, Boston, MA 02210. www.aaboston.org. Multilingual meetings available.

Naranon Family Groups, 1-800-477-6291. A support group for those affected by someone else's addiction. www.nar/anon.org.

Narcotics Anonymous, 1-866-624-3578 (1-866-NA-HELP-U). A support group of men and women helping themselves and others to recover from the disease of addiction.

Medical and Mental Health Services

Medicaid/MassHealth, 1-800-841-2900; TTY 617-988-3301. State health insurance programs for low-income people. Monday–Friday, 8:30 a.m.–5:00 p.m. English and Spanish.



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National Alliance for the Mentally Ill, 1-800-370-9085. A nonprofit advocacy group offering supportive services for people with mental illness and their families. English only. 9:00 a.m.–5:00 p.m. www.nami.org.

Governmental Agencies

Committee for Public Counsel Services, Children and Family Law Division, 1-617-482-6212. For complaints about lawyers.

MA Department of Transitional Assistance, 1-617-348-8500. State agency assisting families/individuals with basic needs (food, emergency shelter, domestic violence support, job assistance) in order to improve their circumstances. Monday–Friday, 8:45 a.m. – 5:00 p.m. www.mass.gov. English and Spanish.

MA Department of Mental Health, 1-800-950-6264. Information and referral for services. Monday–Friday, 8:45 a.m. – 5:00 p.m.

MA Department of Children and Families, Central Office, 1-617-748-2000. Monday–Friday, 8:45 a.m.– 5:00 p.m.

MA Department of Children and Families Ombudsman’s Office (to register complaints): 1-617-748-2444. Monday–Friday, 8:45 a.m.–5:00 p.m.

Office of the Child Advocate, 1-617-979-8360. For concerns about the services your child is receiving from a state agency. Monday–Friday, 8:45 a.m.–5:00 p.m.

Virtual Gateway, 1-800-421-0938, TTY 617-988-3301. Online application and information for services including MassHealth, food stamps, and child care, among others. The Virtual Gateway brings information and access together in a single location on the Internet for individuals, families, providers, and government. Sign in and create a password and you’ll be able to access a lot of helpful information. Monday–Friday, 8:30 a.m.–5:00 p.m. www.mass.gov.

Parenting Support

Family Nurturing Center of Massachusetts, 617-474-1143. For Family Nurturing Programs, parenting support and parent/child playgroups. Daytime and evening programs.

Massachusetts Children’s Trust Fund, 617-727-8957. For information about various parenting classes throughout the state and to access a parenting resource library.

Publications

Rise Magazine. A magazine by and for parents who have gone through the system, mostly in New York City. www.risemagazine.org.

Kids and the Law: A User’s Guide to the Court System. A good resource for parents involved with DCF in a CHINS case. Call to order a copy by mail. 617-494-0135; Adolescent Consultative Services, 40 Thorndike Street, Cambridge, MA 02141.

C. Care and Protection Time Frame

Note: This is typical timing, but not all hearings and other events take place on this schedule.

Day 1:	Filing Care and Protection Petition; Emergency/Ex Parte Hearing—Only DCF is present.
3 days:	72-Hour Hearing
45 days:	Service Plan
60+ days:	Court Investigator Report filed in Juvenile Court (60 days from filing on Day 1 or 45 days from Court Investigator’s appointment at parent’s home)
90 days:	Motion Status Conference
120 days:	Pre-trial Conference
6 months:	Foster Care Review (and every six months thereafter if child is in DCF’s custody)
9 months:	DCF Internal Permanency Planning Conference
11 months:	DCF files Permanency Plan



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12 months:	Permanency Hearing; Foster Care Review
12–15 months:	Trial (“Hearing on the Merits”)
15–18 months:	Findings & Judgment (judge’s decision); Notice of Appeal must be filed within 30 days
18 months:	Foster Care Review
24 months:	Permanency Hearing; Foster Care Review

D. Massachusetts Juvenile Court Phone Numbers

<i>Barnstable County</i>	Barnstable County/Town of Plymouth Division, with sessions in Barnstable, Plymouth, Orleans, Falmouth, Edgartown, and Nantucket 508-362-1389
<i>Berkshire County</i>	Berkshire County Division, with sessions in Pittsfield, North Adams, and Great Barrington 413-443-8533
<i>Bristol County</i>	Bristol County Division, with sessions in Fall River, New Bedford, Taunton, and Attleboro 508-676-0090 x111
<i>Dukes County</i>	See Barnstable County
<i>Essex County</i>	Essex County Division, with sessions in Lawrence, Lynn, Salem, and Newburyport Lawrence: 978-725-4900 Lynn: 781-586-0415 Salem: 978-745-9660 Newburyport: 978-462-0617
<i>Franklin County</i>	Franklin-Hampshire Counties Division, with sessions in Northampton, Ware, Greenfield, and Orange 413-584-7686 x 3
<i>Hampden County</i>	Hampden County Division, with sessions in Springfield, Holyoke, and Palmer Springfield: 413-748-7714 Holyoke: 413-533-1482
<i>Hampshire County</i>	Franklin-Hampshire Counties Division, with sessions in Northampton, Ware, Greenfield, and Orange 413-584-7686 x 3
<i>Middlesex County</i>	Middlesex County Division, with sessions in Cambridge, Framingham, Lowell, and Waltham Cambridge: 617-494-4100 Framingham: 508-879-3561 Lowell: 978-441-2630
<i>Nantucket County</i>	See Barnstable County
<i>Norfolk County</i>	Norfolk County Division, with sessions in Dedham, Quincy and Stoughton Dedham Session: 781-329-1500 Quincy Session: no Care and Protection Stoughton Session: 781-341-9162
<i>Plymouth County</i>	Plymouth County Division, with sessions in Brockton, Wareham, and Hingham 508-586-4030
<i>Suffolk County</i>	Suffolk County Division, with sessions in Boston, Dorchester, West Roxbury, and Chelsea 617-788-8571
<i>Worcester County</i>	Worcester County Division, with sessions in Worcester, Dudley, Fitchburg, Milford, and Leominster Worcester: 508-831-2000 Dudley: 508-949-3070 Fitchburg: 978-345-7620 Milford: 508-478-8638

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E. Documenting My DCF Case

Use this log to help you keep track of all the contacts and people who are a part of your case. Use one line for each contact or interaction about your case. (Interactions include conversations, meetings, correspondence, and messages with people involved with your case.) You can also use the log to track future appointments. For each entry, note the date, who attended, what was discussed or decided, and what follow-up is expected. Also, make an entry if you left a message, mailed, or emailed a letter. The sample entry shows you how to use this chart.

Date/Time, Location (if relevant)	Who (include all attendees for meetings)	Type of Contact (e.g., Meeting, Phone, Voice Message, Mail, E-mail)	Bring With Me	Notes for Meeting	What Was Discussed or Decided	Follow Up Required
SAMPLE ENTRY						
7/21/09, 10:30 am	Mary O'Reilly, Lawyer	Phone Call	n/a	Ask about using my counselor as a witness at the trial.	I am going to ask my counselor to be one of my witnesses.	Call Counselor and ask her to write a letter on my behalf and tell her the trial date.

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[illegible]

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F. My Service Plan Log: Recording Proof of Cooperation

Keep a journal of your participation in activities that are part of your service plan. Each time, ask the group facilitator or other professional to sign this form to confirm that you attended.

This is a sample page, showing what you should record in your notebook. You can photocopy this page if you like, so that you have as many journal pages as you need.

Group or Other Service Plan Task	Date/Time and Location	Follow-Up Expected	Other Notes	Signature of Group Leader to Confirm Your Attendance
SAMPLE ENTRY Attended Weekly Anger Management Group	June 23, 2009, 6pm, Community Church	Complete worksheet assigned.	Try to get there early to talk to the instructor before class.	(signature goes here)



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Signature of Group Leader to Confirm Your Attendance					
Other Notes					
Follow- Up Expected					
Date/Time and Location					
Group or Other Service Plan Task					

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G. Contact Information: How To Get In Touch With . . .

Ask your DCF worker to help you gather this information at your first visit.

DCF Case Worker's name/address/phone/e-mail address:

"Duty Day"/Day in the office: _____

Supervisor's name/address/phone/e-mail:

My Lawyer's name/address/phone/e-mail:

My Child's Lawyer's name/address/phone/e-mail:

Where my child is staying or how to contact my child:

Other Parent's Lawyer's name/address/phone/email:

Other Contacts (name/title/agency/address/phone/email):



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H. Information about My Child

Cut this worksheet out of the guide or else make a copy of it. Fill it in and give it to DCF to give to your child's caretaker. *Add another sheet of paper if you need more room.*

My child's name is: _____ Nickname: _____

Child's Parent's Name: _____

Child's Parent's Contact Information: _____

Other Parent's Name: _____

Sibling Name/s and Age/s: _____

Emergency Contact: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Birthdate: _____ Age: _____

Grade/School Name/Town: _____

Allergies or other medical conditions: _____

Medications/Instructions: _____

Favorite Hobbies: _____

Favorite Foods: _____

Typical Day: _____

Other Important Things to Know (e.g., special bedtime routines or other rituals):

Additional information for my child's caregiver. What else would you like your child's caregiver to know to help your child adjust?

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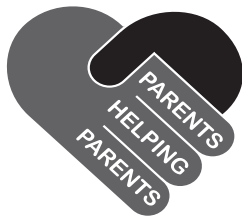
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Parents Helping Parents
108 Water Street
Watertown, MA 02472
617.926.5008
www.parentshelpingparents.org



Family Nurturing Center
200 Bowdoin Street
Dorchester, MA 02122
617.474.1143
www.familynurturing.org

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Tips for Improving Collaboration and Communication between Early Educators and DCF/Child Welfare

1. Assume good intentions

DCF social workers are working hard on behalf of the children and families they serve, but their caseloads are often high and they have frequent crises to deal with that sometimes make it difficult to return phone calls and respond to emails quickly.

2. Discuss the mutual benefits of collaborating

Describe how the early childhood program's perspective enhances the worker's understanding of the strengths and needs of the child and family and how being updated about new developments and the family's progress will improve the early education services you provide to the child. Ask how you can be helpful to DCF.

3. Make a communication plan

Early in your relationship, plan a meeting to discuss how you will communicate and set mutual expectations for your work together. See Toolkit 5c. for a suggested outline to guide collaboration. Be sure to make plans for both routine and emergency communication. For best practice, routine contact should be planned at least once per month.

- If you will meet and/or talk on the phone regularly, with what frequency and on what schedule? Who will be included in meetings? Schedule routine meetings a few months ahead, if possible.
- Set guidelines for written communication: routine reports and any documents that will be shared with releases of information.
- Ask about the best ways and times to reach the worker – Is there a regular time they are in the office to return phone calls? Do they prefer email or voicemail messages? What should you do if their mailbox is full?
- Share the best times and ways to reach you.
- Get the name, phone number and email address for the Supervisor and Area Program Manager in case you are unable to reach the worker on an urgent matter.
NOTE: DCF expects and encourages you to call supervisors/ managers when you are having trouble reaching a worker. You might worry about making trouble for the worker, but the Supervisor's and Manager's job is to support the worker and back her/him up as needed by covering cases. The worker understands that this is how the system works.
- Share contact information for your Supervisor and Program Director in case the worker is unable to reach you.
- If there is an updated organization chart of your local area DCF office, it can be helpful to request a copy, understanding that it will quickly become outdated. Having a general sense of the numbers of units and names of supervisors and managers can be very helpful.

4. Check in regularly about communication and collaboration successes and challenges.

- What has worked well recently?
- How could you have improved something that did not work as well?
- Brainstorm ways you could work more effectively as a team to improve communication and collaboration.

Child's Name:

Collaboration Guide

D.O.B:

Parent/Caregiver Name(s):

Participants in Collaboration:

Collaboration Guide: Families, Early Childhood Educators and Child Welfare Caseworkers

High quality child care/early education is a proven protective factor for children involved with child welfare (DCF) whose development has been impacted by maltreatment, trauma or toxic stress. Whenever possible, DCF Caseworkers should facilitate referrals to ensure that infants, toddlers and preschoolers receive high quality early education, either through a home visiting program like Early Head Start or in an early childhood education center or family child care home. The goals are to support children's social, emotional and brain development, minimize the impact of adverse childhood experiences (ACEs) and promote lifelong well-being.

In this document, "family" may refer to a biological, kinship, foster, guardianship or adoptive family.

1. Preparing to Collaborate:

- The family and DCF Caseworker meet to explore high quality child care/early childhood education (ECE) options that match the family's needs and preferences, e.g. part/full time, home visits/center-based/family child care/public school, subsidy eligibility, transportation needs, etc.
- The family is asked to sign a written release of information for the DCF worker to communicate with ECE program(s) to facilitate the referral process.
- The DCF worker seeks assistance from the DCF Area Child Care Coordinator, the Head Start program, and/or the Child Care Resource and Referral (CCR&R) agency to identify appropriate ECE resources and helps the family apply, as needed. When there are waiting lists, it is advisable to apply to all options the family is eligible for and comfortable pursuing.
- When an opening is identified that meets all the family's needs, the family visits the program and enrolls the child.
- Family signs a release of information for the DCF caseworker and the ECE program to communicate and collaborate on behalf of the child and family. If release is not signed, collaboration ends with this step unless DCF has custody of the child.
- DCF Caseworker provides detailed referral information to the ECE program - recommended format and guidelines in toolkit: "Helping Children Thrive in Early Education/Child Care".

Date process begins:

☐ Written Release by Family for Referral: Date: _____

☐ Written Release by Family for Collaboration: Date: _____

Contact Information (name, phone#, email, best ways/times to contact):

Parent(s)/Caregiver(s):

Early Childhood Educator (ECE):

ECE Supervisor/Administrator:

DCF Caseworker:

DCF Supervisor and Area Program Manager:

2. Establishing Expectations:

- Early Childhood Educator (ECE), DCF Caseworker and family, if possible, meet to discuss collaboration:
- Set schedule for routine contacts. (recommended at least 1x per month)
- Establish procedures for emergency contacts.
- Family, ECE and DCF Caseworker discuss and agree upon roles and responsibilities.
- Family, ECE and DCF Caseworker discuss and agree upon specific guidelines to ensure confidentiality.
- Family, ECE and DCF Caseworker agree upon documents to be shared.
- Family receives contact phone numbers and the best times and ways to reach all partners.

Meeting Date:

☐ Schedule and participants for routine contacts:

☐ Procedures for emergency contacts : (Order, ways to contact)

☐ Document sharing (eg. Service plan, Child care assessments, etc.)

☐ Date/time of next collaboration meeting:

Adapted from Program Planning EI/EEC Collaboration Document 1/10/13

<p>3. Developing the Partnership</p> <p>Building a professional working relationship means recognizing each person's contribution to the child's safety and well-being and requires ongoing feedback about how things are going from all perspectives.</p> <ul style="list-style-type: none"> • Meet to clarify what outcomes family, ECE and DCF hope to achieve from this partnership. • Document any tasks that partners plan to work on. • Set schedule and discuss expectations for collaboration meetings and/or home visits with family • Establish guidelines and processes for open communication about challenges encountered in the partnership among family, ECE and DCF. 	<p>Meeting Date:</p> <p><input type="checkbox"/> Outcomes to be addressed :</p> <p><input type="checkbox"/> Tasks, if any : (who will do what and when)</p> <p><input type="checkbox"/> Date/time/location of next collaboration meeting:</p>
<p>4. Ongoing Work</p> <p>Regularly scheduled updates (recommended at least 1x per month) and collaboration meetings ensure that everyone involved with the child is working towards outcomes and accomplishing the tasks that were identified. They also allow for these to be updated as needed. Page 3 can be copied to document future meetings.</p> <ul style="list-style-type: none"> • All partners share information about changes due to new developments, new assessments or required timelines. • Partners include each other in sharing successes and challenges – celebrate and collaborate! 	<p>Meeting or Update Date:</p> <p><input type="checkbox"/> Updates/changes:</p> <p><input type="checkbox"/> New challenges:</p> <p><input type="checkbox"/> Progress toward outcomes:</p> <p><input type="checkbox"/> Date/time/location of next collaboration meeting:</p>
<p align="center">Benefits of Successful Collaboration</p> <ul style="list-style-type: none"> • Collaboration enhances efficiency and effectiveness through the flexibility to divide up tasks based on the role, strengths, and relationships of each partner. • The Family-ECE-DCF partnership approach facilitates a shared agenda to address the goals of safety and well-being for the child and family. • Families can benefit from their early educators, DCF workers and other service providers working together to offer support and resources to help their child thrive and learn. Confusion due to mixed messages is minimized. • Inclusion as a partner empowers parents/caregivers, and their role as their child's first teacher is honored and supported. • Early educators can share their breadth of knowledge and relationships with the child and family to add to DCF assessment information and enhance service planning to support safety and well-being. • The DCF perspective contributes to early educators' understanding of the whole child in the context of family history and dynamics they might not otherwise be aware of. 	

Adapted from Program Planning EI/EEC Collaboration Document 1/10/13

Source: Massachusetts Department of Early Education and Care

<p>Ongoing Work</p> <p>Regularly scheduled updates (recommended at least 1x per month) and partnership meetings ensure that everyone involved with the child is working towards outcomes and accomplishing the tasks that were identified. They also allow for these to be updated as needed.</p> <ul style="list-style-type: none"> • All partners share information about changes due to new developments, new assessments or required timelines. • Partners include each other in sharing successes and challenges – celebrate and collaborate! 	<p>Meeting or Update Date:</p> <p><input type="checkbox"/> Updates/changes:</p> <p><input type="checkbox"/> New challenges:</p> <p><input type="checkbox"/> Progress toward outcomes:</p> <p><input type="checkbox"/> Date/time/location of next collaboration meeting:</p>
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Adapted from Program Planning EI/EEC Collaboration Document 1/10/13

FAST FACTS



Collaborating
with Child
Welfare (DCF)

Mandated Reporting of Suspected Abuse

WHAT DOES THAT MEAN?

Massachusetts State law mandates that educators, child care staff members and other professionals have a duty to report suspected child abuse or neglect to the Department of Children and Families (“file a 51-A report”).

It is important to educate yourself about the policies and protocol of the program that you work for. However, if you think that a report should be filed and your employer does not agree, you are mandated and have the right to report.

Protections for you:

You cannot be held liable in any way.

You may request that your identity be kept confidential, but need to understand that this may not always be possible.

By law, your workplace cannot retaliate against you for filing a report.

Criminal Penalties:

By law, you can be fined for not filing a 51-A report when you suspect abuse/neglect, but in practice fines have been very rare.

How to file:

You are required to file an oral report immediately, and follow up with a written report within 48 hours.

The written report form can be found on the DCF website: www.mass.gov/dcf. (See Toolkit 5-E for DCF brochure on mandated reporting.)

You can call DCF at any time to go over a concerning situation and they will share information about how their system works and help you think about options.

Phone numbers for reporting:

800-792-5905 (Days); 800-792-5200 (24 Hours)

KEEP IN MIND:

You do not have to have proof or know for a fact exactly what happened—you are required to file a 51-A report of child abuse or neglect if you have “reason to suspect” that the child may have been harmed by a caretaker or may not be safe.

What happens after you file:

The report is either screened in or out. If it is considered an emergency, this process begins within 2 hours. If not an emergency, it may take up to *3 business days*.

If the report is screened in, it either goes through an investigation or an assessment response. If the report is investigated, the investigation must be completed within *5 business days*.

If it goes through the assessment process, the assessment must be completed within *15 business days*.

If DCF has determined that abuse or neglect has occurred (called a “supported 51-A”), or if DCF will stay involved to provide services for another reason, a service plan is written and a comprehensive assessment of the family is completed within *45 business days*.

The mandated reporter will receive a copy of the DCF decision letter that is sent to the family. It explains DCF’s response to the report and DCF’s plans for continuing involvement. After this letter has been sent, any continued contact between the reporter and DCF (except for filing a new 51-A report) must be authorized by a signed release of information form from the parents/caregivers.

DCF Guide for Mandated Reporters (1)

Child Protection Information

For more information about reporting child abuse and/or neglect:

- **www.mass.gov/dcf** for general information or to find a DCF Area Office
- **Child-At-Risk-Hotline 800-792-5200**
- **DCF Ombudsman 617-748-2444** (9 – 5 pm, weekdays) for inquiries about DCF programs, policies or service delivery.

Contact Us

Massachusetts Department of Children and Families
600 Washington Street, 6th Floor
Boston, MA 02111

phone 617-748-2000
fax 617-261-7435
web www.mass.gov/dcf

DCF Area Office Directory

WESTERN

- Greenfield 413-775-5000
- Holyoke 413-493-2600
- Springfield 413-452-3200
- Van Wart Center, East Springfield 413-205-0500
- Worcester, East 508-929-2000
- Worcester West 508-929-1000
- South Central Whitinsville 978-353-3600
- North Central Leominster 413-236-1800
- Pittsfield 413-236-1800

NORTHEASTERN

- Lowell 978-275-6800
- Framingham 508-424-0100
- Haverhill 978-469-8800
- Lawrence 978-557-2500
- Cambridge 617-520-8700
- Malden 781-388-7100
- Cape Ann, Salem 978-825-3800
- Lynn 781-477-1600

SOUTHERN

- Arlington 781-641-8500
- Coastal/ South Weymouth 781-682-0800
- Cape Cod & Islands 508-760-0200
- Plymouth 508-732-6200
- Fall River 508-235-9800
- New Bedford 508-910-1000
- Brockton 508-894-3700
- Taunton/Attleboro 508-821-7000

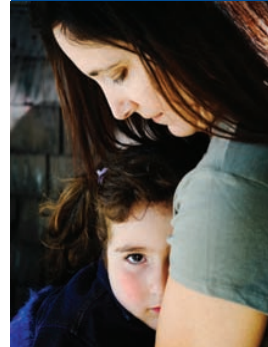
BOSTON

- Dimock Street, Roxbury 617-989-2800
- Hyde Park 617-363-5000
- Harbor, Chelsea 617-660-3400
- Park Street, Dorchester 617-822-4700



Child Abuse and Neglect Reporting

A Guide for Mandated Reporters



Child-At-Risk-Hotline
800-792-5200
www.mass.gov/dcf



DCF Guide for Mandated Reporters (2)



INTRODUCTION

Under Massachusetts law, the Department of Children and Families (DCF) is the state agency that receives all reports of suspected abuse and/or neglect of children under the age of 18. State law requires professionals whose work brings them in contact with children to notify DCF if they suspect that a child is being abused and/or neglected. DCF depends on reports from professionals and other concerned individuals to learn about children who may need protection, more than 75,000 reports are received on behalf of children each year. The Department is responsible for protecting children from abuse and/or neglect. DCF seeks to ensure that each child has a safe, nurturing, permanent home. The Department also provides a range of services to support and strengthen families with children at risk of abuse and/or neglect.

Who is a mandated reporter?

Massachusetts law defines the following professionals as mandated reporters:

- Physicians, medical interns, hospital personnel engaged in the examination, care or treatment of persons, medical examiners;
- Emergency medical technicians, dentists, nurses, chiropractors, podiatrists, optometrists, osteopaths;
- Public or private school teachers, educational administrators, guidance or family counselors;
- Early education, preschool, child care or after school program staff, including any person paid to care for, or work with, a child in any public or private facility, home or program funded or licensed by the Commonwealth, which provides child care or residential services. This includes child care resource and referral agencies, as well as voucher management agencies, family child care and child care food programs;
- Child care licensors, such as staff from the Department of Early Education and Care;
- Social workers, foster parents, probation officers, clerks magistrate of the district courts, and parole officers;
- Firefighters and police officers;
- School attendance officers, allied mental health and licensed human services professionals;
- Psychiatrists, psychologists and clinical social workers, drug and alcoholism counselors;
- Clergy members, including ordained or licensed leaders of any church or religious body, persons performing official duties on behalf of a church or religious body, or persons employed by a religious body to supervise, educate, coach, train or counsel a child on a regular basis; and,
- The Child Advocate.

As a mandated reporter, what are my responsibilities?

Massachusetts law requires mandated reporters to immediately make an oral report to DCF when, in their professional capacity, they have reasonable cause to believe that a child under the age of 18 years is suffering from abuse and/or neglect. A written report is to be submitted within 48 hours.

In addition to filing with the Department a mandated reporter may notify local law enforcement or the Office of the Child Advocate of any suspected abuse and/or neglect. You should report any physical or emotional injury resulting from abuse; any indication of neglect, including malnutrition; any instance in which a child is determined to be physically dependent upon an addictive drug at birth; any suspicion of child sexual exploitation or human trafficking; or death as a result of abuse and/or neglect. In addition, you must report a death as a result of abuse and/or neglect to the local District Attorney and to the Office of the Chief Medical Examiner. Mandated Reporters who are staff members of medical or other public or private institutions, schools or facilities, must either notify the Department directly or notify the person in charge of the institution, school or facility, or his/her designee, who then becomes responsible for filing the report. Should the person in charge/ designee advise against filing, the staff member retains the right to contact DCF directly and to notify the local police or the Office of the Child Advocate. (Ch. 119, § 51A) Under the law, mandated reporters are protected from liability in any civil or criminal action and from any discriminatory or retaliatory actions by an employer. The written report must be submitted to DCF within 48 hours after the oral report has been made.

Any profession defined by law as a mandated reporter, is required to assist in a 51B investigation or initial assessment, even if they are not the filer of the 51A report. Mandated reporters who are licensed by the Commonwealth are required to complete training to recognize and report suspected child abuse and/or neglect.

What if I fail to report?

Any mandated reporter who fails to make required oral and written reports can be punished by a fine of up to \$1,000. Any mandated reporter who willfully fails to report child abuse and/or neglect that resulted in serious bodily injury or death can be punished by a fine of up to \$5,000 and up to 2½ years in jail, and be reported to the person's professional licensing authority.

All mandated reporters who knowingly and willfully file a frivolous report of child abuse and/or neglect can be punished by a fine of up to \$2,000 for the first offense, up to 6 months in jail for a second offense, and up to 2½ years in jail for a third offense.

How do I make a report of suspected child abuse and/or neglect? When must I file?

When you suspect that a child is being abused and/or neglected, you should immediately telephone the local DCF Area Office and ask for the Screening Unit. You will find a directory of the DCF Area Offices at the end of this Guide and on the DCF web site. Offices are staffed between 9 am and 5 pm weekdays. To make a report at any other time, including after 5 pm and on weekends and holidays, please call the **Child-At-Risk Hotline at 800-792-5200.**

DCF Guide for Mandated Reporters (3)

As a mandated reporter you are also required by law to mail or fax a written report to the Department within 48 hours after making the oral report. The form for filing this report can be obtained from a local DCF Area Office or from the DCF website: www.mass.gov/dcf

Your report should include:

- Your name, address and telephone number;
- All identifying information you have about the child and parent or other caretaker, if known;
- The nature and extent of the suspected abuse and/or neglect, including any evidence or knowledge of prior injury, abuse, maltreatment, or neglect; The identity of the person you believe is responsible for the abuse and/or neglect;
- The circumstances under which you first became aware of the child's injuries, abuse, maltreatment or neglect;
- What action, if any, has been taken thus far to treat, shelter, or otherwise assist the child;
- Any other information you believe might be helpful in establishing the cause of the injury and/or person responsible; Any information that could be helpful to DCF staff in making safe contact with an adult victim in situations of domestic violence (e.g., work schedules, place of employment, daily routines); and
- Any other information you believe would be helpful in ensuring the child's safety and/or supporting the family to address the abuse and/or neglect concerns.

Hospital personnel should take photographs of any trauma that is visible on the child and mail or deliver the photographs to DCF with the written report. If you work in a hospital and collect physical evidence of abuse and/or neglect of a child, you must immediately notify the local District Attorney, local law enforcement authorities and the Department. We recommend that you inform the family that you have referred them to DCF for help, but do not do so if you think it would increase the risk to the child.

How does DCF define abuse and neglect?

Under the Department of Children and Families regulations (110 CMR, section 2.00):

Abuse means: The non-accidental commission of any act by a caretaker upon a child under age 18 which causes, or creates a substantial risk of, physical or emotional injury; or an act by a caretaker involving a child that constitutes a sexual offense under the laws of the Commonwealth; or any sexual contact between a caretaker and a child under the care of that individual. This definition is not dependent upon location (i.e., abuse can occur while the child is in an out-of-home or in-home setting).

Neglect means: Failure by a caretaker, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition. This definition is not dependent upon location (i.e., neglect can occur while the child is in an out-of-home or in-home setting).



Physical Injury means: Death; or fracture of a bone, a subdural hematoma, burns, impairment of any organ, and any other such nontrivial injury; or soft tissue swelling or skin bruising, depending upon such factors as the child's age, circumstances under which the injury occurred and the number and location of bruises; or addiction to a drug or drugs at birth; or failure to thrive.

Emotional Injury means: An impairment to or disorder of the intellectual or psychological capacity of a child as evidenced by observable and substantial reduction in the child's ability to function within a normal range of performance and behavior.

Who is a caretaker?

A "caretaker" can be a child's parent, step-parent, guardian, or any household member entrusted with the responsibility for a child's health or welfare. In addition, many other person entrusted with the responsibility for a child's health or welfare, both in and out of the child's home, regardless of age, is considered a caretaker. Examples may include: relatives from outside the home, teachers or staff in a school setting, workers at an early education, child care or afterschool program, a babysitter, foster parents, staff at a group care facility, or persons charged with caring for children in any other comparable setting.

When should a report involving domestic violence be filed?

Domestic violence is defined as a pattern of coercive controlling behaviors that one person exercises over another in an intimate relationship. Not every situation involving domestic violence merits intervention by DCF. Mandated reporters are encouraged to carefully review each family's situation and to identify any specific impact on the child(ren) when considering whether or not to file a 51A report with DCF. In some cases a report may actually create additional risks for the caretaker and the children. If possible, discuss the filing of a report with the caretaker first and address the potential need for safety planning. A report is more likely necessary if the following higher risk circumstances are current concerns:

- The alleged perpetrator threatened to kill the caretaker, children or self and the caretaker fears for their safety;
- The alleged perpetrator physically injured the child in an incident where the caretaker was the target;
- The alleged perpetrator coerced the child to participate in or witness the abuse of a caretaker;
- The alleged perpetrator used or threatened to use a weapon, and the caretaker believes that the perpetrator intended or has the ability to cause harm.

For more information on this topic please refer to the DCF Brochure, Promising Approaches: Working with Families, Child Welfare and Domestic Violence. This brochure is available on the DCF website and from a local DCF Area Office.

DCF Guide for Mandated Reporters (4)

What happens when DCF receives a report of child abuse and/or neglect?

When DCF receives a report of abuse and/or neglect, called a “51A report,” from either a mandated reporter or another concerned citizen, DCF is required to evaluate the allegations and determine the safety of the children. During DCF’s response process, all mandated reporters are required to answer the Department’s questions and provide information to assist in determining whether a child is being abused and/or neglected and in assessing the child’s safety in the household.

Here are the steps in the Child Protective Services (CPS) process:

- 1. The report is screened.** The purpose of the screening process is to gather sufficient information to determine whether the allegation meets the Department’s criteria for suspected abuse and/or neglect, whether there is immediate danger to the safety of a child, whether DCF involvement is warranted and how best to target the Department’s initial response. The Department begins its screening process immediately upon receipt of a report. During the screening process DCF obtains information from the person filing the report and also contacts professionals involved with the family, such as doctors or teachers who may be able to provide information about the child’s condition. DCF may also contact the family if appropriate.
- 2. If the report is “Screened-In,” it is assigned either for a Child Protective Services (CPS) Investigation or Assessment Response:**
 - **CPS Investigation Response:** Generally, cases of sexual or serious physical abuse, or severe neglect will be assigned to the CPS Investigation Response. The severity of the situation will dictate whether it requires an emergency or non-emergency investigation. The primary purpose of the Investigation Response is to determine the current safety and the potential risk to the reported child, the validity of an allegation, identification of person(s) responsible and whether DCF intervention is necessary.
 - **CPS Assessment Response (Initial Assessment):** Generally, moderate or lower risk allegations, are assigned to the CPS Assessment Response. The primary purpose of the Assessment Response is to determine if DCF involvement is necessary and to engage and support families. This response involves a review of the reported allegations, assessing safety and risk of the child, identifying family strengths and determining what, if any, supports and services are needed.
- 3. A determination is made as to whether there is a basis to the allegation,** whether the child can safely remain at home and whether the family would benefit from continued DCF involvement. If DCF involvement continues, a Comprehensive Assessment and Service Plan are developed with the family.

Some families come to the attention of the Department outside the 51A process: **Children Requiring Assistance (CRA)** cases referred by the Juvenile Court, cases referred by the Probate and Family Court, babies surrendered under the **Safe Haven Act**, and voluntary requests for services by a parent/family. These cases are generally referred directly for a Comprehensive Assessment.

What are the timeframes for completing a Screening, and/or an Investigation or Assessment?

- **Screening:** Begins immediately for all reports. For an emergency response it is completed within two hours. For a non-emergency response, screening may take up to three business days as appropriate.
- **Emergency Investigation:** Must begin within two hours and be completed within five business days of the report.
- **Non-Emergency Investigation:** Must begin within two business days and be completed within 15 business days of the report.
- **Assessment (Initial):** Must begin within two business days and be completed within 15 business days of the report.
- **Comprehensive Assessment:** May take up to 45 business days.

Will I be informed about the DCF determination?

If you are the mandated reporter who filed the report, you will receive a copy of the decision letter that is sent to the parents or caretaker. In that letter you will be informed of the Department’s response, the determination and whether DCF is opening a case for continued DCF involvement.

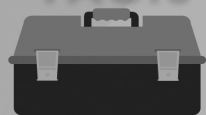
Does DCF tell the family who made the 51A report?

DCF regulations do not allow the Department to disclose the name of a reporter unless ordered by a court or required by statute such as when the Department is required to provide the 51A report to the District Attorney or other law enforcement (CMR 12.00 etseq.).

Referrals to the District Attorney

If the Department determines that a child has been sexually abused or sexually exploited, has been a victim of human trafficking, has suffered serious physical abuse and/or injury, or has died as a result of abuse and/or neglect, DCF must notify local law enforcement as well as the District Attorney, who have the authority to file criminal charges.

FAST FACTS



Collaborating
with Child
Welfare (DCF)

Importance of Continuity in Early Education Programs for DCF Children

WHY IS THIS IMPORTANT?

Children who have experienced trauma and toxic stress have a high need for structure and predictability. High quality early education and care programs provide routines and rich opportunities for brain development and mastering social-emotional skills. They also support caregivers in their efforts to meet the complex needs of these children. Every effort should be made to keep these children in the same early education setting when they or their parents are going through other kinds of transitions in their lives. If continuity is impossible, connect the family to other early learning programs.

When a child enters a DCF supportive slot, start transition planning immediately. Explore all other funding options open to the family that could keep the child in the same program when the DCF case closes. These may include:

- TANF/DTA or Income Eligible vouchers
- Head Start/Early Head Start

Head Start is free for disabled and income-eligible, provides transportation from specified towns, prioritizes DCF and foster children

Vouchers and slots may be available for homelessness, TANF/DTA/"welfare", disabled parent/child, or income-eligible if parents in work, school, training.

See Toolkit 5G for EC options and eligibility guidelines.

WHAT TO DO?

Explore eligibility and options with family (income, work status, disability, other eligibility requirements). Identify barriers to continuity and seek resources: transportation, need for services in public school, etc. If continuity is not possible, explore Head Start, public school preschool, home-visiting and community-based options to keep child and family connected to early learning resources. See Toolkit 6-A through 6-M for Community Resources.

New England Farmworkers Council can also help: www.partnersforcommunity.org, 413-475-3656

TIPS:

Make this a high priority for ALL DCF-involved children, including siblings.

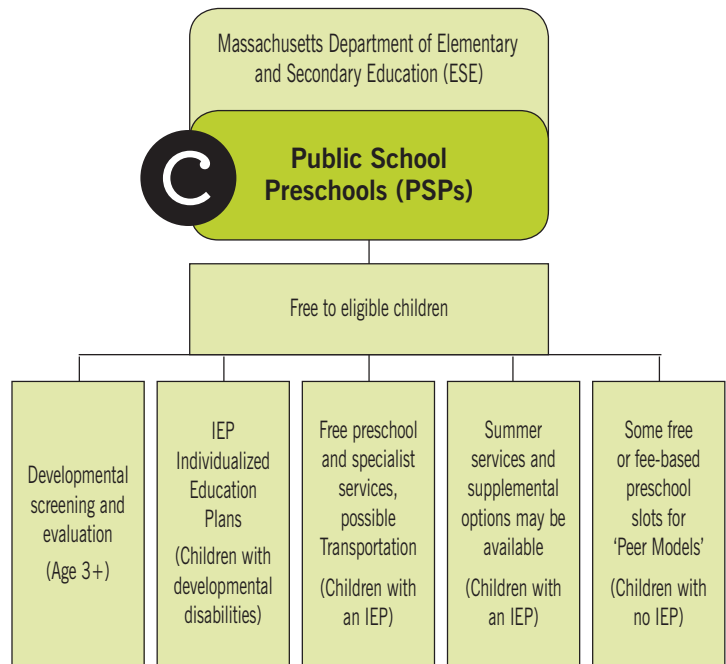
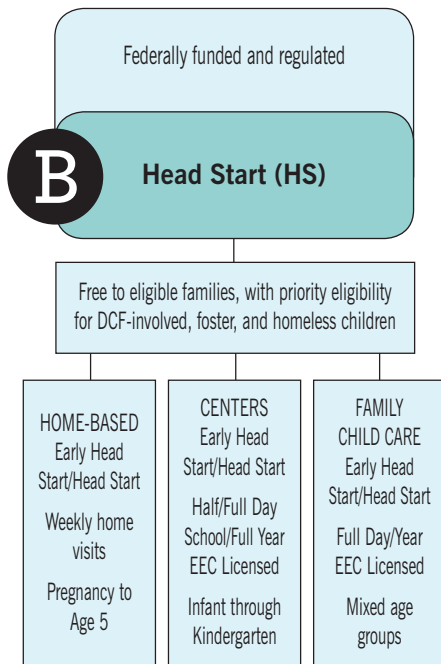
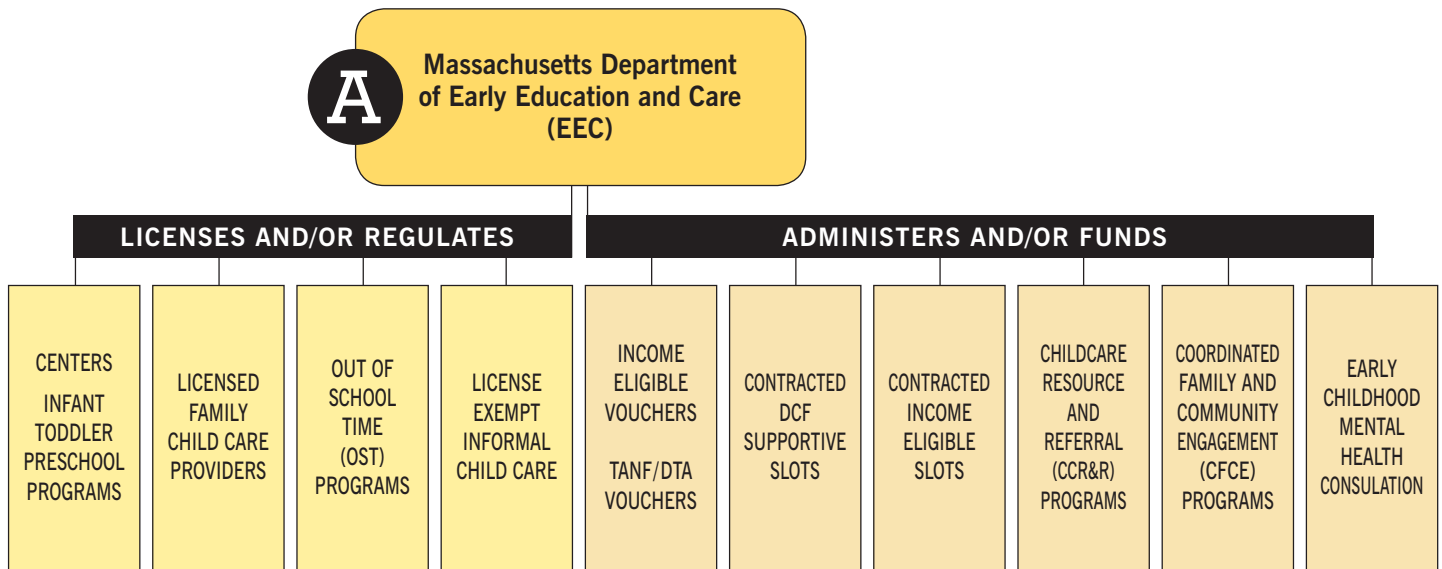
Use toolkit materials (7-B and 7-C) to help parents understand the importance of high quality early education and find the best option for each child in their family.

If at first you don't succeed, try, try again!

Learn about and encourage use of other community-based early learning options, including:

- Free family centers/playgroups
- Early Intervention playgroups (Service Net REACH)
- Home visiting programs like Healthy Families and the Parent-Child Home Program
- Local libraries

Map of the Massachusetts System of Early Care and Education



For more information, refer to the detail sheets for each of the three components of the Early Education and Care System:





ADMINISTERS AND/OR FUNDS:

INCOME ELIGIBLE VOUCHERS

Subsidies for parents in work, school, training or parent/child with disability

Can be used for any licensed program that will accept them, including some summer camps

Long waiting list, typically; list is sometimes frozen, but names can always be added

Worth getting on long list; situation can change

Once a family has a voucher subsidy, they should keep it active once all children are in school; can be used for summer camp

With restrictions, may be used for unlicensed informal care

- **ACCESS:** Apply to local Child Care Resource and Referral (CCR&R) program to get on waiting list: www.partnersforcommunity.org

TANF/DTA (aka “welfare”) VOUCHERS

No waiting list

Automatically available for families on Transitional Assistance to Needy Families (DTA) needing to fulfill the work or training requirement

Can be used for any licensed program that will accept them, including some summer camps

With restrictions, may be used for unlicensed informal care

- **ACCESS:** Get child care referral from DTA, then apply for voucher subsidy through the CCR&R

CONTRACTED DCF SUPPORTIVE SLOTS

Funded/regulated by EEC

Selected pre-approved programs have contracted slots for children with DCF involvement

Goal is to transition family to a different funding source asap (ideally at same site/program)

- **ACCESS:** Through DCF local office Child Care Coordinator only

CONTRACTED SLOTS—INCOME ELIGIBLE

Selected pre-approved programs have contracted slots for income-eligible families

Slot cannot be transferred to another child care site

Family receives a letter when opening is available

- **ACCESS:** Family must be on the EEC waitlist through CCR&R or by calling the contracted child care program

CHILD CARE RESOURCE AND REFERRAL PROGRAMS (CCR&Rs listed on the EEC website)

Local CCR&R:

New England Farmworker’s Council,
413.475.3656; www.partnersforcommunity.org;

office hours in Greenfield, Wed. in Northampton

Provides access to high quality, affordable child care and OST; assists with child care search

Database of licensed programs, provider openings

Personalized help to match providers with family needs

Processes applications for vouchers/subsidies

COORDINATED FAMILY AND COMMUNITY ENGAGEMENT PROGRAMS (CFCEs)

Most services for families with children from birth to kindergarten

Sponsor free educational parent-child playgroups, family centers, and parent education programs; available in most towns

Accessible, free option, even in very rural towns

Provide free parent education and support programs

Option to involve parents in Ages and Stages developmental screening

Referrals for child care and community resources for families with children from birth to age eight

- **ACCESS:** Contact info for local towns is listed at www.mass.gov/EEC

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION (ECMH)

A child (0-5) enrolled in any EEC-licensed child care program may be referred for ECMH consultation services with parent approval

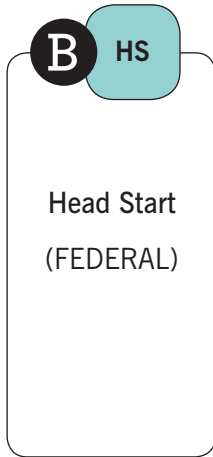
Onsite services help early educators support child’s social-emotional development; may also address broader programmatic issues

Home visits help parents/caregivers build on the child’s strengths and meet their needs

The Collaborative for Educational Services serves Hampshire and Franklin counties and the N.

Quabbin under a subcontract with the Western Region lead agency, Behavioral Health Network

CES—ECMH Referrals: 413.586x4998 x102



The Massachusetts System of Early Care and Education

Head Start: www.eclkc.ohs.acf.hhs.gov

Hampshire/Franklin provider:

Parent-Child Development Center of Community Action (www.communityaction.us)
413.387.1250 (Hampshire County) | 413.475.1405 (Franklin County)

Athol provider:

Montachusett Opportunity Council (www.mocinc.org)
978.343.0185

- Federal funding, regulation and quality monitoring
- Free to eligible families (low income, special needs, etc.)
- Ability to prioritize DCF-involved children; foster children and homeless families are automatically eligible
- Home visiting, family child care and center-based options
- Full-time/full year services available when combined with a voucher, contracted or DCF supportive slot

Includes:

Specialist services in health, nutrition, and mental health
Developmentally based curriculum
Support and information for parents
Community referrals
Group socialization opportunities for children
Parent involvement opportunities
Limited transportation available in some communities

HOME-BASED

EARLY HEAD START and HEAD START

Available from pregnancy to age 5
Weekly home visits
Group socialization opportunities for children

CENTERS

EARLY HEAD START AND HEAD START

EEC Licensed
Age range varies from infant through kindergarten
Half day/school year and Full day/ full year options available

FAMILY CHILD CARE

EARLY HEAD START AND HEAD START

EEC Licensed early educators
Full day/ full year programs
Family-like setting
Typically mixed age groups



PSPs

Public
Preschool
Programs
(STATE)

The Massachusetts System of Early Care and Education

Massachusetts Department of Elementary and Secondary Education:
www.doe.mass.edu

- Developmental screening and evaluation for children age 3+ (aka “CORE evals”)
- Individualized Education Plan (IEP) created for children with significant developmental delays or disabilities that interfere with their learning
- Free preschool for children with an IEP; transportation may be provided
- Specialist services (speech, OT, PT, etc.) provided according to IEP
- Most have slots for “peer models” (typically developing children); may charge a fee based on family income
- Typically half-day, school year programs with rare full-day exceptions
- Summer services are provided for some children in special cases
- Can be supplemented with other options if full-day/full-year care needed and transportation/logistics can be arranged

Helping Children Thrive in Early Education and Child Care (1)

Information to request from DCF to help early educators understand and meet the child's unique needs

Reassure DCF that all information shared in the DCF referral will be used exclusively to inform early educators/child care providers about the child's history and needs in order to provide the best and most appropriate care for the child in the early education/child care setting. As all employees of the early education/child care program are trained professionals, it is understood that this information is confidential and shall *only* be discussed with appropriate parties for the child's benefit. Information will not be disclosed or discussed with anyone outside the program without signed releases, and will never be discussed within hearing distance of the child.

A sample form and guidelines for gathering referral information from DCF follow on the next two pages (5H.2 and 5H.3).

MONTHLY UPDATE CONVERSATIONS BETWEEN EARLY EDUCATORS AND DCF ARE HIGHLY RECOMMENDED!

Explain that child welfare caseworkers can learn a lot about the child from early educators/child care providers, and that the child's care will improve when early educators are updated about the child's life.

Refer to Toolkit 5C, **Collaboration Guide: Families, Early Childhood Educators, and Child Welfare Caseworkers** for a guide to ongoing collaboration between DCF and the Early Education Program.

Helping Children Thrive in Early Education and Child Care (2)

REFERRAL INFORMATION

This is a suggested format for referral information from the DCF social worker assigned to the case when the child enters a new early education/child care setting. Referral information may be provided in writing or during an intake conversation with DCF. Guidelines follow about what to include in each section, understanding that some requested information may not yet be available.

- 1. Developmental history/concerns:**

- 2. Social-emotional history/concerns:**

- 3. Medical history/concerns:**

- 4. Who does the child live with, who has custody, and what are routines like at home?**

- 5. Current situation:**

- 6. Family situation**

- 7. If the child is in foster care, when was the first placement, how many placements has the child experienced, and what is the visitation schedule?**

Helping Children Thrive in Early Education and Child Care (3)

GUIDELINES FOR REFERRAL INFORMATION

1. Developmental history/concerns:

- Delays in reaching developmental milestones; if cause is known, describe. (I.e. organic delay, head injury, prematurity, failure to thrive, etc.)
- Prenatal drug exposure
- Is the child receiving Early Intervention services (Service Net REACH)? If not, are there plans to refer for evaluation? Will the REACH worker visit the child at the early education/child care program or at home?
- If the child is receiving special education services from a public school, please describe and share contact information.

2. Social-Emotional history/concerns:

- Share history of abuse, neglect or other relevant aspects of family relationships. Include any specific details that may help early educators have better insight into the child and/or their behavior. (I.e. if a child was neglected and left for extremely long periods of time alone in a crib, teachers need to know this to be aware that the child may do better on a cot)
- History of behavior challenges/issues? When and where do behavior challenges arise?
- Is the child seeing a therapist or had therapy in the past? With whom, type, duration?

3. Medical history/concerns:

- Any medical concerns, including dental. Names of medical/dental providers.

4. Who does the child live with, who has custody, and what is the routine like at home?

- Include names of the adults, children and pets in the current home, if known. If it's a recent placement, information about why the child was moved and information about family members he/she may be missing is also important.
- A description of the custody history and current status and any information you have about the child's daily routines is helpful, i.e. eating/sleeping patterns and issues, transitional objects for comfort, naps.

5. Current situation:

- Try to paint as detailed a picture as possible of the child's current state/situation.
- What feelings are most often expressed? Anxiety, sadness/tears, anger/aggression, withdrawal, contentment?
- What is stable/unstable in the child's life?

6. Family situation:

- Share anything important to know about the parents and other significant adult relatives, such as grandparents, aunts/uncles, etc. (I.e. domestic violence, one parent living out of the home, recent separation, parent lives with other relatives, unstable housing, substance abuse, working multiple jobs, mental health issues etc.) If it could be impacting the child, it's important.
- Include pertinent information about sibling relationships and/or behavior.
- If the child is in foster care, when was the first placement, how many placements has the child experienced, and what is the current visitation schedule?
- How stable is the current situation and is it likely to change anytime soon? This will allow the early educators to help prepare the child if a move is coming through 'good bye' books etc.
- If applicable, describe any visitation schedules and how the child responds to visits.

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Community Resources

- 6-A Fast Facts | Successful Community Referrals
- 6-B Fast Facts | Early Intervention
- 6-C Fast Facts | Individual Education Plans (IEPs)
- 6-D Fast Facts | Mothers' Support Groups
- 6-E Fast Facts | Community Home Visiting Programs
- 6-F Fast Facts | Early Childhood Mental Health Consultation
- 6-G Opioid Treatment Resource Referral Sheet
- 6-H Fast Facts | Child Behavioral Health Initiative
- 6-I Fast Facts | Finding the Right Therapy
- 6-J Fast Facts | Family Centers and CFCE Programs
- 6-K Fast Facts | Locating Parenting Support and Education
- 6-L Fast Facts | Local Library Resources and Programs
- 6-M BCF Parenting Programs Resource Directory—2014

CHILD WELFARE
TOOLKIT



FOR EARLY CHILDHOOD PROFESSIONALS



FAST FACTS



Community Resources

Successful Community Referrals

WHAT IS IT?

A successful community referral is one that is made to the right service at the right time and includes the support the family needs to overcome emotional and logistical barriers like distrust, transportation and scheduling challenges, etc. The family is gently persuaded to try out a new service, then actively chooses to continue with the service because their needs are being met and services are strengths-based and helpful.

CHARACTERISTICS:

Timing: Referral is made when the family is ready. Not a “yes or no” proposition, but a process of gradually building readiness over time by exploring and addressing the family’s concerns and reservations as they arise. Can be a lengthy process.

Information: Caseworker describes the service in detail and offers written materials, if available at an appropriate literacy level. Encourages family members to share their reactions and concerns and provides linkages for the family to get their questions answered.

Built on relationships: A “warm handoff” is used; caseworker becomes a bridge between the family and the new provider by introducing a carefully chosen person to the family who can discuss logistics, answer questions and address concerns.

Barriers anticipated/addressed: Are they emotional, relational, logistical? E.g. transportation/babysitting challenges, poor fit, fear of strangers, discomfort with new people coming to the home etc. Make back-up plans whenever possible.

Trouble-shooting: Initially, have frequent contact with the family and provider to understand and address difficulties and offer help with logistics, misunderstandings etc.

WHAT TO DO?

Gather detailed information about the array of services available from colleagues, other clients, resource guides and collaboration meetings. Collect brochures. Make a relationship with someone at each agency who seems helpful and non-judgmental and able to engage with reluctant families. Introduce them to the family in person whenever possible. Stay in frequent touch until the family has engaged.

Tips for Success:

When encountering persistent resistance and reservations, try to contract with family to have one exploratory meeting with the provider, and offer to take a break from bringing it up if the family is still not ready to try the service afterward.

When referring to voluntary services, stress that they are voluntary and that the family can change their mind if they’re not satisfied with the service after giving it a try.

Normalize whenever possible, explaining the ways in which people you’ve known have found the service helpful.

Offer solutions to potential barriers during early discussions about the referral, e.g. “I know transportation can be a challenge for you; this service will come to your home.”

Prepare the service provider for the “warm handoff” by sharing insights into family dynamics and brainstorming ways to overcome potential barriers to engaging with the service.

Hold the “warm handoff” meeting at the place most comfortable for the family and plan to stay for all or part of the intake if the family needs continued support and reassurance to engage.



Early Intervention (EI) Programs

WHY REFER?

Many children involved with DCF have developmental delays and/or disabilities caused or impacted by trauma or toxic stress. Early identification and services can dramatically improve outcomes for these children—the earlier the better. Developmental evaluation is free and required by DCF policy for all children birth to 3 with a supported 51-B, but an evaluation referral can be beneficial for ALL infants and toddlers in families on the DCF caseload.

PROGRAM LOCATIONS AND SERVICE AREAS:

Service Net REACH

Serves all of Hampshire and Franklin counties and the North Quabbin area

Office: 108 Main St. Unit A, Sunderland MA 01375

413-665-8717 (ph) 413-665-9383 (fax)

Email: reach@servicenet.org/node/76

Criterion Heritage Early Intervention Program

Most services are in Hampden County, but serves Granby, South Hadley, Belchertown and Ware in Hampshire County

Office: 30 Old Lyman St., South Hadley MA 01075

413-533-7140 (ph) 413-538-9757 (fax)

Website: www.criterionchild.com

SERVICES PROVIDED:

Ages birth to 3. Free developmental evaluation to determine the child's strengths and identify any delays or disabilities. Free services for eligible children and their families. Home visitors may address concerns with feeding, hearing, speech and language, behavior and attention, motor skills, or needs specific to autism. Integrated parent-child interactive playgroups are available at various community locations (include children with and without delays/disabilities). Assistance with transition to public school special education at age 3.

Increasing parent/caregiver comfort level:

Stress that evaluation is free and that others have found it to be worthwhile and a fun way to learn about their child

Normalize and reassure parents by saying you refer all eligible children because it's such a great free resource

Explain that parents learn fun and easy tips about how they can build on their child's strengths and support early learning

Families of children who qualify for services have wonderful feedback about how helpful and supportive the program has been for them and their child

Overcoming barriers to services:

Fear that you think something is wrong with their child (normalize and reassure; focus on learning about strengths; stress that evaluation is helpful for all children)

Resistance to allowing strangers into the home (visits can take place at another location)

Parents may need time to get used to the idea (continue with gentle encouragement during visits; suggest that they ask friends and family members about their experiences with EI services or call the program with questions)

FAST FACTS



Community
Resources

Individualized Education Plan (IEP)

WHAT IS IT?

Plan written by a public school special education program that is tailored to meet the individual needs of a child with developmental delays or disabilities that impede their learning. The plans are intended to help a child achieve educational goals that they would otherwise have difficulty reaching due to their delay or disability. They educate the teachers and other related service professionals about the child's needs and disability and describe services and accommodations the school will provide to support the child's learning. Every child who receives special education services must have an IEP. See *Toolkit 7-J* for a sample letter requesting an evaluation from the local school system that can be provided to parents/caregivers.

ELIGIBILITY:

Any child 3 years old and older, who is suspected of having an educational disability, is eligible to be assessed through their home school district for specialized services through an IEP. Prior to 3, the child should be assessed by Early Intervention. There is no cost to families for either assessment.

WHAT TO DO:

To initiate testing, use the sample letter provided in the SCSC Toolkit. The letter should be signed and sent by the parent or whomever holds educational rights.

The letter should be provided to the principal at the child's school. If the child is not enrolled in school, the letter should be provided to the Special Education coordinator of the school district.

Every child can have
success in school

TIMELINES:

Once written parental consent is received:

30 (school) days to complete the evaluation

45 (school) days convene a Team meeting to discuss the results of the evaluation and formulate an IEP

2 (school) days prior to the Team meeting, the parent will be provided a summary of evaluations

ADDITIONAL HELP:

Disabilities Law Center
413-584-6337 or 800-222-5619

Children's Law Center of MA
888-KIDLAW8 or 781-581-1977
<http://clcm.org/edsped.html>

Resource/advocacy for parents:
Federation for Children with Special Needs
www.fcsn.org

FAST FACTS



Community Resources

Mothers' Support Groups and Resources affiliated with MotherWoman

WHAT ARE THEY?

MotherWoman groups provide safe places of mutual respect and non-judgment where mothers can build community and support one another as they navigate the realities of motherhood. Trained facilitators lead support groups that address issues faced by many mothers: postpartum emotional difficulties including anxiety and depression, adjustment to motherhood for pregnant and new mothers, isolation and building a personal support system.

CONTACT INFORMATION

Office Address:

220 Russell St. (Rt. 9), Ste. 200
Hadley, MA, 01035
413-387-0703

www.motherwoman.org

Mailing Address:

P.O. Box 2635
Amherst, MA 01004

Mission: MotherWoman supports and empowers mothers to create personal and social change by building community safety nets, impacting family policy and promoting the leadership and resilience of mothers.

PROGRAMS:

MotherWoman's Postpartum Support Initiative addresses the crisis of postpartum emotional difficulties through building multi-disciplinary support networks in W. Mass.

Mothers' Support Groups

Communities change, but have included Amherst, Ashfield, Cummington, Greenfield. Hadley, Holyoke, Northampton, Springfield and Wilbraham.

Training for support group facilitators and professionals

Policy and Advocacy to address social justice issues impacting mothers and their families

Related support groups for mothers also listed on the MotherWoman website:

Empty Arms Bereavement Support Program

Trained MotherWoman facilitators provide support groups in Hadley and Northampton for mothers who have lost a baby during pregnancy, birth or shortly after. Other groups include miscarriage support and parenting after loss.

More info at: emptyarmsbereavement@gmail.com

Resource and Referral Guides

MotherWoman Resource and Referral Guides for patients are region-specific directories created by the Pregnancy and Postpartum Support Coalition of Western Massachusetts.

Resource Guide for Care Patients
(PDF for Download, updated 3/12/13)

Resource and Referral Guide for Providers
(PDF, 12/6/12)

Franklin County Resource & Referral Guide for Patients (PDF, 3/12/13)

Available at: www.motherwoman.org

WHAT TO DO?

Refer to *Toolkit 3-F, Maternal and Postpartum Depression aka Perinatal Mood Complications* to learn more about recognizing and supporting families who are affected.

Call MotherWoman or consult the website to learn schedules and locations of local groups and for referral information. Refer mothers to support groups and help them address barriers to participating in a group.

FAST FACTS



Community Resources

Community Home Visiting Programs

WHAT IS IT?

Home visiting/family support programs vary according to their target populations, eligibility and primary focus/goals, but have in common that they are strength-based, family focused and provide services in the home. They are an especially important resource for isolated families and those with transportation challenges, but they can help to build protective factors in any family under stress. The community programs listed below are all free to eligible families. To refer to programs that provide services under contract with DCF, contact the Family Networks program.

TYPES:

Healthy Families

Eligibility: Parent(s) under 21 with a first child under 1 year

Towns served: Statewide in MA. Locally, Community Action serves all of Hampshire and Franklin counties and N. Quabbin

Contact info: 413-475-1545 (FC), 413-387-1270 (HC), 978-544-5423 (NQ) www.communityaction.us

Services: home visits, parenting support, child development education, young parent groups, transportation to appointments and linkage to supportive services, e.g. housing, income support, medical, child care, education/job training

Parent-Child Home Program

Eligibility: Children 16 mos. to 3 yrs. living in selected towns

Contact info and towns served:

Collaborative for Educational Services (Most of Hamp.County)
800-519-1882 x102, www.collaborative.org

Northampton Schools (Northampton/Hadley)
413-587-1471

Community Action (Greenfield, Turners Falls, Orange)
413-475-1550, www.communityaction.us

Services: 2 brief home visits per week over 2 years focused on building early literacy and parenting skills; each week an educational toy or book is provided for the family to keep.

Parent Aide Volunteer Effort

Eligibility: parents under stress/in need of extra support living in Hampshire Co. with children of any age.

Note: Montague Catholic Social Ministries has a similar program in Franklin County:

413.853.4804, www.mcsmccommunity.org

Contact info: Berkshire Children and Families
220 Russell St. Hadley, 413-584-5690
www.berkshirechildren.org/bcf_parenting

Services: weekly home visits by trained volunteers, parent education/support, child development education, linkage to supportive services, e.g. child care, income support, job training care, education/job training

Head Start/Early Head Start

Eligibility: low income, parent or child with disability, homeless/ foster/DCF children can be prioritized

Contact info and towns served:

Parent Child Development Center of Community Action
(Hampshire/Franklin counties)
413-387-1250(HC),413-475-1405(FC)
www.communityaction.us

Services: weekly home visits from pregnancy through age 5, parent education/support, child development/ early education, support for parent as child's first teacher, linkage to supportive services, e.g. child care, income support, medical, job training

WHAT TO DO?

Learn about eligibility guidelines and family-friendly, non-threatening language/"selling points" for each program. Get to know someone from each program—request ability to do a joint home visit with you to introduce the program. If family is eligible for multiple programs, offer a choice. Obtain release of information, make referral, and stay in frequent touch, troubleshooting as necessary until the family is engaged. Refer to *Toolkit 6-A, Successful Community Referrals* for tips.

FAST FACTS



Community
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Early Childhood Mental Health (ECMH) Consultation

WHAT IS IT?

Early Childhood Mental Health (ECMH) Consultation provides a full range of supportive services for parents, early educators and child care providers to meet the social-emotional needs of infants, toddlers and preschoolers. EEC funds ECMH services for children enrolled in any licensed early education/child care program.

ECMH Consultation for Early Childhood Programs

With parental consent, consultation regarding individual children's social and emotional development and behavior

Staff consultation in support of the whole classroom's social and emotional development through curriculum, routine and structure, activities, and interactions

Information and referrals

Coordination and collaboration with community service providers

ECMH Consultation for Parents/Caregivers

Support to parents/caregivers of children birth to five years old regarding child development, behavior, and family issues (child must be enrolled in a licensed child care center or in licensed family child care)

Home visits available; when requested, parent/caregiver consultation can be provided at a community site

Referrals to and coordination with other community services as needed

Referral tips

Because some parents are uncomfortable with the term "mental health," it may work better to describe the service as "early childhood consultation." When parents understand that this is a voluntary service that the child care program and other parents have found to be helpful, they may feel more comfortable signing a release of information for the referral. Normalizing the service as much as possible will help.

WHAT TO DO?

Refer infants, toddlers and pre-school age children with social-emotional, developmental, behavioral or family issues for ECMH consultation. The Collaborative for Educational Services (CES) provides ECMH consultation in Franklin and Hampshire counties and the North Quabbin: 413-586-4998 x102, www.collaborative.org/early-childhood.

HEROIN AND PRESCRIPTION OPIOID TREATMENT RESOURCES

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CRISIS SERVICES

(800) 562-0112
(413) 774-5411 *Franklin County*
(978) 249-3141 *North Quabbin*
If you need immediate support and assistance, call Crisis Services. Crisis Services offers 24 hour support. Crisis Services accepts all insurances and uninsured clients.

Crisis Services CARES Program: peer advocates see individuals in the ER or community who are dealing with substance abuse/ alcohol addiction issues and help access detox programs and other treatment related resources. Insurance not required.

Central intake for YOUTH and PREGNANT WOMEN
Institute for Health and Recovery:
(866)705-2807
(All pregnant women seeking substance abuse treatment have priority access to treatment in Massachusetts)

PEER RECOVERY & SUPPORT

RECOVER Project: Peer-to-peer recovery support Substance abuse treatment resource M-F 9-5. 68 Federal Street, Greenfield, MA 01301. (413) 774-5489.
www.recoverproject.org See resource list on website.

Learn to Cope: Support group for parents and family members dealing with a loved one addicted to heroin, Oxycontin and other drugs. The website includes a discussion board and an extensive resource list – mostly central and eastern MA
www.learn2cope.org

Parent Support Group: For families and/or parents of substance abusers. 3rd Tuesday of the month 7:00pm. Athol Hospital. 2033 Main St, Athol

CASE MANAGEMENT

Community Support Program (CSP): A program of Clinical and Support Options. Pregnant women in recovery, on Masshealth, are prioritized for short term outreach and case management, such as assistance in accessing services. One Arch Place, Greenfield MA 01301. (413)774-1000 Melinda Williams, ext. 2065.

ON-LINE & PHONE RECOVERY SUPPORT

Massachusetts Substance Abuse Information Helpline:
(800)327-5050
TTY (888)448-8321
M-F 8:00-10:00
Sat/Sun 9:00-5:00
Interpreter services available.
www.helpline-online.com

Western Mass Peer Support Line:
Open Fri – Mon 8pm – midnight.
(888) 407-4515.

Narcotics Anonymous:
www.naphone.org

MOM Program: Methadone Pregnancy Information.
www.methadonesupport.org/Pregnancy.html

North Quabbin Community Coalition Resource Directory:
www.nqcc.org/resource.html

OUTPATIENT INTENSE TREATMENT PROGRAMS

Baystate Franklin Medical Center Partial Hospitalization Program: Dual Diagnosis, 164 High Street, Greenfield, MA 01301. (413)773-4444.

Clinical and Support Options-Northampton: Intensive Outpatient Program, 8 Atwood Drive, Day Treatment, Northampton, MA 01060. (413)586-8550.

MEDICATION ASSISTED TREATMENT

Clean Slate: Suboxone Treatment. 278 Main Street, Suite 307A, Greenfield. (413)376-4343 or (877)218-2340 toll free.
www.cleanslatecenters.com

Community Substance Abuse Center: Methadone Clinic. 177 Shelburne Road, Greenfield. (413) 774-3321. www.csachelp.com.

This guide produced by the Opioid Education and Awareness Task Force of Franklin, Hampshire and North Quabbin

opioidtaskforce@gmail.com
(413) 834-3161

Guide design by the Franklin Regional Council of Governments

FRANKLIN COUNTY AND NORTH QUABBIN HEROIN AND PRESCRIPTION OPIOID AWARENESS AND TREATMENT RESOURCES

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OUTPATIENT COMMUNITY MENTAL HEALTH CLINICS

Center for Human Development, Inc.: 489 Bernardston Road, Greenfield, MA 01301. (413)774-6252. Open Access Tuesdays 12-3 pm.

131 West Main St. 1st Floor
Orange, MA 01364
Tel (978) 544-2148

Clinical and Support Options, Inc.:
One Arch Place, First Floor,
Greenfield, MA 01301. Amy Olson,
Clinic Director. (413)774-1000.
Open Access Monday-Friday, 9-4.

491 Main Street
Athol, MA 01331
Tel. (978) 249-9490

ServiceNet, Inc.: 55 Federal Street,
Greenfield, MA 01301. Chris
Neiman, Clinic Director. (413)772-
2935. Press 3 for intake.

OVERDOSE PREVENTION & NARCAN TRAINING & DISTRIBUTION SITES

Tapestry Health– Greenfield:
80 Sanderson Street, Greenfield
MA. (413)773-8888. Call to
schedule appointment.

Tapestry Health– Northampton:
16 Center Street, # 423,
Northampton, MA. (413)586-0310.
Training available on a walk in
basis, Monday through Friday, 9am
to 5pm.

DETOX PROGRAMS

Carlson Recovery Center:
471 Chestnut Street, Springfield
MA 01107. (413)733-1431 -
Main number and admissions
(after 5:00 and on weekends).
(413)733-1423 - Central Intake
(8:00-5:00 M-F). Director, Gustavo
Ramirez, (413)272-1866.

**McGee Unit of Berkshire Medical
Center:** 725 North Street,
Pittsfield, MA 01201. (413)442-
1400.

Providence Detox: 1233 Main
Street, Holyoke, MA 01201. (413)
539-2981. Central Assessment
Center- (800)274-7724.

Adcare Detox: 107 Lincoln Street,
Worcester, MA 01605. (800)345-
3552.

**Community Healthlink Recovery
Services:** Worcester, MA. (508)
860-1000.

Spectrum Detox: 154 Oak Street,
Westborough, MA 01581. (800)
366-7732.

Brattleboro Retreat: 1 Anna Marsh
Lane, Brattleboro, VT 05302.
(802) 258-3700.

PRIMARY CARE OUT- PATIENT BUPRENORPHINE TREATMENT (SUBOXONE)

Trailside Health: (413)625-6240.
Stefan Topolski

Valley Medical Group: (413)774-
6301. Meghan Gump, Janet
Grimes, Ruth Potee.

RESIDENTIAL RECOVERY PROGRAMS

**Beacon House for Men - ServiceNet
(Men)** Contact: Wayne Degrenier. 57
Beacon Street, Greenfield, MA
01301. Tel: (413)773-1706, TTY:
(413)773-3274

**Beacon House for Women -
ServiceNet (Women)** Contact:
Samantha Purinton. 53 Beacon
Street, Greenfield, MA 01301
Tel: (413)773-1705, TTY: (413)773-
3171

**Orange Recovery House -
ServiceNet (Men)** Contact: Mike
Wing. 35 Congress Street, Orange,
MA 01364. Tel: (978)544-6507

**Watershed Recovery Home
(Women)** Contact: Dorrie Christman.
148 Montague City Road,
Greenfield, MA 01301. Tel: (413)
512-5018

Hairston House-Gandara (Men)
Contact: Daniel McCarthy. 25
Graves Avenue, Northampton, MA
01060. Tel: (413)585-8390 TTY:
(413)585-8390

12-STEP SUPPORT PROGRAMS

**Alcoholics Anonymous Western MA
Area:** For a list of AA groups-
www.westernmassaa.org
24 hour informational help line
(413) 532-2111. Spanish only
(413)734-7500.

Narcotics Anonymous:
Info-line (866)624-3578. NA
meetings - www.newenglandna.org

FAST FACTS



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Child Behavioral Health Initiative (CBHI) and Community Mental Health Services

WHAT IS IT?

Research documents the long-term value of providing therapy during infancy and early childhood for children who have experienced trauma, toxic stress or have serious social-emotional or behavioral challenges. CBHI provides a variety of services, but only for children eligible for MassHealth insurance. There are 3 “HUB” services: outpatient therapy—home therapy and intensive care coordination. When additional support is needed to achieve specific goals, a HUB provider may refer for a Family Partner for the parent(s) or a Therapeutic Mentor for a school-aged child. Children with other insurance can be served by a private therapist or a community mental health clinic and might later be eligible for MassHealth based on their diagnosis. www.mabhaccess.com has listings of CBHI provider openings sorted by zip code.

Outpatient Therapy (CBHI HUB)

Individual and/or family therapy up to once per week, plus psychiatric care and collaboration with school, doctor etc.

In-clinic, and limited outreach to schools and homes; Mass Health may provide insurance-paid transportation

Local providers are Center for Human Development (CHD-Greenfield and Easthampton), Clinical and Support Options (CSO-Athol/Orange, Greenfield, Northampton), NE Center for Youth and Families (NCYF-Easthampton) and ServiceNet (Greenfield, Northampton)

In-Home Therapy (IHT—CBHI HUB)

Intensive family focused therapy and support for a child and family when more support needed than weekly outpatient

Two person team—Clinical and Therapeutic Training and Support Worker; psychiatric care and resource support available

Strength-based and home/community-based with collaboration offered across systems to support child and family

Intake contact numbers for outpatient and IHT:

CHD 413-512-5150 | CSO 413-774-1000

NCYF 413-529-7777 | ServiceNet 413-585-1328

Intensive Care Coordination (ICC—CBHI HUB)

Wraparound model used to coordinate services to work as a team whose members are chosen by the parents

Appropriate when needs are complex and additional parental support needed

ICC offers a peer to peer model using a Family Partner with a Care Coordinator in a team approach to meet family needs

Local provider is CSO: Athol/Orange 978-249-9490, Greenfield 413-774-1000, Northampton 413-582-0471

Support for families navigating insurance problems or applying for MassHealth

MassHealth Same Day Access:

Statewide phone number: 800-332-5545

All eligibility documentation must be provided for same day access

Address: 333 Bridge St., Springfield MA 01103

Hours: 8:45-5:00 Monday-Friday; walk-in service; no appointment necessary.

WHAT TO DO?

If eligible for CBHI, help family apply to the appropriate HUB service that provides evidence-based infant or early childhood therapy. If not CBHI eligible, refer family to an early childhood therapist covered by their insurance. Ask about provider's experience working with infants and young children. Some evidence-based treatment modalities are: Dyadic Developmental Psychotherapy, Infant–Parent Psychotherapy, Child–Parent Psychotherapy, Play Therapy for a child 2/3 years or older if caregiver is unavailable, or Attachment Self regulation and Competency therapy. If child is on MassHealth, has a HUB provider and additional support is needed, request a referral for a Family Partner and/or Therapeutic Mentor if child is old enough for individualized service.

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Community
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Finding the Right Therapy for Young Children

WHAT IS IT?

There are different types of therapy for young children. Some examples of evidence-based therapy are: Infant–Parent Psychotherapy, Child–Parent Psychotherapy, Attachment Self regulation and Competency therapy and Play therapy for a child 2/3 years or older.

Ask area mental health clinics what type of therapy they offer to young children and whether they have therapists who have experience with very young children and their families.

QUESTIONS TO ASK

when referring a young child to therapy:

Does the clinic provide trauma specific therapy?

How do they determine if a child needs trauma–informed therapy?

How do they approach therapy with children and caregivers?

Can they describe a typical course of therapy?

Can they describe elements of their treatment approach?

Is a therapist available who has training and experience working with very young children?

THINGS TO KEEP IN MIND

when referring young children to therapy:

The best therapy for young children includes the parent/primary caregiver as an active participant in the treatment. Ask how the therapy model will include and work with parents/caregivers

Children birth to five who have experienced trauma need therapy which includes strengthening their attachment to parents/caregivers and helping parents/caregivers to be responsive to the child's individual strengths and needs

WHAT TO DO?

Refer child and caregiver to effective, trauma-informed evidence-based therapy. Help them find a therapist who is covered by their insurance or offers a sliding fee scale. It is important to determine what types of therapy are provided to children birth to five years old and ask about the availability of therapists with training and experience in working with very young children and their families. An EC Mental Health Consultant can help with the referral process. See Toolkit 6-F.

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Family Centers and Coordinated Family and Community Engagement Programs (CFCE)

WHAT IS IT?

The CFCE program is administered by the MA Department of Early Education and Care (EEC). Each town is served by a local CFCE, which offers free services designed to support parents/caregivers as their infant/young child's first teacher. Services may include: educational parent-child playgroups or family centers, free parent education and support programming and online resources, optional Ages and Stages developmental screening that enables parents to learn more about their child's strengths, challenges and learning style, and assistance with referrals for high quality child care and community resources for children 0- 8.

Locating a local CFCE

Go to: www.mass.gov/eec

Click on "Find Early Education and Care Programs," then click on "Search for Coordinated Family and Community Engagement Programs (CFCE)." Type in the town you are looking for and the name of the contracted school system/agency and the name and contact information for the CFCE Coordinator will be provided.

More resources for families:
www.brainbuildinginprogress.org

CFCE Contact information for selected Hampshire County communities

Hadley, Northampton:

Northampton Schools, 413-587-1471

Amherst, Belchertown, Chesterfield, Easthampton,
Goshen, Granby, Hatfield, Pelham, South Hadley,
Southampton, Ware:

Collaborative for Educational Services, 413-586-4998 x102

Cummington:

Central Berkshire Schools, 413-684-2225 x109

CFCE Contact information for selected Franklin County and North Quabbin communities

Greenfield:

Community Action, 413-475-1546

North Quabbin:

Valuing Our Children, 978-249-8467

South County:

Frontier School District, 413-665-8928

West County:

Mohawk Trails School District, 413-625-6194

North County:

Pioneer Valley School District, 413-498-2660

Erving, Leverett, Shutesbury:

New Salem/Wendell School District, 978-544-5157

Contact information for selected Family Centers

Amherst, Easthampton, Gateway, Northampton,
South Hadley Family Centers and more listed at:
www.collaborative.org/programs/early-childhood/parent-programs/family-centers, 413-586-4998 x102

F.U.N. Center, Salasin Project (Greenfield)
www.wmtcinfo.org, 413-774-4307

Greenfield Family Center:

www.communityaction.us, 413-475-1555

Gill-Montague Family Center (Turners Falls):
www.mcsmcommunity.org, MCSM 413-863-4804

VOC Family Center (Athol)

www.valuingourchildren.org, 978-249-8467

WHAT TO DO?

Locate the local CFCE for the town in which the family resides and contact the CFCE Coordinator to learn the location and schedule for playgroups, parent education/support groups and other parent or parent-child programming. Obtain written materials for the family, if available. Talk with the family and encourage them to attend CFCE activities. Bringing along a friend or family member the first time may help the parent feel more comfortable. Also, consider a personal "warm handoff" to the Coordinator or group facilitator. Refer to *Toolkit 6-A, Successful Community Referrals* for more tips.

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Community Resources

Locating Parenting Support and Education Resources

WHAT IS IT?

At various times during the year, community agencies offer groups designed to support and/or educate parents. Most groups are time-limited and meet once per week. They typically range from a single session to twenty weekly sessions. Some target parents with specific issues, such as substance abuse, learning challenges, fathers, young parents or parents with children at a similar developmental stage. Some groups are offered free of charge to participants, but some charge fees, which are often geared to the family's ability to pay. October, November, March, April and May are the most common months for groups to be held.

Key information and questions:

Target audience, other eligibility considerations, location, schedule, start date, fee, intake process, materials for prospective parents

Is a meal, transportation or childcare provided?

Could the parent either meet the facilitator ahead of time or speak by phone to get any questions addressed?

Could a support person (friend, relative, home visitor) attend with the parent until they are comfortable going on their own?

Will the agency provide documentation of attendance if the parent(s) sign a release of information?

Agencies that have historically provided parenting groups or workshops:

Local Community and Family Engagement programs (CFCEs) and family centers, Berkshire Children and Families (Hadley), United ARC Positive Parenting Program, Montague Catholic Social Ministries, Valuing Our Children (Athol), Parent-Child Development Center of Community Action (for parents in their programs, especially Head Start and Early Head Start), the Salasin Project, Service Net REACH and other Early Intervention programs (parent-child groups for children with disabilities and peer models, Healthy Families (eligible young parents), and public schools.

Consult *Toolkit 6-M, BCF Parent Support Programs Resource Directory* for contact information for these and other family support resources. Many are also listed in local publications.

Helping parents find a parenting program that meets their needs:

If you have time, research the programs most geographically accessible to the family and ask about current or planned parenting groups. If not, provide parents with a list of agencies and websites to contact to learn about current groups.

Ask the questions listed above in “**Key information and questions**” and provide parents with a list of all possible choices, providing contact information that matches their communications options and preferences, e.g. phone, internet, in-person visit, etc.

Discuss with parents possible barriers to their participation: transportation, child care needs, work schedules, discomfort with groups or meeting strangers, etc. Get creative and problem-solve with them about how they can overcome these barriers.

WHAT TO DO?

It's great if you can do the research yourself before meeting with the family about their options, but if you can't, you might be able to find someone else who can work with the family on locating parent education or support resources. Possibilities include a Home Visitor if there is one working with the family, the local Librarian or the local CFCE or Family Center Coordinator, if there is a child age 8 or younger in the family. Consult *Toolkit 6-J, Family Centers and CFCEs* and *6-L, Resources and Programming at Local Public Libraries* for details.

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Community Resources

Resources and Programming at Local Public Libraries

WHAT IS IT?

Families may not know that local libraries aren't just about books anymore. They are a valuable and free resource for early literacy support for young children and their parents/caregivers. Most libraries provide free early childhood programming that often includes weekly story hours, craft activities, clubs for children of various ages and special programming for families with children, such as science shows, music performances or live demonstrations by children's book illustrators. Families can borrow early learning kits at many libraries that include books and related toys; also a wide range of music and entertainment CDs.

Locating a local public library

Go to: www.publiclibraries.com/massachusetts.htm

Library information is listed alphabetically by town. There are links to many local library websites.

**More resources for families, including
Places to Go and Things to Do:**
www.brainbuildinginprogress.org

More information about local library resources

Families aren't limited to using the library in the town where they reside; their local library card can be used at a wide range of libraries in the area.

Pre-registration is not needed for most story hours, and is also rarely required for special programming for children and families.

Some libraries no longer charge fines for books returned late if they're borrowed from their own collection. Fines are more common for CDs and materials ordered from another library.

WHAT TO DO?

Locate the local libraries near the town in which the family resides and use the website or have a conversation with the Children's Librarian to learn the schedule for programming geared to young children and their families. Talk with the family and encourage them to attend library activities at any library that is conveniently located for them. Bringing a friend or family member the first time may help the parent feel more comfortable. Also, consider a personal "warm handoff" to the Children's Librarian; if there is a home visitor working with the family, they may be willing to take this on. Refer to *Toolkit 6-A, Successful Community Referrals* for more tips.

Other services that may be available at a local library

Many libraries provide specialized services for disabled people that may include home delivery of library materials, books on tape, closed captioned media materials, materials in braille, etc.

Libraries may host locally accessible English as a Second Language and related programs for immigrant families and other non-native English speakers.

Tips for encouraging families to use local libraries

Applying for a library card is easy and free.

Children who learn to love books and learning early in life do better in school.

Children who are read to daily enter school with bigger vocabularies than their peers and this is proven to pave the way for success in school and in life.

Most libraries are open and have activities at convenient hours for working families—on weekends and in the early evenings.

Berkshire Children and Families

Parent Support Programs | 2014 Resource Directory

* Statewide resource website: <http://www.massresources.org/>

** For resources in the North Quabbin area: www.nqcc.org/resource.html

Childcare

New England Farm Workers	Franklin & Hampshire County and N. Quabbin 21 Mohawk Trail, Unit 4 Greenfield, MA customizable searches for daycare provided	413-475-3152 www.partnersforcommunity.org/default/index.cfm/voucher-day-care
MA Dept. of Early Education and Care (EEC) Resources to support parents as their child's first teacher and to locate high quality child care/early education programs	Search for licensed childcare programs and providers by zip code or town Listings of Coordinated Family and Community Engagement (CFCE) programs by community (local playgroups and parent education programs, resources and referrals)	www.eec.state.ma.us

Disability Services

Community Resources for People with Autism Easthampton	Information, advocacy, training, support groups and education, and family support for People with Autism	412-529-2428 www.theassociationinc.org
Family Ties of MA	Resource & Referral for families of children and youth with special needs, support groups	1-800-905-TIES (8437) www.massfamilyties.org
Disability Law Center	Provides protection and advocacy for the rights of residents with disabilities.	413-584-6337 www.dlc-ma.org
NAMI - National Alliance for the Mentally Ill	Education, advocacy and support group programs.	413-786-9139 www.namiwm.org
Stavros, Inc.	Programs and services designed to meet the needs of persons of any age or disability. Varied services; housing help, educational, transitional aid	800-804-1899 www.stavros.org
The United Arc	Services for individuals with developmental and intellectual disabilities and their families. Offers many support services and socialization opportunities	413 774-5558 www.unitedarc.org

Source: Berkshire Children and Families

Berkshire Children and Families | 2014 Resource Directory (2)

Domestic Violence Resources

NELCWIT - New England Learning Center for Women in Transition	Domestic Violence Hotline and Related Services Greenfield, MA Serves Franklin County	888-249-0808 24 Hours www.nelcwit.org
Center for Women and Community New Africa House, UMass, Amherst	Services for Survivors of Sexual Assault and Battering Walk-in Hours: Monday-Friday, 9 am to 4	413-545-0800 24-Hour 888-337-0800 24 Hour Long Distance www.umass.edu/ewc
Moving Forward Program of ServiceNet, certified batterer's intervention program	Groups held in communities throughout Western MA	413-587-9050 www.servicenet.org/content/moving-forward-programs
Department of Transitional Assistance (DTA) Domestic Violence Unit	Safety assessment Resource referrals	Greenfield (413) 772-3400 Springfield (413) 858-1300 Holyoke (413) 552-5400
SafeLink	Statewide Domestic Violence Hotline. Safe houses, support programs, legal help	877-785-2020 24 Hour www.casamyrna.org
SafePlan / Court Advocacy	MA Office of Victim Assistance: Northampton, Belchertown	413-732-3121 www.mass.gov/mova/safeplan
Safe Passage	Shelter, Counseling, Support Groups King St., Northampton Serves Hampshire County	413-586-5066 24 Hour Hotline 888-345-5282 24 Hour Free 413-586-1125 Office www.safepass.org

Early Intervention Programs & Special Services for Infants/Toddlers

The REACH Early Intervention Program of ServiceNet	Hampshire and Franklin counties and N. Quabbin area 108 Main St., Unit A Sunderland, MA 01375 Birth to 3; have or at risk for developmental delays; Autism specialty	413-665-8717 413-665-9383 (fax) www.servicenet.org/node/76
Criterion Heritage Early Intervention Program	30 Old Lyman St. South Hadley, MA Developmentally appropriate programs, developmental enrichment groups, early intervention (Belchertown, Granby, Southampton, S. Hadley, Ware)	413-533-7140 www.criterionchild.com
The May Center - Bilingual Early Intervention Services	1111 Elm St. Ste. 2 West Springfield, MA Autism, developmental delays, brain injury, behavioral health services, including Autism schools. Early intervention, bilingual, OT, PT, community playgroups	781-734-0300 www.mayinstitute.org

Source: Berkshire Children and Families

Berkshire Children and Families | 2014 Resource Directory (3)

Early Intervention Programs & Special Services for Infants/Toddlers (continued)

Clarke Schools for Hearing and Speech	Round Hill Rd. Northampton, MA Early intervention for hearing and speech; social programs; summer programs	413-584-3450 www.clarkeschool.org
Willie Ross School for the Deaf Early Intervention Services	32 Norway St. Longmeadow, MA Sign language classes	413-567-0374 www.WillieRossSchool.org

Emergency Resources

Baby Safe Haven	Crisis Counseling; confidential hotline	888-510-BABY (2229)
Crisis Services CSO	Franklin County 140 High St., Greenfield	413-774-5411 or 800-562-0112 24 Hours
Crisis Services CSO	Hampshire County 29 North Main St., Florence	413-586-5555 or 800-322-0424 24 Hours
DCF: Department of Children and Families Hotline	Ages: Birth to 22 To report abuse/neglect	800-792-5905 Days 800-792-5200 24 Hours
DCF: Regional Office	Springfield 140 High St.	413-452-3350
DCF: Franklin/Hampshire	Greenfield 143 Munson St. Unit 4	413-775-5000
DPPC: Disabled Person's Protection Commission	Ages 18 – 59 Reporting abuse	800-426-9009 24 Hours
Elder Abuse Hotline	Trained counselors Reporting abuse	800-922-2275 24 Hours
Eldercare Locator US Administration on Aging	Connect with services for older adults/families	800-677-1116 9am-8pm
Attorney General's Elder Hotline	Information about Elder related issues/programs in MA. Resource and referral for full range of concerns.	888-AG-ELDER (243-5337)
Parental Stress Line	Trained counselors	800-632-8188 24 Hours
National Domestic Violence	Hotline	800-799-SAFE (7233) 24 Hours
Sexual Assault Hotline	Hotline	800-656-HOPE (4673) 24 Hours

Source: Berkshire Children and Families

Berkshire Children and Families | 2014 Resource Directory (4)

Family Centers

Amherst Family Center	Unitarian Universalist Meeting House rear entrance 121 N. Pleasant St. Amherst Go to website for schedule	413-256-1145 www.umass.edu/ofr/familycenter.php
Belchertown Family Center	720 Franklin St. Belchertown, MA	413-283-7594 www.belchertownfamilycenter.org
Easthampton Family Center	The Flywheel Collective 43 Main St. Easthampton, MA	413-634-5362 www.easthamptonfamilycenter.org
F.U.N. Center	Salasin Project 474 Main St. Greenfield, MA	413-774-4307 www.wmtcinfo.org
Gateway Family Center	Hilltown Social Services Building 9 Russell Rd. Huntington, MA Excellent selection of free services to strengthen parents and families	413-667-2203 http://www.hchcweb.org/Community_Programs.html
Gill-Montague Family Center	Montague Catholic Social Ministries 78 Avenue A Turners Falls, MA	413-863-4804 www.mcsmcommunity.org
Greenfield Family Center	Community Action 90 Federal St. Greenfield, MA	413-475-1555 www.communityaction.us
Hatfield Playgroup	First Congregational Church - use side door 41 Main St. Hatfield, MA	Contact Carolyn Mazel: 586-4998 x102 www.collaborative.org/programs/early-childhood
Northampton Parents Center	Edwards Church - lower level 297 Main St. Northampton, MA Summer park play groups and school year pre-school program	413-582-2636 www.northamptonparentcenter.org
South Hadley Family Center	All Saints Episcopal Church - rear entrance 7 Woodbridge St. South	413-533-7096 www.shfamilycenter.org
Ware Parent Center	2nd floor-United Church of Ware, 49 Church	413-967-8127 www.warefamilycenter.org
VOC Family Center	Valuing Our Children 217 Walnut St. Athol, MA	978-249-8467 www.valuingourchildren.org
Collaborative for Educational Services	Complete listing of parent centers/play groups and schedules	www.collaborative.org/programs/early-childhood/parent-programs/family-centers

Source: Berkshire Children and Families

Berkshire Children and Families | 2014 Resource Directory (5)

Food, Clothing, Finances

Amherst Survival Center	138 Sunderland Rd. Amherst Food, clothing, health care, community activities.	413-549-3968 amherstsurvival.org/
Community Action Resources for Basic Needs	Assistance with Heat/Utilities shut-off, food/grocery, housing court, foreclosure prevention, access to health care.	413 582-4237 (Hampshire County) 413-475-1570 (Franklin County) 978-544-8091 (North Quabbin) 413-96794920 (Ware) www.communityaction.us/resources-for-basic-needs.html
Council of Churches Western Mass	Main Office: 39 Oakland St. Springfield, MA	413-733-2149 www.councilofchurcheswm.org/
Department of Transitional Assistance (DTA)	Hampshire County 100 Front St. #3 Holyoke, MA	413-552-5400 www.mass.gov/eohhs/gov/departments/dta/
Easthampton Community Center	12 Clark St. Easthampton Food/Clothing	413-527-5240 www.easthamptoncommunitycenter.org/
Fuel Assistance Community Action	377 Main St. Greenfield, MA Home Energy Assistance: fuel, repairs, efficiency, weatherization	413-774-2310 800-370-0940 http://www.communityaction.us/fuel-assistance.html
Northampton Survival Center	265 Prospect St. Northampton, MA Food/clothing	413-586-6564 http://northampton-survival.org/
Not Bread Alone - Center for Human Development	First Congregational Church 165 Main St. Amherst, MA Soup kitchen	413-548-1271 www.chd.org/index.php/not-bread-alone.html
Food Bank of Western Mass	97 N. Hatfield Rd. Hatfield Food distribution, SNAP outreach and enrollment	413-582-4237 www.foodbankwma.org/
SNAP: Food Stamps	Online screening for benefits	https://service.hhs.state.ma.us/ierhome/LandingPage.do?method=displayConsumerHomePage&pageSwitch=HOME
Women Infant Children WIC (Community Action)	393 Main St., Greenfield Nutrition Program with healthy food supplementation – serves Hampshire and Franklin counties and North Quabbin	413-376-1160 800-WIC-1007

Berkshire Children and Families | 2014 Resource Directory (6)

Health Care Resources

Amherst Survival Center Medical Clinic	138 Sunderland Road Monday 12:30 - 1:30 Thursday 5 - 6	413-549-3968 amherstsurgical.org/
College Church Clinic Walk in Medical Clinic	58 Pomeroy Terrace, Northampton Tuesdays, 7:00-8:30 Director: Dr. Don Lundgren	413-584-3480 www.thecollegechurch.org/index.php/love-our-neighbors/healthcare-project
Hampshire HealthConnect (Partnership with Cooley Dickinson Hospital)	30 Locust St., Northampton / Bangs Community Center 70 Boltwood Walk, Amherst Help accessing health coverage and care	413-582-2848 www.cooley-dickinson.org/main/hampshire-health-connect.aspx email address: hhc@cooley-dickinson.org
Healthy Start MassHealth	Health insurance program for pregnant uninsured, low-income women (at or below 200% fed poverty guidelines).	800-841-2900 www.mass.gov/eohhs/consumer/insurance/more-programs/healthy-start.html
Holyoke Health Center	230 Maple Street	413-420-2200 http://www.hhcinc.org/en/
Huntington Health Center	73 Russell Road	413-667-3009 http://www.hchcweb.org/
MassHealth		888-665-9993 Enrollment 800-841-2900 Customer Service www.mass.gov/eohhs/gov/departments/masshealth
Tapestry Health Serves low-income/ marginalized populations	For all regional location addresses see: www.tapestryhealth.org/index.php/contact/locations Regional services: Family Planning, Reproductive Health, Infections, AIDS testing and counseling, needle exchange, help with insurance enrollment, WIC enrollment	413-586-2539 Northampton 413-548-9992 Amherst www.tapestryhealth.org
Worthington Health Center	58 Old North Road	413-238-5358 http://www.hchcweb.org/

Source: Berkshire Children and Families

Berkshire Children and Families | 2014 Resource Directory (7)

Dental

MassHealth Dental Directory	www.masshealth-dental.net	1-800-841-2900
Community Health Center of Franklin County	338 Montague City Road Turners Falls	413-774-2615 www.chcfc.org
Hampshire Family Dental	12 Center St. Northampton, MA	413-585-5880 www.hampshirefamilydentallc.com
Holyoke Health Center	230 Maple Street	413-420-2200 http://www.hhcinc.org/en/
Huntington Health Center	73 Russell Road	413-667-3009 http://www.hchcweb.org/
Kool Smiles	217 South St. Holyoke, MA	413-315-4984 www.mykoolsmiles.com
Small Smiles	2285 Northampton St. Holyoke, MA	413-534-8700 www.smallsmiles.com
Worthington Health Center	58 Old North Road	413-238-5358 http://www.hchcweb.org/

Housing and Homelessness Resources

Craig's Doors (for single people) Open Nov. 1 through April 30	Amherst 256 North Pleasant Street, Suite 4A Amherst	413-437-0776 www.craigdoors.org
Housing Authorities	Subsidized housing	Amherst 413-256-0206 Greenfield 413-774-2932 Northampton 413-584-4030 Ware 413-967-4477
HAPHousing	Housing assistance and education	413-233-1500 / 800-332-9667
Jessie's House Through Center for Human Development (only family shelter in Hampshire county)	17 Seelye St. Amherst	413-658-0060 www.chd.org/index.php/jessies-house
Grace House Through Center for Human Development	Family recovery program for woman who are recovering from a substance addiction with their young children (up to 10). Licensed recovery program with intensive intervention, clinical support, life skills development, child care and case management services.	413-586-8213 www.chd.org/index.php/grace-house
Greenfield Family Inn (Service Net)	128 Federal Street Greenfield, MA Family homeless shelter	413-774-6382 http://www.servicenet.org/content/franklin-county-shelters
Grove Street Inn Shelter through ServiceNet	91 Grove St. Northampton Adults only, up to three months, work on employment, housing, connect to resources	413-586-6001 / 413-585-1389 www.servicenet.org/content/grove-street-inn

Source: Berkshire Children and Families

Berkshire Children and Families | 2014 Resource Directory (8)

Housing and Homelessness Resources (continued)

Interfaith Emergency Shelter (overnight shelter only) November thru April	43 Center Street Northampton	413-585-1300
Silver Street Inn (ServiceNet)	219 Silver Street, Greenfield Transitional housing program providing long-term supported housing for individuals while they regain economic and housing stability	413-774-6382 http://www.servicenet.org/content/franklin-county-shelters
Shelter Listings	Lists of various shelters by area	www.shelterlistings.org
Wells Street Shelter (ServiceNet)	60 Wells St., Greenfield Year-round, overnight shelter for homeless adults	413-774-6382 http://www.servicenet.org/content/franklin-county-shelters

Mental Health/Therapy

Baystate Family Advocacy Center	50 Maple Street, Springfield, MA The Baystate Family Advocacy Center (BFAC) of Baystate Health is a nationally accredited Child Advocacy Center (CAC) serving the children, families and communities of Western Massachusetts affected by child abuse, domestic violence and/or homicide.	Intake: 413-794-5555 Information: 413-794-9816 http://www.baystatehealth.org/Baystate/fac
Children's Advocacy Center Northwestern District Attorney's Office	Serves Hampshire and Franklin counties and North Quabbin – forensic interviews, medical exams, therapeutic interventions and referrals, victim support, for physically or sexually abused children	P.O. Box 1247 Easthampton, MA 01027 413-586-9225 Hampshire 413-774-3186 Franklin and North Quabbin www.northwesterncac.org email address: NWCAPinfo@gmail.com
The Carson Center for Human Services	96 South St. Ware, MA Behavioral health and rehabilitation services for all ages, CBHI services	413-967-6241 www.carsoncenter.org
Center for Human Development	179 Northampton St. Easthampton, MA Variety of services, including mental health, CBHI services	413-529-1764 www.chd.org
The Children's Clinic	17 Brewster Court Northampton, MA Outpatient and residential programs for children, specializing in trauma recovery, with variety of methodologies	(413) 587-3265 cutchins.org
Clinical & Support Options Serves Hampshire and Franklin counties and North Quabbin	Outpatient mental health, family support, substance abuse, CBHI services	413-582-0471 Hampshire 413-774-1000 Franklin 978-249-9490 North Quabbin www.csoinc.org
Valley Medical Group	Full range of outpatient behavioral health treatment including psychiatry	Amherst (413) 256-8561 Easthampton (413) 529-9300 Greenfield (413) 774-6301 Northampton (413) 586-8400 www.vmgma.com

Source: Berkshire Children and Families

Berkshire Children and Families | 2014 Resource Directory (9)

Mental Health Therapy (continued)

ServiceNet	50 Pleasant Street, Northamp 400 Amity St, Amherst 55 Federal St., Greenfield clinical, residential, rehabilitative, recovery and support services, CBHI services	413-584-6855 413-549-0095 413-772-2935 www.servicenet.org
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Parent Support/Home Visiting

Parent Aide Volunteer Effort (PAVE) at Berkshire Children and Families serving Hampshire County	220 Russell St. Hadley, MA	413-584-5690 www.berkshirechildren.org/bcf_parenting
Healthy Families through Community Action	Hampshire and Franklin Counties and N. Quabbin program first time parents under 21 who are pregnant or have a child under 1	413-387-1270 Hampshire County 413-475-1545 Franklin County 978-544-5423 North Quabbin www.communityaction.us/healthy-families-support-for-parents-under-21
Family Life Support Program Serves families of Franklin Co. with weekly home visits, on an as-needed basis	Montague Catholic Social Ministries 78 Avenue A Turners Falls, MA	413-863-4804 www.mcsmcommunity.org
Family Outreach of Amherst through CHD	401 Main St. Amherst, MA Crisis intervention, case management, family advocacy	413-549-5548 www.chd.org/index.php/family-outreach-of-amherst
Intensive Care Coordination at CSO for Hampshire County	8 Atwood Drive, Suite 201 Northampton / 1 Arch Place Greenfield for children with significant mental health needs - MassHealth required	413-582-0471 / 413-774-1000 www.csoinc.org/intensive-care-coordination
Parent-Child Home Program (PCHP) Through the Collaborative for Educational Services	Home visiting, early learning and literacy program for parents of children 16 months to 3 years in Amherst, Belchertown, Easthampton, South Hadley, Ware.	Contact: Lin Notzelman at lnotzelman@collaborative.org or 413-967-8127 800-519-1882 ext.102. collaborative.org/early-childhood
The Parent-Child Home Program	Bridge Street School 2 Parson St., Northampton / 90 Federal St. Greenfield, MA Literacy, parenting, school readiness, home visiting program	413- 587-1417 Contact: dhaughton@northampton-k12.ma.us 413-475-1553 Contact: rcraig@communityaction.us www.parent-child.org
The United Arc Program	294 Avenue A Turners Falls For developmentally or intellectually disabled people of all ages. Offering case management, parenting groups, family support centers	413-774-5558 / 413-774-2105 (family support office) www.unitedarc.org

Source: Berkshire Children and Families

Berkshire Children and Families | 2014 Resource Directory (10)

Parent Support/Home Visiting

MotherWoman	220 Russell St. Ste. 200 Hadley, MA postpartum support groups mothers support groups	413-587-0703 www.motherwoman.org
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Recovery Services and Supports

Alcoholics Anonymous	Listing of Western MA AA groups and meetings	413-532-2111 www.westernmassaa.org
Al-Anon and Alateen	Program of recovery to help families and friends of alcoholics	413-782-3406 www.ma-al-anon-alateen.org/onlinemt看g.php
Gambler's Anonymous	Massachusetts hotline	855-222-5542 www.gamblersanonymous.org
CODA: Co-Dependents Anonymous	Western MA meetings	978-952-6510 www.necoda.org/contact.htm
Mount Tom Center for Mental Health and Recovery Behavioral Health Network (BHN) Holyoke	Outpatient mental health and substance abuse program providing services in the following areas: child and adolescent, adult, developmentally delayed/mental health, substance abuse and dual diagnosis (SA/MI).	413-536-5473 bhninc.org/content/mt-tom-center-mental-health-recovery
VA Substance Use Disorders Clinic	421 North Main Street, Leeds Variety of substance abuse treatment options for veterans	413-584-4040 SUD Clinic x2603 www.mentalhealth.va.gov/res-vatreatmentprograms
Grace House Through Center for Human Development	Family recovery program for woman who are recovering from a substance addiction while reuniting with their young children. Licensed recovery program with intensive intervention, clinical support, life skills development, child care and case management services.	413-586-8213 www.chd.org/index.php/grace-house
Valley Medical	Amherst: 31 Hall Drive Easthampton: 238 Northampton St. Greenfield: 239 Conway St Northampton: 70 Main St Full range of medical, mental health, substance abuse services.	Amherst: 413-256-8561 Easthampton: 413-529-9300 Greenfield: 413-774-6301 Northampton: 413-586-8400 www.vmgma.com
Holyoke Hospital Center for Behavioral Health	Inpatient, Outpatient Partial Hospitalization & Intensive Outpatient Program for acute mental health, with co-occurring substance abuse or psychiatric disorders	Outpatient Service 413-534-2698 Partial Hospitalization & Intensive Outpatient Program 413-534-2627 www.holyokehealth.com/programs.aspx?id=302
Behavioral Health Network (BHN) Springfield	Detoxification Services Post Detox Residential Long-Term Residential Day Treatment Program Outpatient Services	Opportunity House - Men 413-739-4733 bhninc.org/content/opportunity-house My Sister's House - Women 413-733-7891

Source: Berkshire Children and Families

Recovery Services and Supports (continued)

		bhninc.org/content/my-sisters-house Crisis Services 413-536-2251 bhninc.org/content/emergency-services
Baystate Health Behavioral Health Services Springfield / Greenfield	Short-term intensive psychiatric services for patients ages 18 and older in need of crisis intervention and stabilization.	Springfield: 413-794-5555 Greenfield: 413-773-4444 baystatehealth.com/Baystate/Main+Nav/Clinical+Services/Departments/Behavioral+Health+Services/Adult+Partial+Hospitalization+Service
ServiceNet Amherst Holyoke Greenfield Northampton Orange	Recovery homes and supportive housing services Outpatient Mental Health and Substance Abuse Services	Beacon House for Women 413-773-1705 Beacon House for Men 413-773-1706 www.servicenet.org/content/recovery-homes Outpatient Mental Health and Substance Abuse Services: 877-984-6855 www.servicenet.org/content/outpatient-mental-health-and-substance-abuse-services
Mercy Medical Center: Providence Behavioral Health Program Holyoke	1233 Main St, Holyoke Intensive Inpatient and Outpatient Substance Abuse Programs Methadone Maintenance Treatment Program	General Phone Number 413-536-5111 Clinical Assessment Center 800-274-7724 www.mercycares.com/pages.asp?id=514

Transportation

PVTA	Bus service	413-586-5806 www.pvta.com for schedules and fares
PVTA mobility impaired services	ADA program	ADA coordinator for eligibility (800) 752-1638 x 214 www.pvta.com/media/pdfs/ParatransitGuide.pdf
PT 1 Mass Health	Provides transportation with a medical prescription	800-841-2900 About: www.massresources.org/masshealth-transportation To apply: www.mass.gov/eohhs/gov/newsroom/masshealth/providers/how-to-complete-and-submit-the-pt-1-online

Berkshire Children and Families | 2014 Resource Directory (12)

Training and Education

The Literacy Project	Classes in adult literacy and GED preparation and transitions programs to help students pursue college, vocational training and work. Must be 16 or older and not currently enrolled in school.	Amherst: 413-259-1663 Greenfield: 413-774-3946 Northampton: 413-584-6755 Ware: 413-967-9903 www.literacyproject.org
Franklin Hampshire Career Center	Job search assistance, resumes, cover letters, access to resources including PCs and reference materials, interviewing skills, workshops, coaching	Northampton: 413-586-6506 Greenfield: 413-774-4361 Toll free: 800-457-2603 www.fhcc-onestop.com
Greenfield Community College	Education and training	413-775-1801 www.gcc.mass.edu
Holyoke Community College	Training, education and GED services	413-538-7000 www.hcc.edu
Mass Rehab	Holyoke: 187 High St Greenfield: 238 Main St Assistance for individuals of all disabilities to go to work	Holyoke: 413-536-8200 Greenfield: 413-774-2326 www.mass.gov/eohhs/gov/departments/mrc
Casa Latina	140 Pine Street, Florence Assist Latino families with finding support and services including health care, housing, employment, adult ed, child care resources, legal, transportation, public assistance, violence support, immigration.	413-586-1569 www.casalatinainc.org
Center for New Americans	Free English instruction, citizenship, career development.	Northampton: 413-587-0084 Amherst: 413-259-3288 Greenfield 413-772-0055 centerfornewamericans.weebly.com
The Jones Library ESL Center	English language tutoring	413-259-3093 www.joneslibrary.org/esl/index.html esl@joneslibrary.org

Source: Berkshire Children and Families

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This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Materials to Share with Parents

- 7-A Child Development Handouts
- 7-B High Quality Learning: Importance and Access
- 7-C Choosing High Quality Child Care in Massachusetts
- 7-D Building a Social-Emotional Foundation
- 7-E Brain Development Basics
- 7-F Flash Cards to Prepare for Pediatrician Conversations
- 7-G Infant-Toddler Temperament Tool
- 7-H Helping Young Children Identify their Feelings
- 7-I Teaching Your Child to Identify and Express Emotions
- 7-J Requesting a Public School Evaluation:
Sample Letter and Tips for Parents
- 7-K Ways Adults can Support Children's Language and Reading
- 7-L Books to Help Young Children Make Sense of Their World
- 7-M You Are Not Alone: Guide to the DCF System in MA

CHILD WELFARE TOOLKIT

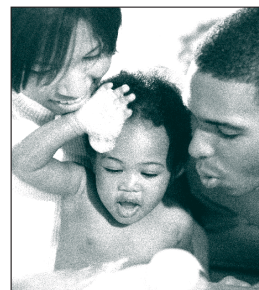



FOR EARLY CHILDHOOD PROFESSIONALS



Everyday Ways to Support Your Baby's and Toddler's Early Learning

Your baby is learning—about you, himself, and the world around him—from the moment he enters the world. The chart below gives you some ideas of the many ways you can support your child's early learning through your everyday activities.



What's Going On With Your Baby or Toddler	What You Can Do
Language and Communication Babies express their needs and feelings through sounds and cries, body movements, and facial expressions. Your baby will begin using words sometime around 1 year. By the time she is 3, she will be speaking in short (3-5 word) sentences.	<ul style="list-style-type: none"> • Watch and listen to see how your baby communicates what she is thinking and feeling. • Repeat the sounds and words your child uses and have back-and-forth conversations. • Read, sing, and tell stories. These are fun ways to help your child understand the meaning of new words and ideas. • Talk about what you do together—as you play, do errands, or visit friends and family.
Thinking Skills Your child is learning how the world works by playing and exploring. Through play, babies and toddlers learn about how things work and how to be good problem-solvers.	 <ul style="list-style-type: none"> • Encourage your child to explore toys in different ways—by touching, banging, stacking, shaking. • Turn everyday routines into playful learning moments. For example bath time is a chance to learn about ideas like <i>sinking/floating</i> and <i>wet/dry</i>. • Follow your child's interests. Children learn best through activities that excite them. • Ask your child questions that get him thinking as he nears age 3. For example, when reading a book together, ask <i>Why do you think the girl is laughing?</i>
Self-Control Over the first 3 years, your child is beginning to develop self-control—the ability to manage his feelings and actions in acceptable ways. He is also learning to wait, share, and work out problems with his friends.	<ul style="list-style-type: none"> • Use words to help your child understand his feelings. <i>You are really mad because we have to leave the park.</i> • Give choices to older toddlers. <i>Would you like to read books before or after we brush teeth?</i> • Stay calm when your child is upset. This helps him feel safe and get back in control.
Self-Confidence Your child is learning that she is a very special person; that she is loved, smart, fun, and capable. When children feel good about themselves, they are more confident and willing to take on new challenges.	<ul style="list-style-type: none"> • Comment on what your child does well. <i>You found the button that makes the bear pop up!</i> • Help your child be a good problem-solver. Give her the support she needs to be successful without completely solving the problem for her. • Give your child the chance to do things for herself like pouring milk from a small plastic pitcher. • Encourage your child to keep trying. <i>You are working so hard to get the ball in the basket. Sometimes it takes lots of tries!</i>

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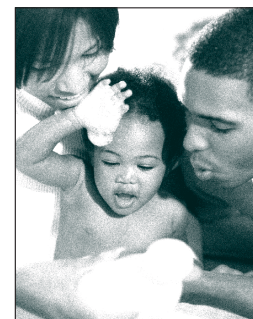



Visit www.zerotothree.org/schoolreadiness for more information on early learning and healthy development.

This handout was developed by ZERO TO THREE and made possible by the generous support of **MetLife Foundation**

Formas cotidianas de apoyar el Aprendizaje Temprano de su bebé y niño pequeño

Su bebé aprende—acerca de usted, de sí mismo, y del mundo que lo rodea—desde el momento que llega al mundo.. El cuadro a continuación le da algunas ideas de las muchas maneras en que usted puede apoyar el aprendizaje temprano de su hijo a través de actividades cotidianas.



Lo que está ocurriendo con su bebé o niño pequeño	Lo que usted puede hacer
Lenguaje y Comunicación Los bebés expresan sus necesidades y sentimientos a través de sonidos y llantos, movimientos corporales, y expresiones faciales. Su bebé comenzará a usar palabras alrededor del primer año. Para cuando ella tenga 3 años, estará hablando en oraciones cortas (de 3 a 5 palabras).	<ul style="list-style-type: none"> • Observe y escuche para ver cómo su bebé comunica lo que piensa y siente. • Repita los sonidos y palabras que su hijo utiliza y sostenga conversaciones con él. • Lea, cante, y cuente cuentos. Estas son maneras divertidas de ayudar a su hijo a entender el significado de palabras e ideas nuevas. • Hable acerca de lo que hacen juntos—mientras juegan, hacen mandados, o visitan amigos y familiares.
Habilidades de Pensamiento Mientras él juega y explora, su hijo aprende cómo el mundo funciona. A través del juego, los bebés y niños pequeños aprenden cómo funcionan las cosas y cómo encontrar solución a los problemas.	 <ul style="list-style-type: none"> • Anime a su hijo a explorar los juguetes en maneras diferentes—tocándolos, batiéndolos, apilándolos, sacudiéndolos. • Convierta las rutinas diarias en momentos de aprendizaje divertido. Por ejemplo, la hora del baño es una oportunidad para aprender acerca de ideas como <i>hundir/flotar</i> y <i>mojado/seco</i>. • Siga los intereses de su hijo. Los niños aprenden mejor a través de actividades que los entusiasman. • A medida que su hijo se aproxima a los 3 años, hágale preguntas que lo hagan pensar. Por ejemplo, cuando lean un libro juntos, pregúntele ¿Por qué crees que se está riendo la niña?
Auto Control Durante sus primeros 3 años, su hijo está comenzando a desarrollar su auto-control — la habilidad de manejar sus sentimientos y acciones en formas aceptables. Él también está aprendiendo a esperar, compartir, y resolver problemas con sus amigos.	<ul style="list-style-type: none"> • Use palabras para ayudar a su hijo a entender sus sentimientos. <i>Estás enojado porque tenemos que irnos del parque.</i> • De opciones a los niños más grandecitos. <i>¿Prefieres leer antes o después de cepillarnos los dientes?</i> • Mantenga la calma cuando su hijo esté molesto. Esto lo ayuda a sentirse seguro y a retomar el control.
Auto Confianza Su hija está aprendiendo que ella es una persona muy especial; que es amada, inteligente, divertida y capaz. Cuando los niños se sienten bien acerca de sí mismos, son más seguros de sí mismos y están más dispuestos a enfrentar nuevos desafíos.	<ul style="list-style-type: none"> • Comente sobre lo que su hija hace bien. <i>¡Presionaste el botón que hace que tu oso favorito aparezca!</i> • Ayude a su hija solucionar sus problemas. Déle el apoyo que necesita para tener éxito sin resolverle todos los problemas. • Déle a su hija la oportunidad de hacer las cosas por sí misma como servirse la leche de una jarrita plástica. • Anime a su hija a continuar intentando. <i>Estás esforzándote tanto por poner la pelota en la cesta. ¡A veces toma muchos intentos!</i>

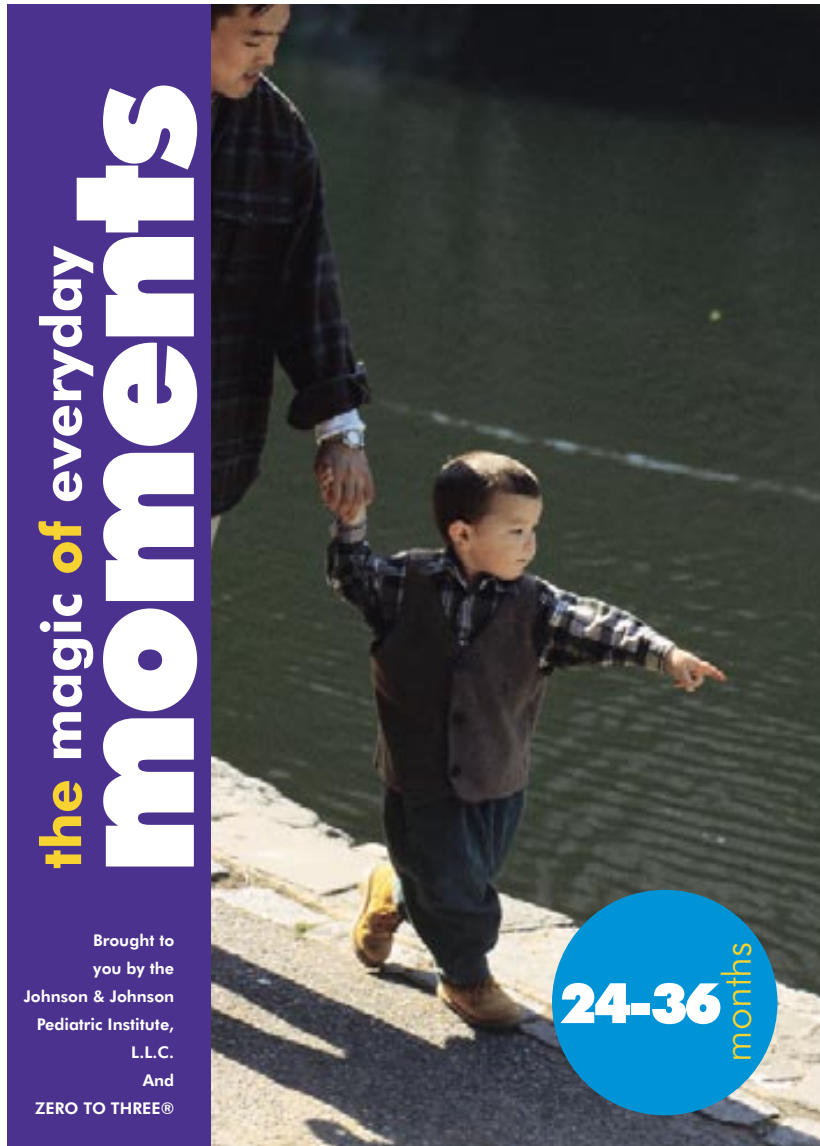
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Para mayor información acerca de aprendizaje temprano y desarrollo saludable, visite www.zerotothree.org/schoolreadiness.

Este folleto fue elaborado por ZERO TO THREE y ha sido posible gracias a la generosidad de **MetLife Foundation**

The Magic of Everyday Moments | 24-36 Months (1)



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Additional booklets in this series are available in both English and Spanish, and may be downloaded online at:
www.zerotothree.org/child-development/early-development/magic-of-everyday-moments.html

The Magic of Everyday Moments™: 0-4 Months

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The Magic of Everyday Moments™ campaign is an initiative between ZERO TO THREE and the Johnson & Johnson Pediatric Institute, L.L.C.



ZERO TO THREE is a national nonprofit organization of renowned pediatricians, educators, researchers, and other child development experts who specialize in the first years of life.



Johnson & Johnson Pediatric Institute, L.L.C., is a company solely dedicated to improving maternal and children's healthcare through the advancement of continued learning and research in pediatrics, child development, parenting and maternity care. Through partnerships with leading healthcare professionals, developmental specialists and inter-national organizations, **Johnson & Johnson Pediatric Institute, L.L.C.**, identifies, develops and implements initiatives and programs that help shape the future of children's health around the world.

Endorsed by
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of Pediatrics**



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Additional booklets in this series are available in both English and Spanish, and may be downloaded online at:
www.zerotothree.org/child-development/early-development/magic-of-everyday-moments.html

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ZERO TO THREE also acknowledges our partner, the **Johnson & Johnson Pediatric Institute, L.L.C.** which, through its educational efforts, is shaping the future of children's health around the world.

The Magic of Everyday Moments

Loving and Learning Through Daily Activities

If you are like most parents today, your greatest challenge is probably caring for your child while also taking care of yourself and your responsibilities. The competing demands on your time and energy make finding the time to connect with your child no small challenge. But daily activities, such as getting dressed and doing household chores and errands don't need to take time away from bonding with and enjoying your child. In fact, these everyday moments are rich opportunities to encourage your child's development by building her: **self-confidence; social, communication and thinking skills; and her capacity for self-control.** Most of all you build her desire to learn about her world.

The booklets in this series are not intended to be general guides to everything that is happening at each specific age. Instead, they focus on how, through interactions with your baby during everyday moments, you build a strong and close relationship—the foundation of your child's learning and her healthy growth and development.

If your child's development is delayed, you can adapt the information in this booklet to meet your child's individual needs. If you are at all concerned about your child's development, consult your pediatric health care provider.

It's the special interplay between parent and child that makes everyday moments so meaningful. The potential is limitless. The starting point is you.

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What's it like for you:

Your “baby” isn’t a baby anymore! He has ideas and opinions of his own. He can also do so much for himself—dress (or at least help), eat, and talk, talk, talk. While these accomplishments may delight you and make you feel proud, you may also feel a sense of sadness or loss, wondering where the time has gone.

This third year is a magical time as imagination is blossoming. Two-year-olds often spend a lot of time in the world of pretend. When you watch your child and join in (while letting him be the director) you will learn a lot about what he is thinking and feeling. He may make up stories where he is the dad who goes to work and you are the child left at home or in child care. He may be the king who gets everything he wants!

There may be some big adjustments ahead for both of you, as well. You might be considering pre-school. Learning to use the potty may be on the horizon. Perhaps there is a new baby coming into the picture. You may be concerned about how your toddler will adjust...or how you will handle two! These are all opportunities to help your child learn to cope with life’s changes.

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making friends

Helping your toddler to develop strong, healthy friendships provides him with the skill and joy of interacting with and getting along with others as he grows.

If your toddler could talk:

I love to watch and play with other children—especially kids my size. We may be at the park, on a “play-date,” or just on the front stoop with the neighbors. I’m fascinated by how they look and what they do. Whether I stop and watch, play next to them, or join in, I learn a lot. I try to do what they do, like build a sand castle or ride the see-saw. I see them beg their moms and dads to stay longer when it’s time to leave. I might try that, too! Making friends can be hard. I don’t get this sharing thing. Why do I have to give up my pail or let someone else have a turn on the swing? And, when there is too much going on, it might get a little overwhelming for me. If I seem hesitant, you can help me ease into playing with another child. I’ll feel safe and sure with you next to me.

What your toddler is learning:

Friendships are an important part of our lives. Learning to get along with others and to build satisfying relationships begins early and takes time. Your toddler learns by watching and playing with other children. She practices skills by copying what she sees. This may also motivate her to try something new—the big slide, a new vegetable, or even sitting on the potty. Friendships also spark creativity as children make up games and stories together. Of course, this can be a rocky road. At this age, children are still learning to share and take turns. Even though your child may know the “right” thing to do, her emotions may still win out over her willpower. Your support and guidance will help her learn how to play fair and experience the joys of friendships. This lays the foundation for developing healthy relationships as she grows.

What you can do:

- Provide opportunities for your child to play with others her age. Parks, libraries, and organized playgroups are all good places to find other kids. Follow her lead and give her the support you think she needs to make friends.
- Be prepared for frustrations if another child is on the swing or wants the bucket in the sandbox. Offer an alternative as your child learns to wait.

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If your toddler could talk:

I can be a firefighter or a daddy or a zookeeper. When I make-believe, the rules are all up to me. I can make anything happen. When you give me hats and clothes and boxes and containers, I make them part of my adventures and stories. I love it when you pretend with me. It lets me know you care about my ideas and about sharing in my fun. Let me be the director. I like to think up the characters and the story myself. I might surprise you with some of the fun things I dream up when I play.

What your toddler is learning:

Many two- and three-year-olds can't get enough of playing pretend. They pretend anytime, anywhere. Whether they're on a trip to the store or taking a bath, their growing imaginations transport them to another place. Pretend play is much more than pure fun. It teaches children about symbols—that an object can represent something else. A doll can be a "real" baby. A block can be a phone. This kind of symbolic thinking fosters creativity and is important for learning later skills like reading and math. Pretend play can also help a child deal with difficult situations, like saying goodbye, or adjusting to a new baby in the family. He can work through some of these challenges by practicing and mastering them through play, especially when you join him. Your child becomes the daddy leaving his little boy (played by you!) to go to work. You help your child's stuffed tiger figure out ways to make friends in his new classroom. Keep in mind that two-year-olds cannot always separate pretend from reality. This is why they develop fears at this time. They will need your help and time to learn what's real and what's not.

What you can do:

- Enter your child's pretend world and follow his lead. Ask questions like "Who should I be?" and "What do I do next?"
- Be a careful observer. Pretend play is a window into your child's thoughts and feelings. Is he acting out something that is scary, confusing, anxiety-producing, or something he enjoys?
- Create pretend scenarios for your child that you think he may be struggling with, like adjusting to a new caregiver. You can help him problem-solve through pretend.

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Reading Your Baby's Cues

What follows is a chart that describes what children are learning at this stage and what you can do to support the development of these new skills. You will see that the age ranges are broad. This is done intentionally because children develop at their own pace and in their own way. Whether a child reaches a milestone earlier or later within the normal timeframe is not significant.

Reading Your Child's Cues

What follows is a chart that describes what children are learning at this stage and what you can do to support the development of these new skills. You will see that the age ranges are broad. This is done intentionally because children develop at their own pace and in their own way. Whether a child reaches a milestone earlier or later within the normal timeframe is not significant.

Building a strong and close relationship with you is the foundation of your child's learning and her healthy growth and development. If your child's development is delayed, you can adapt the information in this chart to meet your child's individual needs. If you are at all concerned about your child's development, consult a health care provider.



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www.zerotothree.org/child-development/early-development/magic-of-everyday-moments.html

what to expect between 24 and 36 months:

what you can do:

Oh Brother!

Or Sister! If your toddler was an only child, a new sibling might be on the way or already in the picture. This is a wonderful gift, but can also bring some challenges.

- Prepare your child with books about a new baby and having siblings.
- Let her help you care for the baby.
- Make special time for each of your children.

I'm Scared!

Your toddler's imagination is blossoming, but he is often not sure about the difference between reality and fantasy. This may lead to new fears.

- Help him talk about his fears. Putting feelings into words can help him understand and feel in control of them. Knowing how he feels will also help you provide the reassurance he needs.
- Never belittle your child or his fears. This may lead to increased fearfulness.

Let me try

Your toddler is becoming capable of doing more and more things by himself.

- Provide opportunities for him to do some things on his own--get dressed, brush his teeth, even use the potty and wash his hands.
- Have him use his skills to help around the house—putting away clothes, setting the table, or picking up leaves in the yard. This will help him feel important.

I'm unique

Your child is beginning to notice similarities and differences among people.

- Help your child understand and appreciate his own culture and background, as well as those of others. Talk respectfully about others who are different from you.
- Expect some embarrassing moments when your child comments on a difference he notices. Use them as opportunities to explain, without judgment, that people are different in many ways – size, skin color, style of dress, etc.

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what to expect between 24 and 36 months:

Batteries not included (or necessary!)

You may be tempted to buy specialized toys, games, or videos, especially those that claim to make your baby smarter.

- Resist the urge to buy based on product claims.
- Choose toys that encourage imagination and that will “grow” with your child like books, play food, dolls, toy animals, and crayons.
- Remember—you are her favorite toy!

Catch Me If You Can

Your child can do a lot with his body: run, jump, climb, spin, and now even play on riding toys and tricycles.

- Limit t.v. time and head outside. Take hikes, walk to the playground, or throw the ball.
- Talk about up, down, over, under, high, and low as you play. Go up and down the slide, climb over and run under the jungle gym,

Now You're Talkin'

After waiting all this time for your child to talk, you may wonder when your 2-year-old will ever stop. She now uses longer sentences--and talks anytime, anywhere.

- Keep the conversation going. Talk about what you are doing together. Ask her about her thoughts and ideas. “What part did you like in the book?” “Why do you think the bear was sad?”
- Read books, sing songs, and play rhyming games with real and nonsense words. This helps develop language skills.

Why?

“Why” may become one of her favorite new words because your curious toddler is learning about the logical connections between things. She begins to understand, “If I write with crayon on the walls, mommy take the crayon away!”

- When your child asks, “Why?” ask her for her ideas before you answer. This builds her thinking skills. It also helps you know how much information she needs. A simple response might be all that is necessary.
- Be patient with the many questions that come. Understanding the “why” of things is a big leap in your child’s thinking.

what you can do:

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**Remember, everyday moments
are rich bonding and learning
opportunities. Enjoy the magic of
these moments with your child.**

*Don't miss the other booklets in
The Magic of Everyday Moments™ series:*



For more information on early childhood development, go to:

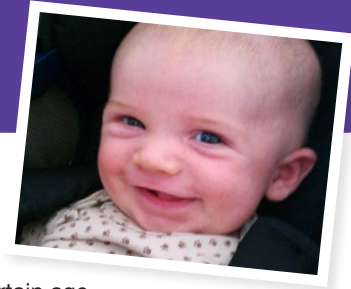
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Your Baby at 2 Months



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 2 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Babies Do at this Age:

Social/Emotional

- ☐ Begins to smile at people
- ☐ Can briefly calm himself (may bring hands to mouth and suck on hand)
- ☐ Tries to look at parent

Language/Communication

- ☐ Coos, makes gurgling sounds
- ☐ Turns head toward sounds

Cognitive (learning, thinking, problem-solving)

- ☐ Pays attention to faces
- ☐ Begins to follow things with eyes and recognize people at a distance
- ☐ Begins to act bored (cries, fussy) if activity doesn't change

Movement/Physical Development

- ☐ Can hold head up and begins to push up when lying on tummy
- ☐ Makes smoother movements with arms and legs

Act Early by Talking to Your Child's Doctor if Your Child:

- ☐ Doesn't respond to loud sounds
- ☐ Doesn't watch things as they move
- ☐ Doesn't smile at people
- ☐ Doesn't bring hands to mouth
- ☐ Can't hold head up when pushing up when on tummy

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

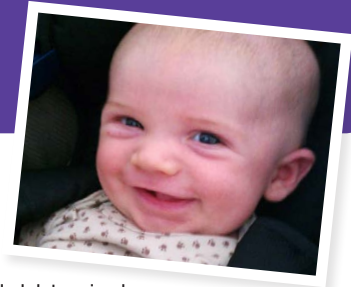
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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Beb  a los 2 Meses



Nombre del ni o

Edad del ni o

Fecha de hoy

La manera en que su hijo juega, aprende, habla y act a nos ofrece pistas importantes sobre c mo se est  desarrollando. Los indicadores del desarrollo son las cosas que la mayor a de los ni os pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo justo antes de cumplir 3 meses. En cada visita m dica de su hijo, lleve esta informaci n y hable con el pediatra sobre los indicadores que su hijo alcanz  y cu les son los que deber a alcanzar a continuaci n.

 Qu  Hacen los Beb s a Esta Edad?

En las  reas social y emocional

- ☐ Le sonr e a las personas
- ☐ Puede calmarse sin ayuda por breves momentos (se pone los dedos en la boca y se chupa la mano)
- ☐ Trata de mirar a sus padres

En las  reas del habla y la comunicaci n

- ☐ Hace sonidos como de arrullo o gorjeos
- ☐ Mueve la cabeza para buscar los sonidos

En el  rea cognitiva (aprendizaje, razonamiento, resoluci n de problemas)

- ☐ Se interesa en las caras
- ☐ Comienza a seguir las cosas con los ojos y reconoce a las personas a la distancia
- ☐ Comienza a demostrar aburrimiento si no cambian las actividades (llora, se inquieta)

En las  reas motora y de desarrollo f sico

- ☐ Puede mantener la cabeza alzada y trata de alzar el cuerpo cuando est  boca abajo
- ☐ Mueve las piernas y los brazos con mayor suavidad

Reaccione pronto y hable con el doctor de su hijo se el ni o:

- ☐ No responde ante ruidos fuertes
- ☐ No sigue con la vista a las cosas que se mueven
- ☐ No le sonr e a las personas
- ☐ No se lleva las manos a la boca
- ☐ No puede sostener la cabeza en alto cuando empuja el cuerpo hacia arriba estando boca abajo

D gale al m dico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para ni os de su  rea, como por ejemplo el programa p blico de intervenci n temprana patrocinado por el estado. Para obtener m s informaci n, consulte www.cdc.gov/preocupado o llame 1-800-CDC-INFO.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Baby at 4 Months



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 4 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Babies Do at this Age:

Social/Emotional

- ☐ Smiles spontaneously, especially at people
- ☐ Likes to play with people and might cry when playing stops
- ☐ Copies some movements and facial expressions, like smiling or frowning

Language/Communication

- ☐ Begins to babble
- ☐ Babbles with expression and copies sounds he hears
- ☐ Cries in different ways to show hunger, pain, or being tired

Cognitive (learning, thinking, problem-solving)

- ☐ Lets you know if she is happy or sad
- ☐ Responds to affection
- ☐ Reaches for toy with one hand
- ☐ Uses hands and eyes together, such as seeing a toy and reaching for it
- ☐ Follows moving things with eyes from side to side
- ☐ Watches faces closely
- ☐ Recognizes familiar people and things at a distance

Movement/Physical Development

- ☐ Holds head steady, unsupported
- ☐ Pushes down on legs when feet are on a hard surface
- ☐ May be able to roll over from tummy to back
- ☐ Can hold a toy and shake it and swing at dangling toys
- ☐ Brings hands to mouth
- ☐ When lying on stomach, pushes up to elbows

Act Early by Talking to Your Child's Doctor if Your Child:

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

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Beb  a los 4 Meses



Nombre del ni o

Edad del ni o

Fecha de hoy

La manera en que su hijo juega, aprende, habla y act a nos ofrece pistas importantes sobre c mo se est  desarrollando. Los indicadores del desarrollo son las cosas que la mayor a de los ni os pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo justo antes de cumplir 5 meses. En cada visita m dica de su hijo, lleve esta informaci n y hable con el pediatra sobre los indicadores que su hijo alcanz  y cu les son los que deber a alcanzar a continuaci n.

 Qu  Hacen los Beb s a Esta Edad?

En las  reas social y emocional

- ☐ Sonr e espont neamente, especialmente con otras personas
- ☐ Le gusta jugar con la gente y puede ser que hasta llore cuando se terminan los juegos
- ☐ Copia algunos movimientos y gestos faciales, como sonr er o fruncir el ce o

En las  reas del habla y la comunicaci n

- ☐ Empieza a balbucear
- ☐ Balbucea con entonaci n y copia los sonidos que escucha
- ☐ Lloro de diferentes maneras para mostrar cuando tiene hambre, siente dolor o est  cansado

En el  rea cognitiva (aprendizaje, razonamiento, resoluci n de problemas)

- ☐ Le deja saber si est  contento o triste
- ☐ Responde ante las demostraciones de afecto
- ☐ Trata de alcanzar los juguetes con la mano
- ☐ Coordina las manos y los ojos, como cuando juega a esconder la carita detr s de sus manos
- ☐ Sigue con la vista a las cosas que se mueven, moviendo los ojos de lado a lado
- ☐ Observa las caras con atenci n
- ☐ Reconoce objetos y personas conocidas desde lejos

En las  reas motora y de desarrollo f sico

- ☐ Mantiene la cabeza fija, sin necesidad de soporte
- ☐ Se empuja con las piernas cuando tiene los pies sobre una superficie firme
- ☐ Cuando est  boca abajo puede darse vuelta y quedar boca arriba

- ☐ Puede sostener un juguete y sacudirlo y golpear a juguetes que est n colgando
- ☐ Se lleva las manos a la boca
- ☐ Cuando est  boca abajo, levanta el cuerpo hasta apoyarse en los codos

Reaccione pronto y hable con el doctor de su hijo se el ni o:

- ☐ No sigue con la vista a las cosas que se mueven
- ☐ No le sonr e a las personas
- ☐ No puede sostener la cabeza con firmeza
- ☐ No gorjea ni hace sonidos con la boca
- ☐ No se lleva las cosas a la boca
- ☐ No empuja con los pies cuando le apoyan sobre una superficie dura
- ☐ Tiene dificultad para mover uno o los dos ojos en todas las direcciones

D gale al m dico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para ni os de su  rea, como por ejemplo el programa p blico de intervenci n temprana patrocinado por el estado. Para obtener m s informaci n, consulte www.cdc.gov/preocupado o llame **1-800-CDC-INFO**.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Baby at 6 Months



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 6 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Babies Do at this Age:

Social/Emotional

- ☐ Knows familiar faces and begins to know if someone is a stranger
- ☐ Likes to play with others, especially parents
- ☐ Responds to other people's emotions and often seems happy
- ☐ Likes to look at self in a mirror

Language/Communication

- ☐ Responds to sounds by making sounds
- ☐ Strings vowels together when babbling ("ah," "eh," "oh") and likes taking turns with parent while making sounds
- ☐ Responds to own name
- ☐ Makes sounds to show joy and displeasure
- ☐ Begins to say consonant sounds (jabbering with "m," "b")

Cognitive (learning, thinking, problem-solving)

- ☐ Looks around at things nearby
- ☐ Brings things to mouth
- ☐ Shows curiosity about things and tries to get things that are out of reach
- ☐ Begins to pass things from one hand to the other

Movement/Physical Development

- ☐ Rolls over in both directions (front to back, back to front)
- ☐ Begins to sit without support
- ☐ When standing, supports weight on legs and might bounce
- ☐ Rocks back and forth, sometimes crawling backward before moving forward

Act Early by Talking to Your Child's Doctor if Your Child:

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

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics. This milestone checklist is not a substitute for a standardized, validated developmental screening tool.

www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Bebê a los 6 Meses



Nombre del niño _____

Edad del niño _____

Fecha de hoy _____

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo justo antes de cumplir 7 meses. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué Hacen los Bebês a Esta Edad?

En las áreas social y emocional

- ☐ Reconoce las caras familiares y comienza a darse cuenta si alguien es un desconocido
- ☐ Le gusta jugar con los demás, especialmente con sus padres
- ☐ Responde antes las emociones de otras personas y generalmente se muestra feliz
- ☐ Le gusta mirarse en el espejo

En las áreas del habla y la comunicación

- ☐ Copia sonidos
- ☐ Une varias vocales cuando balbucea ("a", "e", "o") y le gusta hacer sonidos por turno con los padres
- ☐ Reacciona cuando se menciona su nombre
- ☐ Hace sonidos para demostrar alegría o descontento
- ☐ Comienza a emitir sonidos de consonantes (parlotea usando la "m" o la "b")

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Observa a su alrededor las cosas que están cerca
- ☐ Se lleva la cosas a la boca
- ☐ Demuestra curiosidad sobre las cosas y trata de agarrar las cosas que están fuera de su alcance
- ☐ Comienza a pasar cosas de una mano a la otra

En las áreas motora y de desarrollo físico

- ☐ Se da vuelta para ambos lados (se pone boca arriba y boca abajo)
- ☐ Comienza a sentarse sin apoyo
- ☐ Cuando se para, se apoya en sus piernas y hasta puede ser que salte
- ☐ Se mece hacia adelante y hacia atrás, a veces gatea primero hacia atrás y luego hacia adelante

Reaccione pronto y hable con el doctor de su hijo se el niño:

- ☐ No trata de agarrar cosas que están a su alcance
- ☐ No demuestra afecto por quienes le cuidan
- ☐ No reacciona ante los sonidos de alrededor
- ☐ Tiene dificultad para llevarse cosas a la boca
- ☐ No emite sonidos de vocales ("a", "e", "o")
- ☐ No rueda en ninguna dirección para darse vuelta
- ☐ No se ríe ni hace sonidos de placer
- ☐ Se ve rígido y con los músculos tensos
- ☐ Se ve sin fuerza como un muñeco de trapo

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte www.cdc.gov/preocupado o llame 1-800-CDC-INFO.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Baby at 9 Months



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 9 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Babies Do at this Age:

Social/Emotional

- ☐ May be afraid of strangers
- ☐ May be clingy with familiar adults
- ☐ Has favorite toys

Language/Communication

- ☐ Understands "no"
- ☐ Makes a lot of different sounds like "mamamama" and "babababab"
- ☐ Copies sounds and gestures of others
- ☐ Uses fingers to point at things

Cognitive (learning, thinking, problem-solving)

- ☐ Watches the path of something as it falls
- ☐ Looks for things he sees you hide
- ☐ Plays peek-a-boo
- ☐ Puts things in her mouth
- ☐ Moves things smoothly from one hand to the other
- ☐ Picks up things like cereal o's between thumb and index finger

Movement/Physical Development

- ☐ Stands, holding on
- ☐ Can get into sitting position
- ☐ Sits without support
- ☐ Pulls to stand
- ☐ Crawls

Act Early by Talking to Your Child's Doctor if Your Child:

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

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

The American Academy of Pediatrics recommends that children be screened for general development at the 9-month visit. Ask your child's doctor about your child's developmental screening.

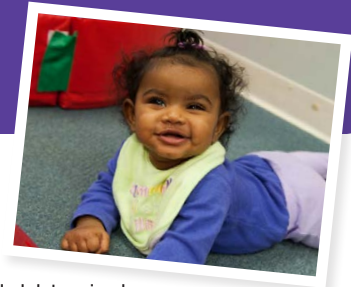
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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Bebê a los 9 Meses



Nombre del niño _____

Edad del niño _____

Fecha de hoy _____

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo justo antes de cumplir 10 meses. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué Hacen los Bebês a Esta Edad?

En las áreas social y emocional

- ☐ Puede ser que le tenga miedo a los desconocidos
- ☐ Puede ser que se aferre a los adultos conocidos todo el tiempo
- ☐ Tiene juguetes preferidos

En las áreas del habla y la comunicación

- ☐ Entiende cuando se le dice “no”
- ☐ Hace muchos sonidos diferentes como “mamamama” y “dadadadada”
- ☐ Copia los sonidos que hacen otras personas
- ☐ Señala objetos con los dedos

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Observa el recorrido de las cosas al caer
- ☐ Va en busca de las cosas que usted esconde
- ☐ Juega a esconder su carita detrás de las manos
- ☐ Se pone las cosas en la boca
- ☐ Pasa objetos de una mano a la otra con facilidad
- ☐ Levanta cosas como cereales en forma de “o” entre el dedo índice y el pulgar

En las áreas motora y de desarrollo físico

- ☐ Puede sentarse solo
- ☐ Se sienta sin apoyo
- ☐ Se parar sosteniéndose de algo
- ☐ Gatea

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ☐ No se apoya en las piernas con ayuda
- ☐ No se sostiene en las piernas con apoyo
- ☐ No balbucea (“mama”, “baba”, “papa”)
- ☐ No juega a nada que sea por turnos como “me toca a mí, te toca a ti”
- ☐ No responde cuando le llaman por su nombre
- ☐ No parece reconocer a las personas conocidas
- ☐ No mira hacia donde usted señala
- ☐ No pasa juguetes de una mano a la otra

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte www.cdc.gov/preocupado o llame **1-800-CDC-INFO**.

La Academia Americana de Pediatría recomienda que se evalúe el desarrollo general de los niños a los 9 meses. Pregúntele al médico de su hijo si el niño necesita ser evaluado.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Child at 1 Year



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 1st birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Children Do at this Age:

Social/Emotional

- ☐ Is shy or nervous with strangers
- ☐ Cries when mom or dad leaves
- ☐ Has favorite things and people
- ☐ Shows fear in some situations
- ☐ Hands you a book when he wants to hear a story
- ☐ Repeats sounds or actions to get attention
- ☐ Puts out arm or leg to help with dressing
- ☐ Plays games such as "peek-a-boo" and "pat-a-cake"

Language/Communication

- ☐ Responds to simple spoken requests
- ☐ Uses simple gestures, like shaking head "no" or waving "bye-bye"
- ☐ Makes sounds with changes in tone (sounds more like speech)
- ☐ Says "mama" and "dada" and exclamations like "uh-oh!"
- ☐ Tries to say words you say

Cognitive (learning, thinking, problem-solving)

- ☐ Explores things in different ways, like shaking, banging, throwing
- ☐ Finds hidden things easily
- ☐ Looks at the right picture or thing when it's named
- ☐ Copies gestures
- ☐ Starts to use things correctly; for example, drinks from a cup, brushes hair
- ☐ Bangs two things together
- ☐ Puts things in a container, takes things out of a container
- ☐ Lets things go without help
- ☐ Pokes with index (pointer) finger
- ☐ Follows simple directions like "pick up the toy"

Movement/Physical Development

- ☐ Gets to a sitting position without help
- ☐ Pulls up to stand, walks holding on to furniture ("cruising")
- ☐ May take a few steps without holding on
- ☐ May stand alone

Act Early by Talking to Your Child's Doctor if Your Child:

- ☐ Doesn't crawl
- ☐ Can't stand when supported
- ☐ Doesn't search for things that she sees you hide.
- ☐ Doesn't say single words like "mama" or "dada"
- ☐ Doesn't learn gestures like waving or shaking head
- ☐ Doesn't point to things
- ☐ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Hijo de 1 Año



Nombre del niño _____

Edad del niño _____

Fecha de hoy _____

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 1 año de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué Hacen los Niños a Esta Edad?

En las áreas social y emocional

- ☐ Actúa con timidez o se pone nervioso en presencia de desconocidos
- ☐ Lloro cuando la mamá o el papá se aleja
- ☐ Tiene cosas y personas preferidas
- ☐ Demuestra miedo en algunas situaciones
- ☐ Le alcanza un libro cuando quiere escuchar un cuento
- ☐ Repite sonidos o acciones para llamar la atención
- ☐ Levanta un brazo o una pierna para ayudar a vestirse
- ☐ Juega a esconder la carita y a las palmaditas con las manos

En las áreas del habla y la comunicación

- ☐ Entiende cuando se le pide que haga algo sencillo
- ☐ Usa gestos simples, como mover la cabeza de lado a lado para decir “no” o mover la mano para decir “adiós”
- ☐ Hace sonidos con cambios de entonación (se parece más al lenguaje normal)
- ☐ Dice “mamá” y “papá” y exclamaciones como “oh-oh”
- ☐ Trata de copiar palabras

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Explora los objetos de diferentes maneras (los sacude, los golpea o los tira)
- ☐ Encuentra fácilmente objetos escondidos
- ☐ Cuando se nombra algo mira en dirección a la ilustración o cosa que se nombró
- ☐ Copia gestos
- ☐ Comienza a usar las cosas correctamente, por ejemplo, bebe de una taza, se cepilla el pelo
- ☐ Golpea un objeto contra otro
- ☐ Mete cosas dentro de un recipiente, las saca del recipiente
- ☐ Suelta las cosas sin ayuda
- ☐ Pide atención tocando a las personas con el dedo índice
- ☐ Sigue instrucciones sencillas como “recoge el juguete”

En las áreas motora y de desarrollo físico

- ☐ Se sienta sin ayuda
- ☐ Se para sosteniéndose de algo, camina apoyándose en los muebles, la pared, etc.
- ☐ Puede ser que hasta dé unos pasos sin apoyarse
- ☐ Puede ser que se pare solo

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ☐ No gatea
- ☐ No puede permanecer de pie con ayuda
- ☐ No busca las cosas que la ve esconder
- ☐ No dice palabras sencillas como “mamá” o “papá”
- ☐ No aprende a usar gestos como saludar con la mano o mover la cabeza
- ☐ No señala cosas
- ☐ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte www.cdc.gov/preocupado o llame 1-800-CDC-INFO.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Child at 18 Months (1½ Yrs)



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 18 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Children Do at this Age:

Social/Emotional

- ☐ Likes to hand things to others as play
- ☐ May have temper tantrums
- ☐ May be afraid of strangers
- ☐ Shows affection to familiar people
- ☐ Plays simple pretend, such as feeding a doll
- ☐ May cling to caregivers in new situations
- ☐ Points to show others something interesting
- ☐ Explores alone but with parent close by

Language/Communication

- ☐ Says several single words
- ☐ Says and shakes head "no"
- ☐ Points to show someone what he wants

Cognitive (learning, thinking, problem-solving)

- ☐ Knows what ordinary things are for; for example, telephone, brush, spoon
- ☐ Points to get the attention of others
- ☐ Shows interest in a doll or stuffed animal by pretending to feed
- ☐ Points to one body part
- ☐ Scribbles on his own
- ☐ Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"

Movement/Physical Development

- ☐ Walks alone
- ☐ May walk up steps and run
- ☐ Pulls toys while walking
- ☐ Can help undress herself
- ☐ Drinks from a cup
- ☐ Eats with a spoon

Act Early by Talking to Your Child's Doctor if Your Child:

- ☐ Doesn't point to show things to others
- ☐ Can't walk
- ☐ Doesn't know what familiar things are for
- ☐ Doesn't copy others
- ☐ Doesn't gain new words
- ☐ Doesn't have at least 6 words
- ☐ Doesn't notice or mind when a caregiver leaves or returns
- ☐ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

The American Academy of Pediatrics recommends that children be screened for general development and autism at the 18-month visit. Ask your child's doctor about your child's developmental screening.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Bebé a los 18 Meses (1½ Años)



Nombre del niño _____

Edad del niño _____

Fecha de hoy _____

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo justo antes de cumplir 19 meses. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué Hacen los Niños a Esta Edad?

En las áreas social y emocional

- ☐ Le gusta alcanzarle cosas a los demás como un juego
- ☐ Puede tener rabietas
- ☐ Puede ser que le tenga miedo a los desconocidos
- ☐ Le demuestra afecto a las personas conocidas
- ☐ Juega a imitar cosas sencillas, como alimentar a una muñeca
- ☐ Se aferra a la persona que le cuida en situaciones nuevas
- ☐ Señala para mostrarle a otras personas algo interesante
- ☐ Explora solo, pero con la presencia cercana de los padres

En las áreas del habla y la comunicación

- ☐ Puede decir varias palabras
- ☐ Dice “no” y sacude la cabeza como negación
- ☐ Señala para mostrarle a otra persona lo que quiere

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Sabe para qué sirven las cosas comunes; por ejemplo, teléfono, cepillo, cuchara
- ☐ Señala una parte del cuerpo
- ☐ Señala para llamar la atención de otras personas
- ☐ Demuestra interés en una muñeca o animal de peluche y hace de cuenta que le da de comer
- ☐ Hace garabatos sin ayuda
- ☐ Puede seguir instrucciones verbales de un solo paso que no se acompañan de gestos; por ejemplo, se sienta cuando se le dice “siéntate”

En las áreas motora y de desarrollo físico

- ☐ Camina solo
- ☐ Jala juguetes detrás de él mientras camina
- ☐ Puede subir las escaleras y correr
- ☐ Puede ayudar a desvestirse

- ☐ Bebe de una taza
- ☐ Come con cuchara

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ☐ No señala cosas para mostrárselas a otras personas
- ☐ No puede caminar
- ☐ No sabe para qué sirven las cosas familiares
- ☐ No copia lo que hacen las demás personas
- ☐ No aprende nuevas palabras
- ☐ No sabe por lo menos 6 palabras
- ☐ No se da cuenta ni parece importarle si la persona que le cuida se va a o regresa
- ☐ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte www.cdc.gov/preocupado o llame **1-800-CDC-INFO**.

La Academia Americana de Pediatría recomienda que, a los 18 meses de edad, se evalúe el desarrollo general de los niños y se realicen pruebas de detección del autismo. Pregúntele al médico de su hijo si el niño necesita ser evaluado.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Child at 2 Years



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 2nd birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Children Do at this Age:

Social/Emotional

- ☐ Copies others, especially adults and older children
- ☐ Gets excited when with other children
- ☐ Shows more and more independence
- ☐ Shows defiant behavior (doing what he has been told not to)
- ☐ Plays mainly beside other children, but is beginning to include other children, such as in chase games

Language/Communication

- ☐ Points to things or pictures when they are named
- ☐ Knows names of familiar people and body parts
- ☐ Says sentences with 2 to 4 words
- ☐ Follows simple instructions
- ☐ Repeats words overheard in conversation
- ☐ Points to things in a book

Cognitive (learning, thinking, problem-solving)

- ☐ Finds things even when hidden under two or three covers
- ☐ Begins to sort shapes and colors
- ☐ Completes sentences and rhymes in familiar books
- ☐ Plays simple make-believe games
- ☐ Builds towers of 4 or more blocks
- ☐ Might use one hand more than the other
- ☐ Follows two-step instructions such as "Pick up your shoes and put them in the closet."
- ☐ Names items in a picture book such as a cat, bird, or dog

Movement/Physical Development

- ☐ Stands on tiptoe
- ☐ Kicks a ball
- ☐ Begins to run

- ☐ Climbs onto and down from furniture without help
- ☐ Walks up and down stairs holding on
- ☐ Throws ball overhand
- ☐ Makes or copies straight lines and circles

Act Early by Talking to Your Child's Doctor if Your Child:

- ☐ Doesn't use 2-word phrases (for example, "drink milk")
- ☐ Doesn't know what to do with common things, like a brush, phone, fork, spoon
- ☐ Doesn't copy actions and words
- ☐ Doesn't follow simple instructions
- ☐ Doesn't walk steadily
- ☐ Loses skills she once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

The American Academy of Pediatrics recommends that children be screened for general development and autism at the 24-month visit. Ask your child's doctor about your child's developmental screening.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Hijo de 2 Años



Nombre del niño

Edad del niño

Fecha de hoy

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 2 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué Hacen los Niños a Esta Edad?

En las áreas social y emocional

- ☐ Copia a otras personas, especialmente a adultos y niños mayores
- ☐ Se entusiasma cuando está con otros niños
- ☐ Demuestra ser cada vez más independiente
- ☐ Demuestra un comportamiento desafiante (hace lo que se le ha dicho que no haga)
- ☐ Comienza a incluir otros niños en sus juegos, como jugar a sentarse a comer con las muñecas o a correr y perseguirse

En las áreas del habla y la comunicación

- ☐ Señala a objetos o ilustraciones cuando se los nombra
- ☐ Sabe los nombres de personas conocidas y partes del cuerpo
- ☐ Dice frases de 2 a 4 palabras
- ☐ Sigue instrucciones sencillas
- ☐ Repite palabras que escuchó en alguna conversación
- ☐ Señala las cosas que aparecen en un libro

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Encuentra cosas aun cuando están escondidas debajo de dos o tres sábanas
- ☐ Empieza a clasificar por formas y colores
- ☐ Completa las frases y las rimas de los cuentos que conoce
- ☐ Juega con su imaginación de manera sencilla
- ☐ Construye torres de 4 bloques o más
- ☐ Puede que use una mano más que la otra
- ☐ Sigue instrucciones para hacer dos cosas como por ejemplo, "levanta tus zapatos y ponlos en su lugar"
- ☐ Nombra las ilustraciones de los libros como un gato, pájaro o perro

En las áreas motora y de desarrollo físico

- ☐ Se para en las puntas de los dedos
- ☐ Patea una pelota
- ☐ Empieza a correr

- ☐ Se trepa y baja de muebles sin ayuda
- ☐ Sube y baja las escaleras agarrándose
- ☐ Tira la pelota por encima de la cabeza
- ☐ Dibuja o copia líneas rectas y círculos

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ☐ No usa frases de 2 palabras (por ejemplo, "toma leche")
- ☐ No sabe cómo utilizar objetos de uso común, como un cepillo, teléfono, tenedor o cuchara
- ☐ No copia acciones ni palabras
- ☐ No puede seguir instrucciones sencillas
- ☐ No camina con estabilidad
- ☐ Pierde habilidades que había logrado

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte www.cdc.gov/preocupado o llame **1-800-CDC-INFO**.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Child at 3 Years



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 3rd birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Children Do at this Age:

Social/Emotional

- ☐ Copies adults and friends
- ☐ Shows affection for friends without prompting
- ☐ Takes turns in games
- ☐ Shows concern for a crying friend
- ☐ Understands the idea of "mine" and "his" or "hers"
- ☐ Shows a wide range of emotions
- ☐ Separates easily from mom and dad
- ☐ May get upset with major changes in routine
- ☐ Dresses and undresses self

Language/Communication

- ☐ Follows instructions with 2 or 3 steps
- ☐ Can name most familiar things
- ☐ Understands words like "in," "on," and "under"
- ☐ Says first name, age, and sex
- ☐ Names a friend
- ☐ Says words like "I," "me," "we," and "you" and some plurals (cars, dogs, cats)
- ☐ Talks well enough for strangers to understand most of the time
- ☐ Carries on a conversation using 2 to 3 sentences

Cognitive (learning, thinking, problem-solving)

- ☐ Can work toys with buttons, levers, and moving parts
- ☐ Plays make-believe with dolls, animals, and people
- ☐ Does puzzles with 3 or 4 pieces
- ☐ Understands what "two" means
- ☐ Copies a circle with pencil or crayon
- ☐ Turns book pages one at a time
- ☐ Builds towers of more than 6 blocks
- ☐ Screws and unscrews jar lids or turns door handle

Movement/Physical Development

- ☐ Climbs well
- ☐ Runs easily
- ☐ Pedals a tricycle (3-wheel bike)
- ☐ Walks up and down stairs, one foot on each step

Act Early by Talking to Your Child's Doctor if Your Child:

- ☐ Falls down a lot or has trouble with stairs
- ☐ Drools or has very unclear speech
- ☐ Can't work simple toys (such as peg boards, simple puzzles, turning handle)
- ☐ Doesn't speak in sentences
- ☐ Doesn't understand simple instructions
- ☐ Doesn't play pretend or make-believe
- ☐ Doesn't want to play with other children or with toys
- ☐ Doesn't make eye contact
- ☐ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Hijo de 3 Años



Nombre del niño

Edad del niño

Fecha de hoy

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 3 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué Hacen los Niños a Esta Edad?

En las áreas social y emocional

- ☐ Copia a los adultos y los amigos
- ☐ Demuestra afecto por sus amigos espontáneamente
- ☐ Espera su turno en los juegos
- ☐ Demuestra su preocupación por un amigo que está llorando
- ☐ Entiende la idea de lo que "es mío", "de él" o "de ella"
- ☐ Expresa una gran variedad de emociones
- ☐ Se separa de su mamá y su papá con facilidad
- ☐ Se molesta con los cambios de rutina grandes
- ☐ Se viste y desviste

En las áreas del habla y la comunicación

- ☐ Sigue instrucciones de 2 o 3 pasos
- ☐ Sabe el nombre de la mayoría de las cosas conocidas
- ☐ Entiende palabras como "adentro", "arriba" o "debajo"
- ☐ Puede decir su nombre, edad y sexo
- ☐ Sabe el nombre de un amigo
- ☐ Dice palabras como "yo", "mi", "nosotros", "tú" y algunos plurales (autos, perros, gatos)
- ☐ Habla bien de manera que los desconocidos pueden entender la mayor parte de lo que dice
- ☐ Puede conversar usando 2 o 3 oraciones

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Puede operar juguetes con botones, palancas y piezas móviles
- ☐ Juega imaginativamente con muñecas, animales y personas
- ☐ Arma rompecabezas de 3 y 4 piezas
- ☐ Entiende lo que significa "dos"
- ☐ Copia un círculo con lápiz o crayón
- ☐ Pasa las hojas de los libros una a la vez
- ☐ Arma torres de más de 6 bloquitos
- ☐ Enrosca y desenrosca las tapas de jarras o abre la manija de la puerta

En las áreas motora y de desarrollo físico

- ☐ Trepa bien
- ☐ Corre fácilmente
- ☐ Puede pedalear un triciclo (bicicleta de 3 ruedas)
- ☐ Sube y baja escaleras, un pie por escalón

Reaccione pronto y hable con el doctor de su hijo se el niño:

- ☐ Se cae mucho o tiene problemas para subir y bajar escaleras
- ☐ Se babea o no se le entiende cuando habla
- ☐ No puede operar juguetes sencillos (tableros de piezas para encajar, rompecabezas sencillos, girar una manija)
- ☐ No usa oraciones para hablar
- ☐ No entiende instrucciones sencillas
- ☐ No imita ni usa la imaginación en sus juegos
- ☐ No quiere jugar con otros niños ni con juguetes
- ☐ No mira a las personas a los ojos
- ☐ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte www.cdc.gov/preocupado o llame 1-800-CDC-INFO.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Child at 4 Years



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 4th birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Children Do at this Age:

Social/Emotional

- ☐ Enjoys doing new things
- ☐ Plays "Mom" and "Dad"
- ☐ Is more and more creative with make-believe play
- ☐ Would rather play with other children than by himself
- ☐ Cooperates with other children
- ☐ Often can't tell what's real and what's make-believe
- ☐ Talks about what she likes and what she is interested in

Language/Communication

- ☐ Knows some basic rules of grammar, such as correctly using "he" and "she"
- ☐ Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus"
- ☐ Tells stories
- ☐ Can say first and last name

Cognitive (learning, thinking, problem-solving)

- ☐ Names some colors and some numbers
- ☐ Understands the idea of counting
- ☐ Starts to understand time
- ☐ Remembers parts of a story
- ☐ Understands the idea of "same" and "different"
- ☐ Draws a person with 2 to 4 body parts
- ☐ Uses scissors
- ☐ Starts to copy some capital letters
- ☐ Plays board or card games
- ☐ Tells you what he thinks is going to happen next in a book

Movement/Physical Development

- ☐ Hops and stands on one foot up to 2 seconds
- ☐ Catches a bounced ball most of the time
- ☐ Pours, cuts with supervision, and mashes own food

Act Early by Talking to Your Child's Doctor if Your Child:

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

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

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www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Hijo de 4 Años



Nombre del niño _____

Edad del niño _____

Fecha de hoy _____

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 4 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué Hacen los Niños a Esta Edad?

En las áreas social y emocional

- ☐ Disfruta haciendo cosas nuevas
- ☐ Juega a "papá y mamá"
- ☐ Cada vez se muestra más creativo en los juegos de imaginación
- ☐ Le gusta más jugar con otros niños que solo
- ☐ Juega en cooperación con otros
- ☐ Generalmente no puede distinguir la fantasía de la realidad
- ☐ Describe lo que le gusta y lo que le interesa

En las áreas del habla y la comunicación

- ☐ Sabe algunas reglas básicas de gramática, como el uso correcto de "él" y "ella"
- ☐ Canta una canción o recita un poema de memoria como "La araña pequeñita" o "Las ruedas de los autobuses"
- ☐ Relata cuentos
- ☐ Puede decir su nombre y apellido

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Nombra algunos colores y números
- ☐ Entiende la idea de contar
- ☐ Comienza a entender el concepto de tiempo
- ☐ Recuerda partes de un cuento
- ☐ Entiende el concepto de "igual" y "diferente"
- ☐ Dibuja una persona con 2 o 4 partes del cuerpo
- ☐ Sabe usar tijeras
- ☐ Empieza a copiar algunas letras mayúsculas
- ☐ Juega juegos infantiles de mesa o de cartas
- ☐ Le dice lo que le parece que va a suceder en un libro a continuación

En las áreas motora y de desarrollo físico

- ☐ Brinca y se sostiene en un pie hasta por 2 segundos

- ☐ La mayoría de las veces agarra una pelota que rebota
- ☐ Se sirve los alimentos, los hace papilla y los corta (mientras usted lo vigila)

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ☐ No puede saltar en el mismo sitio
- ☐ Tiene dificultades para hacer garabatos
- ☐ No muestra interés en los juegos interactivos o de imaginación
- ☐ Ignora a otros niños o no responde a las personas que no son de la familia
- ☐ Rehúsa vestirse, dormir y usar el baño
- ☐ No puede relatar su cuento favorito
- ☐ No sigue instrucciones de 3 partes
- ☐ No entiende lo que quieren decir "igual" y "diferente"
- ☐ No usa correctamente las palabras "yo" y "tú"
- ☐ Habla con poca claridad
- ☐ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte www.cdc.gov/preocupado o llame 1-800-CDC-INFO.

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www.cdc.gov/pronto | 1-800-CDC-INFO



Aprenda los signos. Reaccione pronto.

Your Child at 5 Years



Child's Name _____

Child's Age _____

Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 5th birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What Most Children Do at this Age:

Social/Emotional

- ☐ Wants to please friends
- ☐ Wants to be like friends
- ☐ More likely to agree with rules
- ☐ Likes to sing, dance, and act
- ☐ Is aware of gender
- ☐ Can tell what's real and what's make-believe
- ☐ Shows more independence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
- ☐ Is sometimes demanding and sometimes very cooperative

Language/Communication

- ☐ Speaks very clearly
- ☐ Tells a simple story using full sentences
- ☐ Uses future tense; for example, "Grandma will be here."
- ☐ Says name and address

Cognitive (learning, thinking, problem-solving)

- ☐ Counts 10 or more things
- ☐ Can draw a person with at least 6 body parts
- ☐ Can print some letters or numbers
- ☐ Copies a triangle and other geometric shapes
- ☐ Knows about things used every day, like money and food

Movement/Physical Development

- ☐ Stands on one foot for 10 seconds or longer
- ☐ Hops; may be able to skip
- ☐ Can do a somersault
- ☐ Uses a fork and spoon and sometimes a table knife
- ☐ Can use the toilet on her own
- ☐ Swings and climbs

Act Early by Talking to Your Child's Doctor if Your Child:

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

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to www.cdc.gov/concerned or call 1-800-CDC-INFO.

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics. This milestone checklist is not a substitute for a standardized, validated developmental screening tool.

www.cdc.gov/actearly | 1-800-CDC-INFO



Learn the Signs. Act Early.

Su Hijo de 5 Años



Nombre del niño

Edad del niño

Fecha de hoy

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 5 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué Hacen los Niños a Esta Edad?

En las áreas social y emocional

- ☐ Quiere complacer a los amigos
- ☐ Quiere parecerse a los amigos
- ☐ Es posible que haga más caso a las reglas
- ☐ Le gusta cantar, bailar y actuar
- ☐ Está consciente de la diferencia de los sexos
- ☐ Puede distinguir la fantasía de la realidad
- ☐ Es más independiente (por ejemplo, puede ir solo a visitar a los vecinos de al lado) [para esto todavía necesita la supervisión de un adulto]
- ☐ A veces es muy exigente y a veces muy cooperador

En las áreas del habla y la comunicación

- ☐ Habla con mucha claridad
- ☐ Puede contar una historia sencilla usando oraciones completas
- ☐ Puede usar el tiempo futuro; por ejemplo, "la abuelita va a venir"
- ☐ Dice su nombre y dirección

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ☐ Cuenta 10 o más cosas
- ☐ Puede dibujar una persona con al menos 6 partes del cuerpo
- ☐ Puede escribir algunas letras o números
- ☐ Puede copiar triángulos y otras figuras geométricas
- ☐ Conoce las cosas de uso diario como el dinero y la comida

En las áreas motora y de desarrollo físico

- ☐ Se para en un pie por 10 segundos o más
- ☐ Brinca y puede ser que dé saltos de lado
- ☐ Puede dar volteretas en el aire
- ☐ Usa tenedor y cuchara y, a veces, cuchillo
- ☐ Puede ir al baño solo
- ☐ Se columpia y trepa

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ☐ No expresa una gran variedad de emociones
- ☐ Tiene comportamientos extremos (demasiado miedo, agresión, timidez o tristeza)
- ☐ Es demasiado retraído y pasivo
- ☐ Se distrae con facilidad, tiene problemas para concentrarse en una actividad por más de 5 minutos
- ☐ No le responde a las personas o lo hace solo superficialmente
- ☐ No puede distinguir la fantasía de la realidad
- ☐ No juega a una variedad de juegos y actividades
- ☐ No puede decir su nombre y apellido
- ☐ No usa correctamente los plurales y el tiempo pasado
- ☐ No habla de sus actividades o experiencias diarias
- ☐ No dibuja
- ☐ No puede cepillarse los dientes, lavarse y secarse las manos o desvestirse sin ayuda
- ☐ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte www.cdc.gov/preocupado o llame 1-800-CDC-INFO.

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría. Esta lista de verificación de indicadores del desarrollo no es un sustituto de una herramienta de evaluación del desarrollo estandarizada y validada.

www.cdc.gov/pronto | 1-800-CDC-INFO



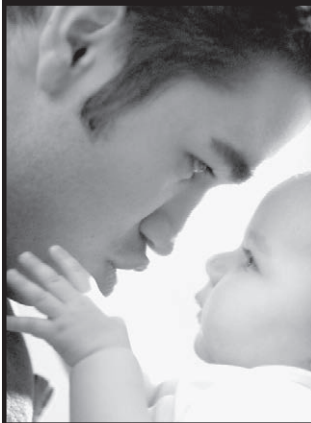
Aprenda los signos. Reaccione pronto.

Healthy Minds:

Nurturing Your Child's Development from **0 to 2 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

These handouts are brought to you by ZERO TO THREE, the nation's leading resource on the first 3 years of life, and the American Academy of Pediatrics, dedicated to the health of all children.



► Key findings from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

When 2-month-old Benjamin cries and cries each evening and kicks his arms and legs wildly, his parents try everything they can think of to comfort him. They rock, walk and swaddle him, massage his tummy in case he has gas and sing lullabies, all to calm him down. Sometimes it takes 20 minutes; sometimes it takes 2 hours.

Benjamin's crying, and his parents' response to it, shows how all areas of his development are linked, and how his parents help to encourage his development. Benjamin cries because he has come to expect that his parents will respond. When mom and dad don't give up trying to comfort Benjamin no matter

how frustrating it can be, they are nurturing his **social and emotional development** because it makes him feel important and he learns to trust that his parents will care for him. This gives him the confidence to trust others, which will help him form healthy relationships as he grows. In addition, being soothed by his parents in these early months will help him learn to soothe himself as he gets older, a very important skill throughout life. Using his voice and body to communicate is part of Benjamin's early **language and motor development**. When his parents answer his cries, he learns that his efforts at communicating are successful, which encourages him to communicate more, first through gestures and sounds, and later through words.

Relationships are the foundation of a child's healthy development.



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Charting Your Child's Healthy Development: **0 to 2 months**

The following chart describes many of the things your baby is learning between 0 and 2 months and what you can do to support your child in all areas of his development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what his strengths are and where he needs more support, is essential for promoting his healthy development. If you have questions regarding your child's development, ask your pediatrician

What's going on:	What you can do:	Questions to ask yourself:
One of the most important tasks of the first 2 months is to help newborns feel comfortable in their new world. They are learning to regulate their eating and sleeping patterns and their emotions, which help them feel content, safe and secure.	<ul style="list-style-type: none"> ● Observe carefully. This will help you figure out what your baby's cries are telling you. ● Soothe your baby. When you respond to your baby's cries and meet his needs, you let him know he is loved. You can't spoil a baby. In fact, by responding lovingly to his needs, you are helping him learn skills now that allow him eventually to soothe himself. You are also promoting a strong bond and healthy brain development. 	<ul style="list-style-type: none"> ● What soothes your baby? How do you know? ● What most distresses him?
Newborns use their gestures (body movements), sounds and facial expressions to communicate their feelings and needs from day 1. They use different cries to let you know they are hungry, tired or bored. They ask for a break by looking away, arching their backs, frowning or crying. They socialize with you by watching your face and exchanging looks.	<ul style="list-style-type: none"> ● Figure out what your baby is trying to tell you. Responding makes him feel important and tells him he is a good communicator. This builds a positive sense of self and a desire to communicate more. ● Talk and sing to your baby. Tell him about everything that's going on around him. Pay attention to the sights and sounds he likes. Find toys and everyday objects with different colors and textures and see which he likes best. 	<ul style="list-style-type: none"> ● How does your baby communicate with you? ● What kinds of interactions does he like best? How do you know? ● How does he let you know when he has had enough?
Even as newborns, babies can play in many ways. They can connect sounds with their sources, and love when you talk and sing to them. Play helps babies learn about the world around them. It is also an important way they connect with you, helping them to develop a strong attachment and promoting healthy social development.	<ul style="list-style-type: none"> ● Offer your baby lots of different objects for him to look at, touch and even grip in his palms. He can focus best on things that are 8 to 12 inches away. ● Play "tracking" games by moving yourself and interesting objects back and forth. First he will use his eyes to follow. Eventually he will move his head from side to side. This helps strengthen his neck muscles as well as exercise his visual abilities. 	<ul style="list-style-type: none"> ● What experiences does your baby seem to like best? (For example, talking with him; looking at toys or other objects; hearing the cat "meow.") ● What kind of toys grab your baby's attention? How does he let you know what he's interested in? ● What kind of play do you enjoy most with your baby?

"The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2½-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.

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Healthy Minds: Nurturing Your Child's Development from **2 to 6 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

These handouts are brought to you by ZERO TO THREE, the nation's leading resource on the first 3 years of life, and the American Academy of Pediatrics, dedicated to the health of all children.



► Key findings from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Five-month-old Tara loves playing peek-a-boo with her mom and dad. When they stop, she squeals and reaches out her arms to let them know she wants more. So they continue. Soon her parents add another twist to the game as they start to hide behind the pillow for a few seconds before they "reappear" to give her time to anticipate what will happen next.

This simple game is more than just fun. It shows how all areas of Tara's development are linked and how her parents help to encourage her healthy development. Tara's interest in playing with her parents is a sign of her **social and emotional development** because she has fun with her parents and can see how much they enjoy being with her. This makes her feel loved and secure, and will

help her develop other positive relationships as she grows. Her desire to play this game with mom and dad leads to the development of new **intellectual abilities** as she learns to anticipate what comes next, an important skill for helping her feel more in control of her world. Knowing what to expect will also help her to more easily deal with being separated from you as she learns that people exist even when she can't see them.

Tara's early **language and motor abilities** emerge as she squeals, makes sounds and moves her arms to let her parents know that she does not want them to stop. When they continue, her parents let her know that she is a good communicator, and each time they reappear, she learns that she can trust them to always come back.

Relationships are the foundation of a child's healthy development.



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Charting Your Child's Healthy Development: 2 to 6 months

The following chart describes many of the things your baby is learning between 2 and 6 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Babies are very interactive at this age. They use their new language and communication skills as they smile and coo back and forth, and enjoy babbling, starting with "ohs" and "ahs" and progressing to P's, M's, B's and D's. Your baby may babble and then pause, waiting for you to respond. They also love to imitate, which helps them learn new skills. For example, mom sticks out her tongue, baby imitates and mom does it again. This also teaches them about the back and forth of conversation.	<ul style="list-style-type: none"> ● When your baby babbles, both talk and babble back, as if you both understand every word. These early conversations will teach her hundreds of words before she can actually speak any of them. ● Engage in back-and-forth interactions with gestures. For example, hold out an interesting object, encourage your baby to reach for it and then signal her to give it back. Keep this going as long as your baby seems to enjoy it. 	<ul style="list-style-type: none"> ● How does your baby let you know what she wants and how she's feeling? ● How do you and your baby enjoy communicating with each other? What do you say or do that gets the biggest reaction from her?
Babies this age love to explore. They learn from looking at, holding and putting their mouths on different objects. At about 3 months, babies begin to reach for things and try to hold them. Make sure all objects are safe. A toy or anything else you give her shouldn't fit entirely in her mouth.	<ul style="list-style-type: none"> ● Introduce one toy at a time so your baby can focus on, and explore, each one. Good choices include a small rattle with a handle, a rubber ring, a soft doll and a board book with pictures. ● Lay your baby on her back and hold brightly colored toys over her chest within her reach. She'll love reaching up and pulling them close. You will start to see what most interests her. 	<ul style="list-style-type: none"> ● What kind of toys or objects does your baby seem most interested in? How do you know? ● How do you and your baby most enjoy playing together? Why?
Babies have greater control over their bodies. By 4 to 6 months, they may be able to roll both ways, become better at reaching and grasping and will begin to sit with assistance. They also begin wanting to explore their food and help feed themselves. Touching and tasting different foods is good for learning and for building self-confidence.	<ul style="list-style-type: none"> ● Place your baby in different positions—on her back, stomach, and sitting with support. Each gives her a different view and a chance to move and explore in different ways. ● Let your baby play with your fingers and explore the bottle or breast during feedings. As she grows, let her handle finger foods and help hold the spoon. 	<ul style="list-style-type: none"> ● How does your baby use her body to explore? Which positions does she like the best and least? ● How would you describe your baby's activity level? Does she like/need to move around a lot or is she more laid-back?

**The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2½-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.*

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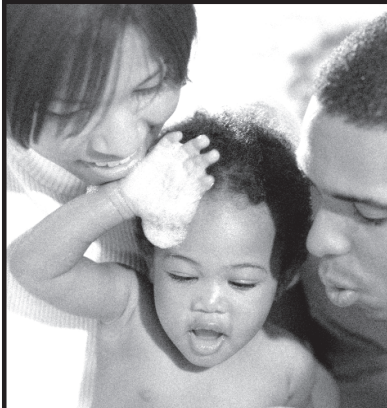
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Healthy Minds:

Nurturing Your Child's Development from 6 to 9 Months

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

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Key findings from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Anne is the mother of 8-month-old Jenna. Anne's best friend, Claudia, is coming into town to meet Jenna for the first time. When Claudia arrives, Jenna will have nothing to do with her. Every time Claudia tries to talk to or play with Jenna she whimpers, turns away and clings to Anne. Anne feels frustrated and embarrassed. While tempted to just hand Jenna to Claudia, she stops, and instead holds Jenna on her lap and asks Claudia to sit next to them and read Jenna's favorite book. Slowly Jenna starts to look at Claudia and shows increasing interest. Soon Jenna starts to crawl off Anne's lap to get closer to Claudia.

This shows how all areas of Jenna's development are connected, and how her mother's

response supports her healthy development. Jenna's strong bond with her mother, the trust she shows as she clings to her for safety and her fear of strangers are all signs of her **social and emotional development**. Her **intellectual development** enables her to tell the difference between who she knows and who she doesn't, and helps her take steps to get the comfort and protection she wants. She uses her sounds (**language development**), facial expressions and gestures (**motor development**) first to communicate to Anne that she is uncomfortable and wants support. Later she uses them to communicate that she is ready to interact. Anne's sensitivity to Jenna's need to warm up slowly to new situations and people helps Jenna feel loved and secure, which will help her feel more comfortable meeting new people as she grows.

Relationships are the foundation of a child's healthy development.



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Charting Your Child's Healthy Development: 6 to 9 months

The following chart describes many of the things your baby is learning between 6 and 9 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Babies this age are big communicators. They use many sounds, gestures and facial expressions to communicate what they want. Their actions are their communications. They may be starting to put consonants and vowels together to form words like "dada" and "mama."	<ul style="list-style-type: none"> ● Talk a lot with your baby. For example, label and narrate. "You're eating a big banana!" Give her time to respond. ● Respond to her communications. See how long you can keep a back-and-forth conversation going. For example, she makes a sound, you imitate it, she makes another sound and so on. 	<ul style="list-style-type: none"> ● How does your baby let you know what she wants; what she's feeling and thinking? ● What, if anything, do you find frustrating about understanding your baby's communications? Why?
As her brain grows, your baby will start to imitate others, especially you. This leads to the development of lots of new skills. Babies this age can also use toys in more complex ways. For example, instead of just holding a plastic cup, a baby this age may use it to pour water in the bathtub.	<ul style="list-style-type: none"> ● Give your baby time to take in what you did and then copy you. Push a button on the jack-in-the-box, then wait for your baby to do it before you do it again. This teaches your baby cause and effect. Seeing that she can make things happen builds her self-confidence and makes her want to take on new challenges. ● Provide a variety of safe toys for the bath—containers, rubber toys, plastic bath books, plastic ladles. These will encourage your baby to explore and experiment with the different ways to use objects. Of course, never leave your baby alone in the bath. 	<ul style="list-style-type: none"> ● How have you seen your baby imitate? ● What kind of play does your baby most enjoy? What does this tell you about her?
Babies' motor skills are advancing by leaps and bounds at this stage. But all babies grow at their own rate. Many babies at this age can roll over both ways, scoot, crawl and even stand. Their motor skills allow them to make the ideas in their head happen, for example, getting the ball that rolled away.	<ul style="list-style-type: none"> ● Encourage your baby to use her body to get what she wants. If she's showing you with her sounds and gestures that she wants the toy that is out of reach, don't just get it for her. Help her get it for herself by bringing it close enough for her to grab. This builds her confidence. ● Create an environment that is safe for exploration. Make sure only safe objects are within your baby's grasp, and that anything she might use to pull herself up to her feet is sturdy and fastened down to the floor or wall. This kind of baby-proofing of your house also will reduce conflicts between you and your baby. 	<ul style="list-style-type: none"> ● How does your baby use her body—to explore, to express her feelings? ● What do you need to do to make your home safer for your "little explorer?"

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Healthy Minds: Nurturing Your Child's Development from **9 to 12 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

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- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Eleven-month-old Tyra is with her dad, Kevin, at the park. Tyra is playing alone in the sandbox when a group of toddlers joins her. At first, Tyra smiles and eagerly watches their play. But as the toddlers become more active and noisy, Tyra's smiles turn quickly to tears. She starts to crawl out of the sandbox and reaches for Kevin who picks her up and comforts her. But then Kevin goes a step further. After Tyra calms down, Kevin gently encourages her to play near them. He sits at her side, talking and playing with her. Soon Tyra is slowly creeping closer to the other children, curiously watching their moves.

This shows how all areas of Tyra's development are linked, and how her father's response encourages her healthy development. Tyra's looking to her dad for comfort shows that she has developed a close and trusting relationship with him. This is an important sign of her **social and emotional development**. She uses her **intel-**

lectual skills to make a plan ("I want to be comforted by Dad, how do I do that?"), and her **language** (crying) and **motor skills** (crawling away, reaching up to Dad) to carry out the plan and successfully get the comfort she is seeking.

Kevin's sensitive response has a powerful influence on what Tyra learns from this experience. He lets Tyra know that her needs and feelings are important. This will help Tyra develop future relationships based on love and trust. He is also letting her know that she is a good communicator, which will encourage Tyra to communicate more and more and help her develop good language and literacy skills. His response also makes Tyra a good problem-solver. She wanted comfort and she found a way to get it. By sitting with her near the other children, he lets Tyra know that she has the support she needs to successfully meet new challenges. This will help her feel confident to handle other challenges as she grows.

Relationships are the foundation of a child's healthy development.



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Charting Your Child's Healthy Development: 9 to 12 months

The following chart describes many of the things your baby is learning between 9 and 12 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Babies this age are very good at expressing their feelings with their gestures, sounds and facial expressions. They can engage in "conversation," for example, handing things back and forth to you, imitating each other's sounds and actions. They also understand "cause and effect"—that they can make something happen: "If I cry, Mom will come."	<ul style="list-style-type: none"> ● Help your baby handle her feelings. Comfort her when she cries, acknowledge when she's frustrated and help her calm down and try again. This helps your child manage her very strong feelings and develop self-control. ● Engage in "circles" of communication with your baby. Keep it going as long as she's engaged. If she reaches for a book, ask, "Do you want that book?" Wait until she responds, and then hand it to her. See what she does with it and join her without taking over. These "conversations" help boost her overall development—social, emotional, language, intellectual and even motor. 	<ul style="list-style-type: none"> ● How would you describe your baby's personality? In what ways are you and your baby alike and different? ● How does your baby let you know what she wants; what she's thinking and feeling?
Thanks to their new memory skills, babies this age know that when you leave, you still exist. This is a very important skill, but also can lead to difficulty when leaving. This is why babies often protest at bedtime and cry out for you in the middle of the night. They try to get you to come back by gesturing, crying and calling out.	<ul style="list-style-type: none"> ● Play hide-and-seek games like peek-a-boo. Disappearing and reappearing games like this help your baby learn to cope with separation and feel secure that you always come back. ● Be positive when leaving her. Go to her at night to reassure her you are still there but don't pick her up and rock her back to sleep. Falling asleep in your arms makes it more difficult for her to soothe herself back to sleep if she wakes up again at night. When saying "goodbye," tell her you will miss her, but that you will return. Make sure she has something that gives her comfort, like her "blankie" or favorite stuffed toy. 	<ul style="list-style-type: none"> ● How does your baby handle it when you leave? What helps make it easier? ● What's hardest for you about being away from your child? Being aware of your own feelings is very important.
Babies this age do things over and over again because that's the way they figure out how things work, and doing things repeatedly builds their self-confidence. It also strengthens the connections in their brains. Their ability to move in new ways (crawl, stand, even walk) makes it easier to explore and helps them make new discoveries, such as finding their favorite book under the chair.	<ul style="list-style-type: none"> ● Be your child's learning partner and coach. Observe her closely to see what she can do. Then help her take the next step. For example, encourage her to put one more block on her tower or to try and fit the cube into a different hole. ● Follow your child's lead. The more she directs the play, the more invested she is and the more she will learn. 	<ul style="list-style-type: none"> ● What are your baby's favorite activities? What does this tell you about her? ● What does your baby do well? What does she find challenging? How can you be a partner in helping her face these challenges?
<p><i>*The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2½-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.</i></p>		

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Healthy Minds: Nurturing Your Child's Development from **12 to 18 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

These handouts are brought to you by ZERO TO THREE, the nation's leading resource on the first 3 years of life, and the American Academy of Pediatrics, dedicated to the health of all children.



► Key findings from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Sixteen-month-old Carlos wants juice and his mom doesn't know it. He is sitting in his high chair banging his cup and pushing the cartons of milk away when his mom, Marta, tries to pour some for him. They both are very frustrated. Marta takes Carlos out of the high chair and announces lunch is over. Carlos marches to the refrigerator and starts banging on the door. Marta is about to tell him to stop banging, but instead asks, "Do you want to open the refrigerator?" Carlos smiles and shakes his head "Yes!" Marta opens the door and Carlos points to the drinks on the shelf. Marta then points to each carton and asks, "Is this what you want?" Carlos shakes his head no until he gets to the juice. Then he jumps around and says, "juju!!" Marta pours him juice as he happily plops himself on her lap.

This shows how all areas of Carlos's development are linked, and how his mother's response encourages his healthy development. Carlos has learned to count on his mom as someone who helps him as he struggles to communicate what he wants. This signals strong **social and emotional development**. He uses his **intellectual ability** to make a plan to get what he wants, and uses his **motor and language skills** to carry out the plan as he walks to the refrigerator and bangs, points and uses sounds to get his message across.

Despite her frustration, Marta takes the time to watch and listen to Carlos. This encourages Carlos to feel like a good communicator and reinforces his sense of self-esteem by letting him know that he is worth listening and paying attention to.

Relationships are the foundation of a child's healthy development.



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Charting Your Child's Healthy Development: 12 to 18 months

The following chart describes many of the things your toddler is learning between 12 and 18 months and what you can do to support your child in all areas of his development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what his strengths are and where he needs more support, is essential for promoting his healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
<p>Toddlers are great communicators. They are learning new words every day, and use them, along with their gestures, to let you know what they are thinking and feeling. For example, they take your hand, walk you to the shelf and point to what they want and say, "Book."</p> <p>Toddlers understand a lot more than they can say. By 12 months they will probably follow a 1-step instruction such as "Go get your shoes." By 18 months they will likely follow 2- and even 3-step directions.</p>	<ul style="list-style-type: none"> ● Encourage your child to use his words, sounds and gestures to communicate, even if you think you know what he wants. ● Play games that include instructions and see how many he can follow. ● Read with your toddler. It helps him learn new words and concepts. It also helps him develop a love of books and reading. 	<ul style="list-style-type: none"> ● How does your child communicate what he wants; what he's thinking and feeling? ● How does your child like to read with you? What are his favorite books?
<p>Toddlers are beginning to do pretend play, a major developmental milestone. They continue to imitate what they see around them, for example, using a child-size broom to sweep the floor. But now, they are beginning to understand symbols and ideas—not just concrete things they can see and feel. For example, they begin to use objects in new and creative ways. A spoon can become an airplane or a toothbrush. Pretend play helps develop important intellectual skills and creativity.</p>	<ul style="list-style-type: none"> ● Offer toys that represent objects in your toddler's world, such as a play kitchen with plastic food, a mini-grocery cart or a toy telephone. Join in his play; help him develop his own stories by letting him be the director. ● Give your child different objects and watch the many ways he uses them. 	<ul style="list-style-type: none"> ● What kind of play does your child enjoy most? How do you see him pretending? ● What kind of play do you most/least enjoy with your toddler? Why?
<p>During this stage of development, toddlers motor skills are taking off. They begin to walk and run, which opens up a whole new world of exploration for them, and a whole new world of watchfulness for you. As you try to keep your toddler safe, remember that while they understand "Stop!" or "Don't Touch," they don't have the impulse control yet to stop themselves the next time the temptation appears. Since they are better at doing things rather than stopping what they are doing, "Walk slowly" works better than "Don't run."</p>	<ul style="list-style-type: none"> ● Create lots of low, safe places in your home where your child can crawl under furniture, cruise around a coffee table or stand on his own. Help a child who's walked up the stairs to get down safely. ● Think of ways to divert your child away from a forbidden object so you don't have to say "no" all day long. If he's fixated on the TV remote, maybe a toy with buttons and twisty knobs could be a substitute. 	<ul style="list-style-type: none"> ● How does your child use his motor skills? Is he a very active child who uses his whole body, or does he prefer to explore with his fingers and hands? ● How is your child's need for physical activity the same or different from yours? How does this affect you and your relationship with your child?

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Healthy Minds: Nurturing Your Child's Development from **18 to 24 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

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► Key findings from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Darryl is excited about taking his 21-month-old daughter, Alicia, to story hour at the local library. He is planning to meet a friend there, who is taking his own daughter. As they enter the room, Alicia spots the noisy crowd, buries her head in her dad's legs, and pulls him toward the door, whining, "Go home!" Darryl is disappointed and tries to get her to take a seat in the circle of children that's forming. But the more he pushes, the more distressed she becomes. Dad is ready to give up and go home. As they are leaving, he sees Alicia look at a book. He stops and asks if she'd like to read it and she nods yes. They sit in the back of the room and read quietly together. The group begins, and Alicia starts to look up more and more frequently to watch and listen to the storyteller. The next week, when Darryl asks if she'd like to go to story time, Alicia smiles and says, "Yes!"

This shows how all areas of Alicia's development are linked and how her father's response encourages her healthy development. Because of Alicia's **social and emotional connection** to her father, he is the one she goes to for safety and comfort when she is feeling anxious. She knows that she can count on her father for support. Her **intellectual ability** enables her to communicate her feelings by using her **language skills** – gestures, facial expressions and words. She uses her **motor ability** to pull on Dad to get him to take her home. Darryl's response helps Alicia master a challenging situation. He is able to put aside his own interest in staying at the group and "listens" to what Alicia is trying to tell him. This allows him to help her feel more comfortable entering a new situation, now and in the future.

Relationships are the foundation of healthy development.



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Charting Your Child's Healthy Development: 18 to 24 months

The following chart describes many of the things your toddler is learning between 18 and 24 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Toddlers' vocabularies are growing by leaps and bounds. They are learning and saying many new words, and stringing words together, such as "Dolly fall." Toddlers are very independent and eager to be in control. Among their favorite words are "Me" and "Mine!"	<ul style="list-style-type: none"> ● Expand on what your child says. When she says, "Dolly fall!" you can say, "Yes, Dolly tumbled down to the floor!" This helps you expand your child's language skills. ● Give your toddler ways to feel in control by giving choices among options that are all acceptable. Let her choose between the red or blue cup and the pink or green shirt. Avoid asking her opinions when only one option is okay; for example, do not ask, "Are you ready to go?" unless she can stay longer. Use language to help her predict what will happen. "In five minutes it will be time to go." 	<ul style="list-style-type: none"> ● What are your child's strengths in communicating? Where does she need help? ● How does your child express her thoughts and feelings? Is she more likely to use her words or actions? How do you respond?
Toddlers are developing self-control, but they still cannot stop themselves from doing something unacceptable, even after many reminders. They also don't yet understand the consequences of their actions.	<ul style="list-style-type: none"> ● Help prevent tantrums or loss of control by heading them off at the pass. If you see your child getting frustrated, try to calm her down and suggest another activity before she starts hurling puzzle pieces. Help your obviously angry toddler avoid a fight with her friend by inviting them to pause for a snack. ● Use consequences that are directly connected to the behavior of your child. If she is pouring water on her high chair after being told not to, take her out of her high chair. Then offer other acceptable options such as water play in the bathtub or outside. 	<ul style="list-style-type: none"> ● What behaviors do you find most difficult to handle? Why? ● How were you disciplined as a child? How do you think that influences how you discipline your child?
<p>Toddlers are able to play and explore in more complex ways. They like toys that they can play with in many different ways such as blocks, cars and stuffed animals that lend themselves to imaginative play.</p> <p>Toddlers love to move. In just a matter of months, children go from crawling to walking to practically running! Practicing their new moves strengthens the brain connections that help with coordination. Children learn a lot from active play. For example, they learn about gravity and up and down when they swing and go down the slide.</p>	<ul style="list-style-type: none"> ● Provide your child with objects and toys that lend themselves to imaginative play and join in with them. You will learn a lot about her thoughts and feelings and can help her expand her thinking. Sand, water, play dough and drawing materials are all good choices for children this age. They help develop your child's creativity and strengthen muscles that your toddler will use later in handwriting. ● Turn a walk into a learning opportunity. Point out big and small dogs in the park. Talk about the colors of the cars on the street. This kind of learning makes new ideas and concepts stick. 	<ul style="list-style-type: none"> ● What are some of the ways your child uses pretend play? What does this tell you about her? ● What do you most/least enjoy about playing with your toddler?
<p><i>*The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2½-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.</i></p>		

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Healthy Minds: Nurturing Your Child's Development from **24 to 36 Months**

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

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► Key findings from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Thirty-month-old Anthony wants to build a castle with his mom, Lena. They are almost done when Anthony begins to take it apart, block by block, and arrange the blocks in a straight line. Annoyed, Lena starts to pick up the blocks and put them back on the castle. Anthony starts to cry and tell his mom that she is not doing it right. Lena stops and asks Anthony what he is doing. Surprised that his mom isn't "getting it," he explains that he is building the path so the dragons can find their way to the castle. Lena smiles and watches as he completes his "dragon path."

This shows how all areas of Anthony's development are linked and how his mother's response encourages his healthy development. Anthony's ability to play cooperatively with his mom, not just side by side, demonstrates his **social and**

emotional development. His **intellectual ability** now enables him to pretend as he uses his imagination to play "castle." Using blocks in new ways, such as building a path for his dragons, shows creativity and good problem-solving skills. He uses his **language skills** to clearly let Mom know what he's thinking and planning. He uses his **fine motor skills** (his fingers and hands) to build the structure that he's picturing in his mind. When Lena happily joins in Anthony's pretend play, she makes him feel important and loved. She is flexible as she is able to put aside her annoyance and try to understand what Anthony wants to do. This lets Anthony know that he is appreciated and respected. It also leads to Lena letting Anthony direct the play, which encourages his creativity and imagination, 2 very important aspects of overall healthy development.

Relationships are the foundation of a child's healthy development.



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Charting Your Child's Healthy Development: **24 to 36 months**

The following chart describes many of the things your baby is learning between 24 and 36 months and what you can do to support your child in all areas of his development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what his strengths are and where he needs more support, is essential for promoting his healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:	What you can do:	Questions to ask yourself:
Two-year-olds typically can speak between 200 and 250 words. By the age of 3 years, their vocabulary is much larger still and they are able to put together 3- and 4-word sentences. Despite all this word power, 2-year-olds often lack the verbal skill to describe their emotions. This can leave them feeling powerless and frustrated.	<ul style="list-style-type: none"> ● Have lots of conversations with your child. This will boost his language skills, introduce him to the pleasure of conversation and make him feel important. Also, read with your child as often as you can. ● Let your 2-year-old know that you understand what he's experiencing by saying, for example, "I know you are upset that you can't find your magic cape." Acknowledging his feelings will help calm him and make it easier for him to tackle the challenge. 	<ul style="list-style-type: none"> ● What does your child like to talk about? How do you and your toddler enjoy conversations together? ● How does your child manage difficult feelings and situations? What helps him cope?
Play is essential for the 2-year-old. It builds all areas of his development. Through play, he interacts more with friends, uses pretend play to understand things in more complex ways and learns important concepts such as big and small and up and down.	<ul style="list-style-type: none"> ● Encourage pretend play and get involved. This will build a strong connection between you and your child, and can help encourage creativity. You can do this in many ways. For example, ask what will happen next in the story he is acting out. If he is "cooking," you might say, "What are you cooking? It smells good. Can I have some?" ● Make plans for your child to spend time with other children. He will learn about the pleasure of making friends. And the more opportunity he has to interact with peers, the more he will learn about how to get along well with others. 	<ul style="list-style-type: none"> ● What kind of play does your child most enjoy? How do you know? What does this tell you about him? ● How does your child use his imagination? What do you think he is learning through his pretend play?
Two-year olds are very active. Their motor development allows them the freedom to explore in new ways as they run, jump and climb.	<ul style="list-style-type: none"> ● Spend time outside, where there is plenty of room to safely run, jump and climb. Visit a neighborhood park where there are other children to play with. Include your child in family sports, like swimming together or kickball. ● Create a safe place in your home where your child can actively explore. Take walks with your child and use them as opportunities to teach him important concepts such as big and small as you compare the houses on your block or the leaves on the ground. 	<ul style="list-style-type: none"> ● How active is your child? Does he seem to be in constant motion or is he happy to sit and play quietly for long periods, or somewhere in between? ● What do you think your child is learning when he is playing actively? How do you know?

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High Quality Learning: Importance and Access for Parents

Did you know that there's a simple way to start your child on the path to future success?

Scientific studies recommend enrolling your young child in a high quality early education/child care program. High quality early learning programs:

- build strong brains and good vocabularies that help children arrive at kindergarten ready to learn
- provide the building blocks for all future learning
- help children learn to get along well with other children and adults
- strengthen early literacy skills that will make it easier for children to learn to read and develop a love of learning
- teach children to be good problem solvers
- reduce the need for Special Education services when children are older

Examples of high quality early learning programs are Head Start and Early Head Start (free to eligible families), public school preschools, licensed child care centers and licensed family child care homes. If transportation is a problem, you may be eligible for a high quality early learning program that can be provided free of charge in your home.

Need help finding an affordable high quality early learning program for your child in Hampshire County, Franklin County or the north Quabbin area?

Contact the [Child Care Resource and Referral Program](#) at the New England Farmworkers Council and ask for materials and recommendations to help you choose a high quality early learning program that you can afford. They have information about free programs and can tell you if your family qualifies for a child care subsidy to lower the cost.

Address: 21 Mohawk Trail, Unit 4, Greenfield MA 01301
(Wednesday office hours at the Franklin Hampshire Career Center in Northampton)

Phone: 413-475-3656 or 866-573-4684 (toll free) Fax: 413-475-3152
www.partnersforcommunity.org

Choosing Child Care in Massachusetts: A Personal Decision

As a parent at home with your child, you know better than anyone how to respond to your child's needs. So what do you do when it comes time to trust your child to someone else? There are many different kinds of early education and care programs to choose from, and selecting an option that meets your personal considerations from the long list of possibilities can be overwhelming.

The information below is adapted from Choosing Child Care, a publication of MA Department of Early Education and Care (EEC). Some indicators of quality child care are also based on an article found on the Zero to Three website, Choosing Quality Child Care:

www.zerotothree.org/early-care-education/child-care/choosing-quality-child-care.html

Where do I start?

1. **Does the program have an EEC license?** The EEC regulates health, safety, and staffing at licensed early education and after school programs. If the program has a license, it means that the program is required to be healthy, safe, and to offer activities that help children develop and grow; educators have training in first aid and are CPR certified; educators have specialized training in child development and curriculum implementation; all employees are required to undergo a criminal background check; and the program maintains an appropriate ratio of teachers to children.
2. **Is the space clean and inviting?** Can you imagine your child learning and having fun?
3. **Are the teachers/care providers qualified to work with children?** Are they warm and welcoming? Do they engage children in activities and conversation?
4. **Does the activity level in the program match your child's personality?** Do books and toys match the age of the children in the program? Does the daily routine include a mix of indoor and outdoor play, and active and quiet activities?
5. **Are snacks and meals well balanced and nutritious?**
6. **Do the program's behavior management policies fit with your parenting philosophy?**
7. **Are parents invited to play an active role?** Are parents allowed to visit at any time?

Choosing Child Care in Massachusetts (2)

Parents will learn a lot by visiting the program and observing caregivers and teachers interacting with children throughout the day. Look for the following indicators of a quality program.

Infants

- Caregivers are responsive, nurturing, engaged and clearly enjoy babies.
- Caregivers take primary responsibility for specific babies to create consistency in care and the opportunity to establish secure and responsive relationships.
- Caregivers nurture the child's learning while feeding, diapering, playing and in other everyday moments
- Caregivers are playful and follow the child's lead when playing, but also are skilled at extending the play to support new learning.
- Space allows developing infants to freely explore their environment.
- Organized, comfortable sleeping, eating, diapering and play areas.
- A daily routine that meets the needs of each baby.

Toddlers

- Caregivers set clear and consistent limits, but do so with loving kindness.
- Caregivers are consistently talking to children about what they're seeing and doing, especially before children can use words to talk back.
- Space is stimulating to allow active toddlers to safely explore their environment.
- Caregivers spend most of the time engaging with the children at the children's level (on the floor, at low tables)
- There are books in the space for children to look at on their own and that are read to them by adults.

Preschoolers

- Teachers plan activities that engage the interests and learning needs of the children.
- Teachers are tuned into children's individuality: temperament, strengths, challenges
- There are opportunities for children to choose activities; or to play along or with other children.
- Children access toys and materials on their own at appropriate times during the day.
- Opportunities for children to help and cooperate in the classroom.

School-aged Children

- Involve your child in the selection of a program which best meets his or her interests, such as hands-on activities, art, music, science, sports, creative dance, community involvement, field trips, academic support, or a combination of these activities.
- The program provides space for socialization and a quiet space to work on homework or to have down time and has a rich learning atmosphere that supports your child's education.
- The program seems to encourage your child's independence and builds self-esteem.

Choosing Child Care in Massachusetts (3)

QUESTIONS TO ASK PROSPECTIVE CHILD CARE PROVIDERS

- Is your program EEC licensed or authorized as license exempt?
- Do you have any openings?
- What hours are you open?
- What are the ages of the other children my child would be grouped with?
- What is the ratio of adults to children?
- Are there holidays or other dates that the program closes?
- Do you offer part-time or flexible care?
- What backup care is provided in case of provider illness?
- What activities would my child experience?
- How will you accommodate my child with special needs?
- What is your policy when a child is ill?
- Do you have a written discipline policy?
- What type of indoor and outdoor activities do you provide?

For more information about the types of child care and education programs and a list of all licensed local child care programs and providers, visit the [EEC website](#),

Stay connected and involved

Child care choices don't end with selecting a program; your continued active involvement in the care and education of your child is central to your child's success. The program you select should allow you to feel comfortable engaging with your child's teachers and care providers. You should feel empowered to make the choices that will most benefit your child.

Affordable Care: Financial Assistance

EEC helps eligible families find and pay for early education and care and school-aged programs. As funding for financial assistance is limited, even if you qualify, you may be put on the EEC waitlist until funding is available. For assistance in selecting and paying for child care or to be put on the EEC waitlist, contact your local Child Care Resource and Referral agency: **New England Farmworker's Council**, www.partnersforcommunity.org , 413-475-3656; regular office hours in Greenfield and on Wed. in Northampton.

EEC Regional Office for Western MA

1441 Main St. Suite 230, Springfield, MA 01103 (413)788-8401 (phone), (413) 784-1227 (fax)

Choosing Child Care in Massachusetts (4)

TYPES OF CHILD CARE

Almost all child care provided outside a child's own home, whether it be in a child care center, an after school program, or in a family child care home, must be licensed and authorized by the Massachusetts Department of Early Education and Care (EEC). Exemptions to licensing requirements may apply if the care is occasional, in a relative's home where all children are related to the caregiver, or in the child's home. The different types of licensed providers for which EEC sets rules for health, safety, and staffing are listed below:

Center-Based Programs

Centers serve children full or part-time in groups or classrooms of children. Children are usually grouped according to age:

- **Infant/Toddler:** birth through two years and nine months old.
- **Nursery Schools, Preschools and Pre-K:** two years and nine months old to kindergarten.
- **Early Head Start/Head Start:** infants through five years old whose families receive public assistance, children with a disability, and low-income families (free to eligible families; children involved with DCF can be prioritized)
- **School-Age:** five through fourteen years old (these programs are sometimes called extended day or after school programs and are open before and/or after school and/or during school vacations).

Family Child Care

Family child care is delivered in a provider's home. Children in a family child care home may range in age from infant through school age and programs may serve between a maximum of six or ten children (higher number with an additional assistant). Some family child care providers are part of a *Family Child Care System*, which may provide additional supports to providers and families.

The current license for all these programs will be posted in a prominent location, so look for the license.

Other Authorized Programs

EEC also authorizes programs that are license-exempt, such as **Public School Preschool Programs**. To find out if your local Public School offers an early childhood program, call your local public school, or visit the Department of Education's web site at:
profiles.doe.mass.edu

The EEC website has listings of all licensed child care providers, organized by community:
www.eec.state.ma.us

Excerpted from Choosing Child Care, a publication of MA EEC

How to Build the Child's Social-Emotional "House"

Visualize the house as the social-emotional well-being within all of us. We each have our own individual "house," with all its individual intricacies and unique sections. This is a slow process that happens over a lifetime, but without proper foundation (the base of the house) in the early years, it is impossible to build a solid structure throughout our lives.

Clearing space:

Clearing the space for the baby's social-emotional foundation begins as early as being pregnant. Parents make emotional space for the baby.



Usually this can't be done by one person. Family, friends, partners, community professionals need to be there to help.

Starting the foundation:

A solid foundation is needed for every person's social-emotional house. Without it, everything on top will be compromised.



A group of skilled people need to assist with the building. Family, friends, professionals all are needed to help the baby build their foundation.

To help the baby build a solid foundation: caregivers need to protect the child, make them feel safe and be consistent in meeting their needs. Infants need to learn that the world is a safe place and that adults can be trusted to meet their needs.

Watch the cracks!



Little foundational cracks (or emotional cracks in the child's social-emotional development) appear over time if the foundation was not built well.



Unaddressed, these little cracks become bigger and start affecting the structural integrity of the entire house.

Cracks begin to form when there is no consistent caregiver, or an abusive/neglectful caregiver.

Foundation failure:



FOUNDATION FAILURE

As time passes, the smaller emotional cracks/issues continue to grow, ultimately compromising the entire structure.



This was probably a grand building at one point, but without a solid foundation, it crumbles and begins to degrade.

If the social-emotional building blocks for the foundation are not there in the beginning, behavioral and emotional concerns develop in the child which can easily extend into relational, behavioral, emotional and health concerns in adulthood.

A house doesn't need to be fancy or grand - it needs to be solid from the ground up.



To ensure the social-emotional health of a child – consistent, responsive caregiving and a supportive environment are critical components.

*****Remember though, it is never too late to do repairs.*****

Adults can help kids repair their foundation--sometimes professional help is needed. When children are older and the damage to the house is more severe, the repairs are more difficult and costly. This is why intervening early on is so critical.

FAST FACTS



Information
for Parents

Building Your Baby's Brain

WHAT IS IT?

Helping your baby's brain to develop will help him/her succeed in school and life. The more you grow a baby's brain, the greater the impact on the brightness of their future.

Helping a child to develop and grow their brain is not rocket science. **Anyone can do it!**
Here are a few key things to remember when helping your baby to grow their brain:

- 1 Babies' brains grow fastest between birth and 3 years. This is the most important time in their lives.**
- 2 Babies' daily experiences tell the brain how to grow and develop.**
- 3 Babies' brains are built through back-and-forth interactions with adults. When you talk, sing, play, and laugh with your baby you are building a brain.**
- 4 Positive experiences and caregivers who respond to their laughing and crying give their brains the greatest chance of growing pathways for learning.**
- 5 When babies have negative experiences (family violence, stress, unresponsive caregivers etc.) their brains have to concentrate more on basic survival rather than growth and this can lead to developmental delays.**

Caregiver/Parent Tips for Healthy Brain Development:

Ensure good health, safety and nutrition	Be responsive to crying
Help children feel safe and secure	Really listen to them; respond to verbal and non-verbal cues
Consistent interactions. Respond to the baby's cues.	Remove physical and emotional threats
Talk, read, sing to and have conversations with child	Shield them from violence and if they are exposed, help them cope with the stress
Consistent, responsive and loving caregiving	Find professional help if needed to support the child
Encourage safe exploration and play	
Establish flexible routines	

REMEMBER: Babies are affected by stress and conflict. They can experience developmental delays because of the impact on their brain development. You can help them by following these tips.

Flash Cards to Help You Prepare for Pediatrician Conversations (1)

Raising a healthy and happy child.



How to talk to your pediatrician.

Your child's social and emotional development is just as important as their physical health.

That's why it's important to talk to your pediatrician about how your child feels and acts – if they have trouble getting along with others or sharing; if they get upset when you leave; if they don't sleep well or can't concentrate.

If you have any concerns it is important to discuss your concerns with your pediatrician.

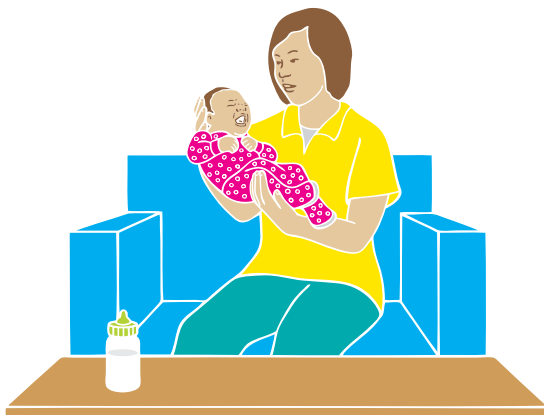
The cards in this pack will help you start a conversation with your child's doctor.

Together, you and your pediatrician can support your child's social and emotional growth, and help raise a healthy, happy child.



For more information visit ECMHMATTERS.ORG

0 - 6 MONTHS



Does your baby cry a lot?



All babies cry, but some babies experience colic, a pattern of intense, unexplained crying or fussiness for more than 3 hours per day. Try these tips:

- Soothe your baby with firm, but not too tight, swaddling and rocking.
- Make steady, loud whooshing sounds.
- Rub your baby's back or tummy.
- Take your baby for a walk or ride outdoors.
- Remember, caring for a baby who has colic is very stressful. Do not be too hard on yourself if it is near impossible to soothe your baby during a colicky time. Remember, it will end.

Source: ecmhatters.org

Flash Cards to Help You Prepare for Pediatrician Conversations (2)

0 - 6 MONTHS



Do you recognize how your baby “talks to you?”



Babies at this age love to communicate, and even though they can’t talk yet, you can help them express their feelings. Try these tips:

- Talk to your baby and make silly faces. They love it!!
- Give your baby attention when they smile or make talking sounds.
- When your baby turns away, they are telling you they need a quick break from “talking.” Watch for signs that she is ready to engage you again.
- Give your baby rattles and other safe toys to hold and shake. It doesn’t have to be anything fancy.
- Babies love faces, yours and theirs. Show her a mirror and watch her light up.

6 - 18 MONTHS



Does your child cry or get upset when you leave him?



It’s natural for young children to get upset when they are separated from their parents or caregivers. Next time this happens, try these tips:

- Stay calm and explain to your baby where you are going and when you will be back.
- Repeat the same message each time you go. Your baby will start to learn patterns, like the fact that you go to and return from work each day, for example.
- It’s hard to hear your baby cry but he needs to know you are comfortable with the separation and you are looking forward to seeing him again. Try saying, “I will miss you too, but you will have so much fun and I will be glad to see you at the end of the day.”

Source: ecmhatters.org

Flash Cards to Help You Prepare for Pediatrician Conversations (3)

6 - 18 MONTHS



**Do you talk to
your baby whenever
you get the chance?**



**That's a great thing to do because you are your baby's tour guide to the world.
Try these tips to help their learning:**

**Tell your baby about each new thing you are doing.
Here are some examples:**

- "Now we are going in the stroller."
- "Mommy is putting on her coat to take you out."
- "Daddy is getting your snack."

**Talk about what your child sees around them.
When they point to something, explain what it is.**

18 - 36 MONTHS



**Does your child ever get
upset when they have to
share with others?**



**That's okay because sharing things like toys or treats can be hard for children at this age.
Next time your child gets upset about sharing,
try these tips:**

- When you have two or more children, always try to have more than one toy. When kids are playing together, have them switch toys back and forth occasionally so they learn how to share.
- If your child gets upset about having to share something, re-direct their attention so that they find something new and interesting to play with.
- Let your child know that it's okay to be mad or sad, but it is not okay to grab, hit, or hurt anyone when they're upset.
- Children need help with their feelings about sharing. Teach turn taking before a child is very upset.

Source: ecnhmatters.org

Flash Cards to Help You Prepare for Pediatrician Conversations (4)

18 - 36 MONTHS



Does your child have tantrums when she doesn't get her way?



You can help ease your child's anger and begin to teach her to clam down during a tantrum. Try these tips.

- Remind yourself to remain calm even when your toddler is very upset.
- Acknowledge your child's strong feelings about what she wants or does not want in a situation, and remember that it can be tough for her to manage her feelings at this age.
- Avoid situations that can easily trigger tantrums like bringing a tired child shopping or giving their favorite toy to a friend that has come over to play.
- Before you remind your child of how you'd like her to behave, repeat what she has told you about her feelings so they know you're listening.
- When your child is really upset, don't try to talk or teach. Wait calmly for the feelings to get smaller. They WILL!

3 - 5 YEAR OLDS



Does your child become bored?



Children at this age are constantly looking for activities to keep them busy. You can use their energy to learn about "helping out." Ask them to help you with your daily activities. Find ways to let them help you organize toys, prepare meals, clean up the house, or go shopping.

- Slow down a little when you do these familiar activities. Letting your young child take part might mean things take slightly longer, but this is a great chance to make your child feel like she's being a helper.
- Break activities into short, simple steps, like, "pass me the pot," or "put the cereal in the basket. This will make your child feel good and excited about helping.

Source: ecmhatters.org

Flash Cards to Help You Prepare for Pediatrician Conversations (5)

3 - 5 YEAR OLDS



Does your child sometimes appear shy, or disconnected from people around him?



Children at this age are still learning about how to interact with other people, and you can play a big role in developing these skills with them. Try these tips:

- Observe your child's behavior, and talk to him about how he might be feeling. For example, if you notice that he seems sad, tell him, "You don't seem very happy right now." Listen to how he reacts to your statement, and then talk to him about how he's feeling and what would make him feel better.
- Help your child meet other children who like to play the same sort of games.
- Choose activities that your child can do alone but close to other children, such as art. This will help to develop their sense of independence while also being part of a group.

3 - 5 YEAR OLDS



Is your child a picky eater?



Picky eating is very common. Help them explore new and different foods in creative ways. Try these tips:

- **Dunk fruits and veggies** in healthy sauces or dips to make them more appealing.
- Use cookie cutters to make **cucumber stars or apple suns** so that your child gets excited about the shapes.
- Minimize distractions and turn off the TV during meals. Make the meal a special time for being together and eating.
- **Shred carrots and zucchini** in casseroles and spaghetti sauce so that your child is eating healthy foods even if she doesn't know it.
- Top cereal with **fruit slices instead of sugar**.
- **It's okay if your child doesn't eat everything on the plate.** Encourage her to try at least one bite of every item though.

Source: ecmh.matters.org

INFANT TODDLER TEMPERAMENT TOOL (IT³)

SUPPORTING A “GOODNESS OF FIT”



INTRODUCTION TO TEMPERAMENT

Temperament is an important feature of social and emotional health. The word “temperament” refers to the way we approach and react to the world. It is our own personal “style” and is present from birth. There are three general types of temperaments: easy-going, slow-to-warm, and active.

Easy-going children are generally happy and active from birth and adjust easily to new situations and environments. Slow-to-warm children are generally observant and calm and may need extra time to adjust to new situations. Children with active temperaments often have varied routines (eating, sleeping, etc.) and approach life with zest.

There are nine common traits that can help describe a child’s temperament and the way he or she reacts to and experiences the world. The **Temperament Chart** on the next page explains these traits in more detail. They are:

- Activity level
- Regularity
- Adaptability
- Distractibility
- Sensitivity
- Persistence
- Intensity
- Approachability
- Mood

GOODNESS OF FIT

Each caregiver and parent also has his or her own temperament. The compatibility between adult and child temperaments can affect the quality of relationships. This compatibility is often called “goodness of fit.” Goodness of fit happens when an adult’s expectations and methods of caregiving match the child’s personal style and abilities. Goodness of fit does not mean that adult and child temperaments have to match. The parent or caregiver does not have to change who they are. They can simply adjust their caregiving methods to be a positive support to their child’s natural way of responding to the world. For example, if a child is highly active, a caregiver may pack extra activities in the diaper bag for waiting times at visits to the doctor, grocery store lines, etc. For a child who needs some extra time in approaching new activities, a caregiver might stay close by, giving the child time to adjust and feel safe.

The Infant Toddler Temperament Tool (IT³) was developed for the Center for Early Childhood Mental Health Consultation, an Innovation and Improvement Project funded by the Office of Head Start. (Grant #90YD026B)

Source: The Infant Toddler Temperament Tool (IT³) | Center for Early Childhood Mental Health Consultation

T E M P E R A M E N T T R A I T S

DIMENSIONS	TYPICAL BEHAVIORAL INDICATOR	THE ADULT ...	THE CHILD ...
ACTIVITY LEVEL refers to the general level of motor activity when one is awake or asleep. Motor activity involves large and small muscle movement like running, jumping, rolling over, holding a crayon, picking up toys, etc.	HIGH ACTIVITY	has difficulty sitting still.	is squirmy and active.
	LOW ACTIVITY	sits back quietly and prefers sedentary activities.	prefers less noise and movement.
DISTRACTIBILITY is the ease with which one can be distracted, or one's level of concentration or focus.	HIGH DISTRACTIBILITY	has difficulty concentrating, and paying attention when engaged in an activity and is easily distracted by sounds or sights during activities.	is very distracted by discomfort, noticing even small signals of discomfort such as hunger, feeling sleepy, etc.
	LOW DISTRACTIBILITY	has a high degree of concentration, pays attention when engaged in an activity, and is not easily distracted by sounds or sights during activities.	can handle discomfort and does not seem very bothered at all.
INTENSITY refers to the energy level of one's emotional response, both positive and negative.	HIGH INTENSITY	has strong/intense positive and negative reactions.	
	LOW INTENSITY	has muted emotional reactions.	
REGULARITY relates to the predictability of biological functions such as eating, sleeping, etc.	HIGHLY REGULAR	has predictable appetite, sleep, and elimination patterns.	
	IRREGULAR	has unpredictable appetite, sleep, and elimination patterns.	
SENSITIVITY describes how sensitive one is to physical stimuli such as light, sound, and textures.	HIGH SENSITIVITY	is sensitive to physical stimuli including sounds, tastes, touch, and temperature changes; is a picky eater and has trouble sleeping in a strange bed.	
	LOW SENSITIVITY	is not sensitive to physical stimuli, including sounds, tastes, touch and temperature changes; can fall asleep anywhere and tries new foods easily.	
APPROACHABILITY is one's initial response to new places, situations, or things.	HIGH APPROACHING	eagerly approaches new situations or people.	
	LOW APPROACHING	is hesitant and resistant when faced with new situations, people or things.	
ADAPTABILITY describes how easily one adjusts to changes and transitions.	HIGH ADAPTABILITY	transitions easily to new activities and situations.	requires a very small amount of time to feel OK in new situations.
	LOW ADAPTABILITY	needs more time for transitioning to new activities or situations.	may cry or stay close to caregiver before approaching a new situation.
PERSISTENCE relates to the length of time one continues in activities in the face of obstacles.	HIGH PERSISTENCE	continues with a task or activity in the face of obstacles and does not get easily frustrated.	
	LOW PERSISTENCE	moves on to a new task or activity when faced with obstacles and gets frustrated easily.	
MOOD is one's tendency to react to the world mainly in a positive or negative way.	POSITIVE MOOD	reacts to the world in a positive way and is generally cheerful.	
	SERIOUS MOOD	reacts to situations in an observant, sometimes more serious way; tends to be thoughtful about new situations.	

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 2 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

DIRECTIONS FOR COMPLETING THE **TODDLER** VERSION OF IT³

FOR INFANTS 18 TO 36 MONTHS.

COMPLETION TIME: 5-10 MINUTES.

I AM COMPLETING THE IT³ FOR MYSELF AND _____

(TODDLER'S NAME)

Complete this brief **TODDLER** version of the IT³ to determine the “goodness of fit” between you and the child you have in mind for this activity. Remember, there are no “good” or “bad” temperamental traits; we are all born with unique personalities that make us special. The results and “goodness of fit” suggestions will help you to enhance your caregiving methods as a positive support for the child.

Please rate yourself and the toddler on the following nine traits. For each trait, fill in the circle that comes closest to describing your regular behaviors and those of the infant. You can refer to the previous page and chart of Temperament Traits for definitions of each trait.

Use the following statements to focus your thinking as you review each trait for yourself and the toddler:

- More often than not, I behave in a way that can be described as:
- More often than not, the toddler behaves in a way that can be described as:

DIMENSIONS	TYPICAL BEHAVIORAL INDICATOR	I AM ...	MY TODDLER IS...
1. ACTIVITY LEVEL	Highly Active	<input type="radio"/>	<input type="radio"/>
	Less Active	<input type="radio"/>	<input type="radio"/>
2. DISTRACTIBILITY	Easily Distracted	<input type="radio"/>	<input type="radio"/>
	Less Distracted (More Focused)	<input type="radio"/>	<input type="radio"/>
3. INTENSITY	Intense Personality	<input type="radio"/>	<input type="radio"/>
	Relaxed Personality	<input type="radio"/>	<input type="radio"/>
4. REGULARITY	Highly Regular	<input type="radio"/>	<input type="radio"/>
	More Spontaneous (Irregular)	<input type="radio"/>	<input type="radio"/>
5. SENSITIVITY	Highly Sensitive	<input type="radio"/>	<input type="radio"/>
	Less Sensitive	<input type="radio"/>	<input type="radio"/>
6. APPROACHABILITY	Highly Approachable	<input type="radio"/>	<input type="radio"/>
	Less Approachable	<input type="radio"/>	<input type="radio"/>
7. ADAPTABILITY	Highly Adaptable	<input type="radio"/>	<input type="radio"/>
	Less Adaptable	<input type="radio"/>	<input type="radio"/>
8. PERSISTENCE	Highly Persistent	<input type="radio"/>	<input type="radio"/>
	Less Persistent	<input type="radio"/>	<input type="radio"/>
9. MOOD	Positive Mood	<input type="radio"/>	<input type="radio"/>
	Serious Mood	<input type="radio"/>	<input type="radio"/>

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 3 •

Source: The Infant Toddler Temperament Tool (IT³) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

ACTIVITY LEVEL

Refers to the general level of motor activity when one is awake or asleep. Motor activity involves large and small muscle movement like running, jumping, rolling over, holding a crayon, picking up toys, etc.

I am ...

My toddler is ...

● **Highly Active**

● **Highly Active**

You and your child share a similar activity level.

- Enjoy scooting, crawling, walking, running and climbing inside and outside with your child.
- Make sure that you and your child both take time for rest. Help your child learn to take a break by modeling the signs of feeling tired, as well as ways that you like to take rests — for example, relaxing in a chair with a book, taking a deep breath, or coloring.
- If your child is younger, describe the signals he/she gives to let you know that he/she is ready for a break. *“I see you are looking around at other things and you are wiggling in my lap. How about we go outside for a while?”*

I am ...

My toddler is ...

● **Highly Active**

● **Less Active**

You and your child seem to differ in activity level. Here are some ideas to help you support your child’s lower level of activity.

- Make sure there are specific quiet areas that are still in full view where your child can relax and observe. For example, use beanbag chairs that toddlers can move around the room and sit in when they need time for themselves.
- Do not require your child to participate in movement or other active activities (such as dancing while you play a song) until he/she is ready to join.
- Let your child know he/she can take breaks during the day if he/she is tired.
- Give positive attention to your child when he/she successfully transitions to naptime or another quiet experience.
- Support your child in playing with things he/she enjoys such as books, puzzles, blocks, dolls, etc.
- Allow your child to wake up at his/her own pace and re-enter classroom activities.

I am ...

My toddler is ...

● **Less Active**

● **Highly Active**

You and your child seem to differ in activity level. Here are some ideas to help you support your child’s higher level of activity.

- Allow extra time for outdoor activities (for example, crawling, running, climbing, etc.) so that your child can “let off steam.”
- Provide many indoor opportunities to support your child’s large muscle skills, such as creating an obstacle course with pillows and cushions, dancing to music, etc.
- Use your child’s energy level as an example to excite other children. *“You are jumping up and down to the music. Jason and Lei, would you like to join him?”*
- Give advance warning of naptime, because it may be hard for your child to transition to resting. Start winding down from active play about 30 to 60 minutes before bedtime or napping.

I am ...

My toddler is ...

● **Less Active**

● **Less Active**

You and your child share a similar activity level.

- Enjoy cozying up on the couch or in a chair with a book or soothing music.
- Establish brief, consistent times during the day for outlets of physical activity. This will help you and your child feel ready to get moving.
- Expand favorite activities as a way to get in some movement. For example, stand up and act out a favorite story with your child, or put on his/her favorite music and rock and sway together around the room.
- Support your child if he/she is not ready to join others in highly active play. Narrate what you see and let him/her observe. *“The kids are chasing each other. Do you see them going fast?”*

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 4 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

DISTRACTIBILITY

Is the ease with which one can be distracted or one's level of concentration or focus.

I am ...	My toddler is ...
● Easily Distracted	● Easily Distracted

You and your child share a similar level of distractibility.

- Try to limit distractions while spending time with your child. For example, choose to listen to music or read a book rather than having the music on in the background while reading.
- Help your child learn to recognize the signs of becoming overstimulated. You can do this by talking about what overstimulates you and how you refocus your attention. *"The television is making it hard for me to cook dinner. I am going to turn it off so I can pay attention."*
- Label the signals your child provides to communicate that he/she is getting distracted or overstimulated. *"You are yawning and turning away from me when I sing. I think you are done with the song."*

I am ...	My toddler is ...
● Easily Distracted	● Less Distracted

You and your child seem to differ in the area of distractibility. Here are some ideas to support the fit between you and your child's more focused nature.

- Accommodate your child by allowing longer experiences that he/she can handle. *"You are so busy looking at the stories — would you like to look at a few more?"*
- Give your child frequent reminders that a transition is coming, so he/she can be prepared in advance: *"It's almost time for lunch. We have about five minutes left for playtime."* When possible use many different ways to remind children of transitions. Adults can use picture cards to remind children what is happening next, a gentle tap on the shoulder, a simple transition song, or other methods that support the child's style of learning.
- Encourage your child to interact with other children while playing, and notice and describe interactions between him/her and other children. *"Adam is looking at the red ball you have. Could you roll it back and forth?"*

I am ...	My toddler is ...
● Less Distracted	● Easily Distracted

You and your child seem to differ in the area of distractibility. Here are some ideas to support the fit between you and your child's distractibility.

- Use simple step-by-step directions that are clear and easy to understand: *"First put on your shoes. Next, you can put on your coat."*
- Limit the number of choices, so it is easier for your child to respond. *"Do you want milk or juice?"* It can be helpful to hold up the actual choices as a visual reminder.
- Acknowledge when your child is becoming distracted. Then gently redirect his/her attention to the current experience he/she is engaged with. *"I notice you are looking away from the puzzle. Would you like to put one more piece in to finish it up?"*
- Follow your child's lead in play when possible: *"Your car is going fast! Can my car follow?"* Be willing to shorten activities to accommodate his/her emerging ability to concentrate and focus.

I am ...	My toddler is ...
● Less Distracted	● Less Distracted

You and your child share a similar level of focus.

- Take pleasure and joy in your chance to have uninterrupted time with each other and with objects. Use this time to discover together and share laughter.
- When making plans for your day, use advance warnings about transitions and changes in your schedule. You might use visuals to help with transitions. For example, if you are going to visit someone, you could show that person's photo to your child and give warning. *"In a few minutes we are going to drive over to visit Ms. Lohmann."*
- Because it may be easy to get lost in one type of activity, consider planning several activities to provide a variety of experiences during the day, such as, climbing or crawling outside, interactive play like "Peekaboo" or hide-and-seek, sharing stories with colorful pages, and taking part in daily routines.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — TODDLER VERSION

• 5 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

INTENSITY

Refers to the energy level of one's emotional response, both positive and negative.

I am ...	My toddler is ...
● Intense	● Intense

You and your child both have fairly intense personalities.

- Enjoy sharing big smiles and laughter while recognizing your child's similarly big frowns and tears.
- Help your child learn to accept his/her big feelings by providing descriptions of those feelings as well as ways to calm down when the feelings (positive or negative) become too big. *"You are kicking your legs and waving your arms to the music — are you excited?"*
- Model the types of reactions you would like to see in your child. For example, if you are feeling frustrated, take a few deep breaths to calm down.
- Find ways to sooth your child when he/she is feeling strong emotions (for example, rubbing his/her back, swaying to gentle music, singing softly, gently holding, etc.). Be sure to share your most successful strategies with your child's caregivers.

I am ...	My toddler is ...
● Intense	● Relaxed

You and your child seem to differ in the area of intensity. Here are some ideas to support the fit between you and your child's "low intensity."

- Because your child may not have strong reactions, try to label possible emotions for him/her. *"You are frowning. Are you sad that the puppy ran off?"*
- Support emotions as your child experiences them. *"You feel upset that it is time to go outside. You are not done with your puzzle."*
- Provide cozy, quiet areas so that your child is not overwhelmed by active situations. You can use beanbag chairs, pop-up tents, or pillows and blankets to create safe areas for your child to calmly observe and take in activities around him/her.
- Create activities that promote emotional awareness, such as asking your child how he/she feels each morning. Share how you feel as well. Try creating a feelings chart with pictures of different emotions that can help your child identify how he/she is feeling.

I am ...	My toddler is ...
● Relaxed	● Intense

You and your child seem to differ in the area of intensity. Here are some ideas to support the fit between you and your child's level of intensity.

- Try to accommodate strong emotional reactions by putting yourself in your child's shoes. Ask yourself, *"What must it be like to be my child in this situation?"*
- Help your child through a strong negative reaction by relating it to you. For example: *"I don't like it when people take my things without asking either. How can we make this better?"*
- When your child is having a strong negative reaction, try to remain calm and be a "safe place" for your child. *"I know you are upset right now. I will be right here when you need me."*
- Label your child's emotions and help to validate them. *"I can tell you are really excited right now to have this applesauce. That's great! In a few minutes you may be a little calmer, and I can give you your spoon to use by yourself!"*

I am ...	My toddler is ...
● Relaxed	● Relaxed

You and your child both have fairly relaxed personalities.

- Consider practicing, identifying, and labeling emotions with your child, so that he/she can recognize and accept his/her own and others' emotions. Look at storybooks about emotions. Reflect together on what you see.
- Take time to explain to your child what others may be feeling. *"The baby is crying! She dropped her toy."*
- Label your child's emotions, paying special attention to both obvious and subtle clues in their behavior, like furrowed brows, upturned eyes, looking away, cooing, clenching of fists, babbling, waving arms, etc.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — TODDLER VERSION

• 6 •

Source: The Infant Toddler Temperament Tool (IT³) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

REGULARITY

Relates to the predictability of biological functions such as eating, sleeping, etc.

I am ...	My toddler is ...
● Highly Regular	● Highly Regular

You and your child share a similar level of regularity.

- Follow your instincts of maintaining a consistent and predictable routine for you and your child.
- Share your child's preferred daily routine with others who care for him/her.
- Help your child learn to feel comfortable with unplanned interruptions in his/her schedule by using descriptions to label how it makes you feel when this happens.
- Support him/her by using a picture schedule. For example, use single-object pictures to create a schedule that shows your child that he/she will eat breakfast first and then get dressed.

I am ...	My toddler is ...
● Highly Regular	● More Spontaneous

You and your child seem to differ in the area of regularity. Here are some ideas to support the fit between you and your child's spontaneity.

- Try to allow your child to nap or rest for shorter or longer than other children if it seems necessary. Have your child use quiet toys while awake if others are still resting.
- Watch your child closely to notice his/her eating patterns — and try your best to accommodate them.
- Provide many opportunities for diaper changing or toileting.
- Give advance reminders when transitions are coming, so that your child can be prepared.

I am ...	My toddler is ...
● More Spontaneous	● Highly Regular

You and your child seem to differ in the area of regularity. Here are some ideas to support the fit between your spontaneity and your child's regularity:

- Accommodate your child's regular appetite by providing meals at the same time each day.
- Recognize how your child lets you know that it's time to use the bathroom.
- Try to provide your child with a routine nap schedule that he/she can feel secure with.
- Try to give advance reminders to your child when the daily schedule will be disrupted.

I am ...	My toddler is ...
● More Spontaneous	● More Spontaneous

You and your child share a similar level of spontaneity.

- Enjoy the spontaneity of the day. For example, if you planned to go outside but your child is interested in the water and bubbles as you wash dishes, let him/her join in by providing a sponge and a bowl of warm sudsy water.
- Be prepared for change as you plan for the day. This will also be helpful for your child. If he/she gets tired a little earlier, go with it and make time to rest. Or, if your child is not showing signs of being tired, let him/her stay up a little longer doing some quiet activities.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 7 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

SENSITIVITY

Describes how sensitive one is to physical stimuli such as light, sound, and textures.

I am ...	My toddler is ...
● Highly Sensitive	● Highly Sensitive

You and your child share a similar level of sensitivity.

- Enjoy the quiet, cozy moments of your day together, like nap and bedtime, as times to connect. Use these times to talk softly about your day or sing songs in a soothing tone.
- When you find yourselves in environments that are louder or brighter than you both enjoy, help your child adjust by finding a quiet space to be together.
- Provide soft clothing and textures for your child.
- Use a warm, supportive tone to help your child as he/she works through emotions.

I am ...	My toddler is ...
● Highly Sensitive	● Less Sensitive

You and your child seem to differ in the area of sensitivity. Here are some ideas to support the fit between you and your child's lower sensitivity.

- Engage your child in activities with lots of sensory experience (for example, playing a song while dancing and holding hands with others, finger painting, water play, play dough, etc.)
- Use a funny, dramatic voice while reading stories. Be silly!
- Even though your child may have lower sensitivity, still check in to see if he/she is handling a stimulating situation well. *"It's loud in here — how are you feeling?"*
- Offer new kinds of foods for your child to try.
- Draw positive attention to your child when he/she is enjoying a new experience. *"You are playing with the sudsy water and are pouring it in and out. How does it feel on your hands?"*

I am ...	My toddler is ...
● Less Sensitive	● Highly Sensitive

You and your child seem to differ in the area of sensitivity. Here are some ideas to support the fit between you and your more sensitive child.

- When engaging in a stimulating experience such as music, offer your child other less stimulating options such as quiet reading time or an area close by to safely observe.
- React sensitively when your child is overwhelmed by his/her surroundings. Help find a quiet activity. *"I notice you are tightening your fists and frowning. Is the bright light bothering your eyes?"*
- Let your child know when you are about to touch him/her. *"I am going to pick you up gently now so we can go and put on a fresh diaper."*
- Give your child experiences with sensory materials by putting sand, dirt, corn starch, water, etc., inside sealed plastic baggies.
- Offer tools that your child can use to experience new textures at his/her own pace. For example, have tongs available for picking up textured objects, paint brushes for experimenting with sticky glue, gloves for finger painting, etc.

I am ...	My toddler is ...
● Less Sensitive	● Less Sensitive

You and your child share a similar level of sensitivity.

- Have fun singing loudly and dancing to music together.
- Provide fun activities using bubbles, sand, water, sandpaper, or feathers. These activities let your child explore sounds, textures, and smells.
- Label these experiences for your child. *"You are popping so many bubbles!"*
- Even though you can both tolerate high levels of sensory input, take time to check in and notice when it is too much, and describe how this feels for your child. This will also help him/her learn how to monitor his/her experiences and reactions to the environment.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 8 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

APPROACHABILITY

Is one's initial response to new places, situations, or things.

I am ... My toddler is ...
☒ **Highly Approachable** ☒ **Highly Approachable**

You and your child both share a similar tendency to approach new situations or people.

- Share the pleasure with your child as you take on new adventures and outings to museums (even if he/she just watches people go by), playgroups, parks, or the zoo.
- Take time to be around other children and families if possible.
- Be close by to help your child as he/she learns to interact with others. Sometimes very approachable children may come into contact with a child who is less open to new people. The more approachable child may need help to navigate the situation.

I am ... My toddler is ...
☒ **Highly Approachable** ☒ **Less Approachable**

You and your child seem to differ in the area of approachability. Here are some ideas to support the fit between you and your child's lower level of approachability.

- Be your child's safe base. Introduce him/her to new surroundings and people from the safety of your arms or while holding hands. Talk to him/her gently and in a reassuring way about what is going.
- Help others connect with your child by letting them know to take it slow. Share your child's favorite toys or activities with the other person to build a connection.
- Don't make your child participate in a new experience if he/she seems unsure. If possible, provide a space for him/her to observe what is going on until he/she is ready to take part.
- Be careful not to label your child as "shy." Letting others know that he/she just needs a little time to watch and take it slow is more gentle and respectful. Labels can stick over time.
- Prepare children for new things. For example, if your child will be going to a new child care center, drive by and visit before the first day.

I am ... My toddler is ...
☒ **Less Approachable** ☒ **Highly Approachable**

You and your child seem to differ in the area of approachability. Here are some ideas to support the fit between you and your child's high approachability.

- Try to accommodate your child's wish to explore new situations. Explore during nature walks, listen and dance to new music, taste new foods, take part in new social experiences like playdates, etc.
- Provide games and activities that encourage side-by-side or cooperative play like wagons, balls that can be rolled back and forth, puppets, water table play, blocks and vehicles, etc.
- Even though your child likes to be social, sometimes certain situations call for the help of an adult. *"You are so happy to see Arianna and you gave her such a big hug! Arianna is frowning and holding her arms close to her. I think she is trying to say, 'Please be gentle! How about saying, 'Good morning, Arianna,' and giving her a gentle pat on the hand?'"*

I am ... My toddler is ...
☒ **Less Approachable** ☒ **Less Approachable**

You and your child both share a similar tendency to withdraw from new situations or people.

- Just like you, your child might prefer individual interactions or small gatherings of people. Plan for these types of experiences versus many larger group gatherings in one day.
- Take time to talk to your child about new situations as you remain his/her safe base, holding him/her or standing close by. *"The children are splashing in the water."*
- Your child is likely to enjoy playing with the same toy and spending time in familiar places. Encourage him/her to take familiar objects to new places and to have special places to relax, such as on the couch reading stories with you.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 9 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

ADAPTABILITY

Describes how easily one adjusts to changes and transitions.

I am ...

My toddler is ...

● **Highly Adaptable**

● **Highly Adaptable**

You and your child share a similar level of adaptability.

- Just like you, your child will probably find it easy to try new situations and will not feel caught off guard during transitions or disruptions in a usual routine. Continue to use words to narrate when change will occur.
- Continue to enjoy a variety of activities during the day, since you both have an easy time switching between activities.
- Keep an eye out for cues or behavior signaling that your child has had enough changes. *Some* routine is good for all children. Try to keep some things the same each day, like eating, napping, sleeping, etc.

I am ...

My toddler is ...

● **Highly Adaptable**

● **Less Adaptable**

You and your child seem to differ in the area of adaptability. Here are some ideas to support the fit between you and your child's lower level of adaptability.

- Give many advance reminders when transitions are coming so that your child can be prepared.
- Try not to introduce too much too fast. A new child or teacher in the classroom might be scary or confusing for your child, so react sensitively.
- Allow your child to not participate in a new experience if he/she is having difficulty adjusting.
- Let your child know that you are available for comfort. *"I know that this is hard for you since it's so new. Do you want to play with your favorite blocks instead?"*
- Try to keep to a normal daily routine to minimize confusion for your child.

I am ...

My toddler is ...

● **Less Adaptable**

● **Highly Adaptable**

You and your child seem to differ in the area of adaptability. Here are some ideas to support the fit between you and your child's higher level of adaptability.

- Try to accommodate your child's ability to explore new situations by introducing new experiences often.
- Positively reinforce your child by talking about how easily he/she adapts to new classmates, new situations, etc.

I am ...

My toddler is ...

● **Less Adaptable**

● **Less Adaptable**

You and your child share a similarly low level of adaptability.

- Follow your instinct of taking new situations, people, and transitions slowly, with advance preparation and adequate time. Allow extra time when approaching something new, so the experience is not hurried.
- When you have to do something that is new that does not feel good, explain that you feel nervous or uncomfortable, and describe how you might help yourself.
- Describing your experience to your child will help him/her learn to recognize feelings in himself/herself and others, as well as how to help himself/herself.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 10 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

PERSISTENCE

Relates to the length of time one continues in activities in the face of obstacles.

I am ...	My toddler is ...
● Highly Persistent	● Highly Persistent

You and your child share a similarly high level of persistence.

- Have fun providing a range of activities and new objects and take delight watching all the ways your child explores and interacts with his/her surroundings. Like you, he/she may feel really happy working on a problem and discovering all the possible angles.
- Describe this feeling for your child and consider praising his/her efforts rather than the final product.

I am ...	My toddler is ...
● Highly Persistent	● Less Persistent

You and your child seem to differ in the area of persistence. Here are some ideas to support the fit between you and your child's lower level of persistence.

- Provide encouragement as your child attempts a task. *"You scooted so close to the toy! You are almost there!"*
- Provide experiences that your child has already mastered so that he/she can feel successful.
- Encourage emotional vocabulary development by labeling emotional reactions. *"You are stomping your feet and tightening your fists. Are you feeling angry that your tower fell down?"*
- Check in with your child often so that he/she knows you're available to help.

I am ...	My toddler is ...
● Less Persistent	● Highly Persistent

You and your child seem to differ in the area of persistence. Here are some ideas to support the fit between you and your child's higher level of persistence.

- Recognize and offer feedback when your child is working really hard at something. *"You stacked two blocks, your tower is growing."*
- Provide activities that challenge your child. *"You are doing a four-piece puzzle. Would you like to try the new animal puzzle with more pieces?"*
- Check in with your child as he/she persists through a task to make sure he/she doesn't become too frustrated with an activity. *"You are working very hard to get all of the pieces to fit together, and they sometimes fall apart. How are you feeling?"*
- Encourage emotional vocabulary development by asking your child how he/she feels when he/she persists at something. *"You are able to pull your friend Matthew in the wagon, and he is giggling! How does that make you feel?"*

I am ...	My toddler is ...
● Less Persistent	● Less Persistent

You and your child share a similar, lower level of persistence.

- Just as you may do for yourself, break new and challenging activities into smaller parts, and praise your child for his/her efforts.
- Help your child learn how to recognize when he/she is beginning to feel frustrated and what he/she could do to feel better. You can do this by describing your own feelings during frustrating times and what strategies you use to calm down and finish the job.
- Make sure to baby-proof or toddler-proof your home so your child can explore and experience his/her environment.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 11 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

R E S U L T S F O R

MOOD

Is one's tendency to react to the world primarily in a positive or negative way.

I am ...	My toddler is ...
● Positive Mood	● Positive Mood

You and your child share a similarly positive mood.

- Take delight sharing a giggle or belly laugh at the world around you. Describe your child's happy feelings as you experience these moments together.
- Play fun games throughout the day, such as hide-and-seek and "Peekaboo."
- Look in the mirror together and share smiles.
- Even though you may both have a generally positive mood, remember to also describe feelings of sadness, anger, or fear so that your child learns that these feelings are OK too.

I am ...	My toddler is ...
● Positive Mood	● Serious Mood

You and your child seem to differ in the area of mood. Here are some ideas to support the fit between you and your child's different dispositions.

- Try to match your child's mood when he/she is feeling serious, so that he/she knows that this emotion is OK.
- Try not to force your child into a positive mood; allow him/her to express himself/herself.
- Encourage emotional vocabulary development by labeling emotional reactions. *"Your face tells me you're upset. Did you not like that story?"*
- Allow your child to not participate in an experience if he/she is getting upset.

I am ...	My toddler is ...
● Serious Mood	● Positive Mood

You and your child seem to differ in the area of mood. Here are some ideas to support the fit between you and your child's different dispositions.

- Try to match your child's mood when he/she is feeling cheerful so that he/she knows that this emotion is good.
- Acknowledge when your child is really enjoying an activity. *"Look at the big smile on your face; you look happy riding the tricycle!"*
- Encourage emotional vocabulary development by labeling emotional reactions. *"You are smiling so much! That must mean you liked the clapping!"*
- Check in throughout the day even when your child appears cheerful.

I am ...	My toddler is ...
● Serious Mood	● Serious Mood

You and your child share a similarly serious mood.

- Your child may like choices. As he/she gets older, allow choices for daily routines such as which story to read together before naptime.
- Give your child straightforward information about day-to-day happenings. *"We are going to child care, and I will be back to pick you up after your nap."*
- Try to relate to your child's thoughtful approach to his/her surroundings, and recognize that being thoughtful or serious does not mean being angry.
- Allow time for your child to engage in observing what is going on before joining in.
- Point out cues that your child uses to show engagement or joy. Sometimes these signs might be more subtle than a smile or laughter. You might notice raised eyebrows, bright eyes, or turning towards a sound.

INFANT TODDLER TEMPERAMENT TOOL (IT³) — **TODDLER** VERSION

• 12 •

Source: The Infant Toddler Temperament Tool (IT3) | Center for Early Childhood Mental Health Consultation

FAST FACTS



Information
for Parents

Helping Children to Identify Feelings

WHAT DOES THIS MEAN?

Even very young children feel emotions just like adults do. As they learn to talk, children need to learn how to use their words instead of acting out their feelings in inappropriate ways. Adults in their lives need to help them understand their feelings and learn to express them in acceptable ways.

WHAT PARENTS/CAREGIVERS CAN DO:

Explain feelings by using words that your child can understand:

You can use pictures, books, and video to help children identify facial expressions and emotions.

Share how you're feeling using words children can understand and also explaining feeling words that are new to them.

When you teach new feeling words to children (for example: brave, excited, relieved), it broadens their understanding of emotions.

Teach the child the different ways we can express our feelings appropriately:

Talk about positive ways to express feelings.

Let the child come up with ways to express feelings.

Teach new ways to express emotions appropriately. For example: taking a deep breath, going to a quiet place to calm down, or asking for a hug.

When there are problems, talk about how it might have gone differently.

KEEP IN MIND:

To develop empathy, children need to know how to identify their own emotions before they can understand how others are feeling.

Praise the child for any attempt to talk about his/her feelings:

Be specific. It's important that you tell the child exactly what he/she did to earn your praise.

This is an opportunity to teach that all feelings are acceptable and that it is always OK to talk about feelings. It is how the child shows what he/she is feeling that may need practice.

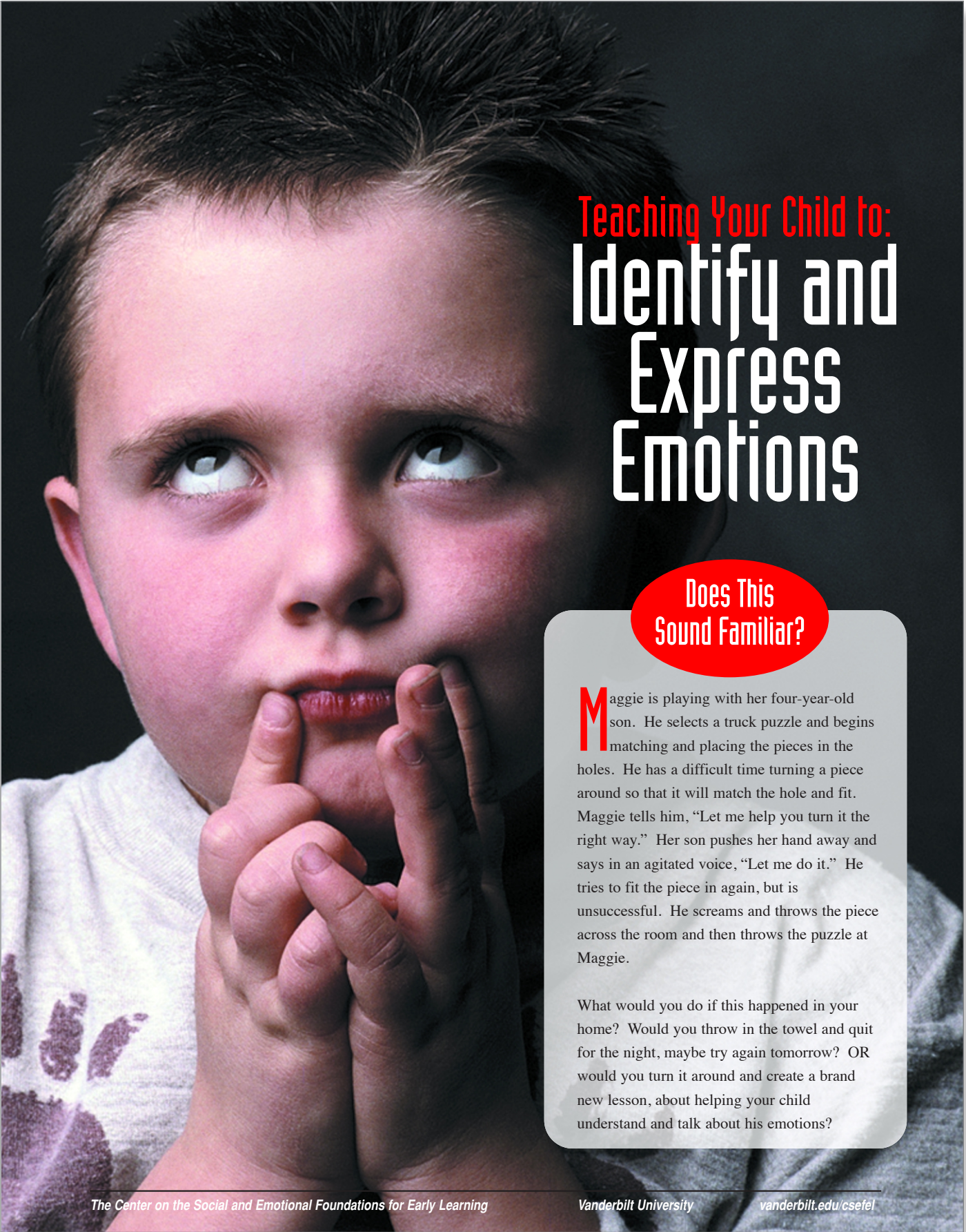
Practice new ways to deal with emotions

Use quiet, calm times to practice new skills.

Talk about feelings while doing everyday tasks. For example: when playing a game, riding in the car, eating dinner.

Ask your child what the characters in books might be feeling and whether they are showing their feelings in a helpful way.

The more that a child practices, the faster he/she will learn.



Teaching Your Child to: Identify and Express Emotions

Does This Sound Familiar?

Maggie is playing with her four-year-old son. He selects a truck puzzle and begins matching and placing the pieces in the holes. He has a difficult time turning a piece around so that it will match the hole and fit. Maggie tells him, "Let me help you turn it the right way." Her son pushes her hand away and says in an agitated voice, "Let me do it." He tries to fit the piece in again, but is unsuccessful. He screams and throws the piece across the room and then throws the puzzle at Maggie.

What would you do if this happened in your home? Would you throw in the towel and quit for the night, maybe try again tomorrow? OR would you turn it around and create a brand new lesson, about helping your child understand and talk about his emotions?

The Center on the Social and Emotional Foundations for Early Learning

Vanderbilt University

vanderbilt.edu/csefel

Source: Vanderbilt University, The Center on the Social and Emotional Foundations for Early Learning | vanderbilt.edu/csefel

The Focus

Young children deal with many of the same emotions adults do. Children get angry, sad, frustrated, nervous, happy, or embarrassed, but they often do not have the words to talk about how they are feeling. Instead, they sometimes act out these emotions in very physical and inappropriate ways. For example, when Maggie's son was frustrated, he threw the puzzle piece and the puzzle.

The Solution

Parents can help their children understand and express their emotions. The following strategies are some of the ways you can help your child express his feelings:

- Help your children understand their emotions by first giving the feelings names and then encouraging them to talk about how they are feeling. For example, you might say to your child, "Daddy left on a trip, you are sad. You said you want your Daddy." By giving your child a label for her emotions, you enable your child to develop a vocabulary for talking about feelings.
- Give children lots of opportunities to identify feelings in themselves and others. For example, you might say to your child, "Riding your bike is so much fun. I see you smiling. Are you happy?" Or you might point out a situation and ask your child to reflect on what someone else may be feeling: "Joey bumped his head on the slide. How do you think Joey feels?"
- Teach your children the different ways they can respond to specific feelings, conflicts, or problems. Talk about your own feelings with your children. "Remember yesterday when the water in the bathtub would not go down the drain? Mommy got so mad and do

you remember what my face looked like when I got mad? Can you make a mad face like Mommy's?"

Talk with your children about different ways you deal with specific feelings. "When I get mad I take a deep breath, count to three, and then try to think of the best way to deal with my problem."

- Teach your child to identify and express their emotions in ways that your family and friends find acceptable. For example, you might tell your child "Sometimes Grandfather is angry when things don't go well at work. What does he do? He sits on the porch until he figures out what he wants to say about it. You should sit and think when you get angry."

The Steps

1. Explain the feeling by using words your child can easily understand. Try to use pictures, books, or videos to help get your point across. "Look at Little Red Riding Hood's face; she is so scared when she sees the wolf in her Grandma's bed!"
2. Teach your child the different ways we can deal with feelings. Let your child come up with ways she can deal with her feelings. Talk about positive and not so positive ways to express feelings. There are many strategies you can use to teach new ways to appropriately express feelings:
 - Use real-life examples or teach in the moment. For example, "You are having a difficult time putting your trike in the carport. You look frustrated. What can you do? I think you could ask for help or take a deep breath and try again. What do you want to do?"
 - Teach your child new ways to respond to feelings by discussing common situations that your child might remember or that



happen frequently. For example, "Yesterday, you were angry because Joey would not let you play with his truck. You were so mad that you hit him. When you feel angry that Joey won't let you have a turn, what should you do?"

- You can use children's books to talk about feelings. For example, ask your child when reading a book, "What is (character in book) feeling right now? How do you know? Have you ever felt that way? What do you do when you feel that way?"
- Keep it simple, use visuals or pictures to help get your point across, and always try to relate your lesson back to something that happens in your child's life.
- Teach your child new strategies to use when feeling emotions that may be expressed inappropriately (e.g., anger, frustration, sadness). Strategies to share with your child might include taking a deep breath when frustrated or angry, getting an adult to help resolve a conflict, asking for a turn when others won't share, asking for a hug when sad, and finding a quiet space to calm down when distressed.

3. Praise your child the first time he tries to talk about his feelings instead of just reacting. It is **REALLY** important to let your child know exactly what she did right and how proud you are of her for talking about feelings. It should always be OK to say what we are feeling. It's how we choose to show our feelings and respond to them that requires special effort.

4. Support your child to talk about feelings and practice her new strategies for expressing emotions appropriately every chance you get. For example, you can talk about feelings when you are playing a game, when you are riding in the car, or when you are eating dinner. There will be all kinds of things that happen every day that will be great opportunities for you to talk about feelings. The more often your child practices, the faster your child will learn.

WARNING – Do not try and practice when your child is in the middle of a “meltdown.” Use quiet, calm times to teach and practice the new strategies. For example, if your child is having a “meltdown” because she does not want to wait for a cookie until after dinner, she will not be in the mood to practice expressing her frustration with words, rather than a tantrum. In this situation, you have to be deal with her emotions (e.g., “I know you really want a cookie now, but that is not an option, we are going to eat dinner in 5 minutes. You may have a cookie after dinner.”). However, you can talk with your child about the incident after she is calm and discuss the best way for expressing those emotions (“When you are frustrated that you can’t have what you want, you can tell me, but you



can't hit me or shout at me. Earlier, you wanted a cookie before dinner and you hit me. The next time you feel frustrated, you can tell me and then take a deep breath and calm down if you feel angry.”)

Practice Makes Perfect

Here are some activities that you can do with your child to help him or her understand feelings.

Here are some activities you can do with your child to help him or her understand feelings.

Play **Make a Face** with your child. You start the game by saying, “I am going to make a face, guess what I am feeling by looking at my face.” Then, make a happy or sad face. When your child guesses the feeling word, respond by saying, “That’s right! Do you know what makes me feel that way?” Follow by describing something simple that makes you have that feeling (e.g., “Going to the park makes me happy.” “I feel sad when it rains and we can’t go to the park.”). Please note, this is not the time to discuss adult circumstances that are linked to your emotions (e.g., “When your Daddy doesn’t call me, I feel sad.”). Then say to your child, “Your turn, you make a face and I will guess what you are feeling.” Don’t be surprised if your child chooses the same emotion that you

just displayed; it will take time before your child can be creative with this game. Once you guess, ask your child to name what makes him have that emotion. Keep taking turns until your child shows you that he is not interested in continuing the game.

Share a story in a new way. Read a book to your child that shows characters who experience different emotions (e.g., sad, happy, scared, worried, confused, etc.). Stop on a page where the character is showing the expression. Ask your child “What do you think he is feeling?” “Why is he feeling that way?” or “Look at her face, how can you tell that she is ___?” Other questions could be “Have you ever felt ___? What make you feel that way?” or “What will happen next?” or “What should he do?” Do not pause too long on one page and only continue the discussion as long as your child shows an interest.

Make an **emotion book** with your child. An easy project to do with your child is to create a homemade book. All you need is paper, crayons or markers, and a stapler. You can make a book about one emotion and have your child fill the pages with things that make her feel that way. For example, a “Happy Book” may have pictures that you and your child draw of things that make her happy, pictures cut out of magazines that are glued on the pages, or photographs of friends and family members. Another approach is to have the book be about a variety of feeling words and do a page on each of several emotions (happy, mad, surprised, scared, irritated, proud, etc.). For children who have a lot to say about their feelings, you may want to have them tell you a sentence about what makes them



feel an emotion so you can write the sentence on the page. Then, your child can cut out a picture to glue in the book or draw a picture to go with the emotion. Warning, this activity is more likely to be enjoyable to your child if you do it together, but might be difficult for your child to do alone.

Play “**Mirror, Mirror...what do I see?**” with your child. Using a hand mirror or a mirror on the wall, play this game with your child. Look in the mirror and say “*Mirror, mirror, what do I see?*” Then make an emotion face. Follow by naming the emotion by saying, “*I see a sad Mommy looking at me.*” Turn to your child and say “your turn.” Help your child remember the phrase “*Mirror, mirror what do I see?*” You may have to say it with your child. Then, tell your child to make a face and help him say the next sentence “*I see a happy Patrick looking at me.*” Don’t be surprised if your child always wants to use the emotion that you just demonstrated. Play the game until your child loses interest.



The Center on the Social and Emotional Foundations for Early Learning

Teaching Feeling Words

We often only think of teaching common emotions like happy, sad, mad, etc. But there are many other feeling words that children should learn to express, such as the following:

Brave	Cheerful
Cheerful	Bored
Confused	Surprised
Curious	Proud
Disappointed	Frustrated
Embarrassed	Silly
Excited	Uncomfortable
Fantastic	Worried
Friendly	Stubborn
Generous	Shy
Ignored	Satisfied
Impatient	Safe
Important	Relieved
Interested	Peaceful
Jealous	Overwhelmed
Lonely	Loving
Confused	Tense
Angry	Calm



Expressing Feelings

Sometimes children express their emotions in ways that are problematic. Your child might cry when frustrated or throw toys when angry. Here are some different ways you can teach your child to act on feelings:

Ask for help
Solve problems with words
Say it, don’t do it (*say “I am mad” instead of throwing toys*)
Tell a grown-up
Take a deep breath
Describe what you are feeling
Think of a different way to do it
Relax and try again
Walk away
Ask for a hug

Putting it All Together

Understanding emotions is a critical part of children’s overall development. It is up to adults to teach children to understand and deal with their emotions in appropriate ways. They are experiencing so many new and exciting things for the first time. It can be overwhelming! We need to be sure we always validate our children’s emotions and don’t punish them for expressing their feelings. You might want to remind your child that, “It’s ok to tell me how you feel, but it’s not ok to hurt others or things when you feel (name feeling).” Teach them about their emotions, help them come up with new ways to deal with emotions, give them lots of time to practice their new strategies, and always remember to give lots of positive encouragement when they use the new strategy instead of reacting in the “old” way!



Child Care Bureau



Office of Head Start

Requesting a Public School Evaluation (1): Sample Letter

[Name of principal]

[Name of school]

[Address]

[Town/City, zip code]

Re: Request and Parental Consent for Special Education Evaluation

CHILD'S FULL NAME

DOB:

SCHOOL NAME AND GRADE:

PARENT or ED. RIGHT HOLDER NAME

ADDRESS

DATE:

To Whom It May Concern:

I am the parent (OR WHOMEVER IS THE ED. RIGHT HOLDER) of CHILD'S FULL NAME (herein referred to as CHILD'S FIRST NAME), DOB: 00/00/0000. CHILD'S FIRST NAME is currently enrolled within NAME OF SCHOOL DISTRICT, at SCHOOL NAME (****IF THE CHILD IS NOT IN SCHOOL DUE TO AGE, WRITE:** CHILD'S FIRST NAME is not currently enrolled in public school due to HIS/HER age, however HIS/HER home school district is NAME OF SCHOOL DISTRICT).

I am concerned about my child's progress in school. BRIEFLY LIST YOUR OBSERVATIONS AND CONCERNS.

I am writing to make a referral for assessment for special education services for CHILD'S FIRST NAME as required by Massachusetts law, Chapter 766 and Federal Law, Individuals with Disabilities Education Act (IDEA). SHE/HE may be eligible for special education assistance. I am requesting that CHILD'S FIRST NAME be given a comprehensive assessment by the school district and that an IEP Team meeting be scheduled for HER/HIM. Within the assessment, I would specifically like CHILD'S FIRST NAME to be assessed for, but not limited to, LIST OF ANY CONCERNS (e.g. general evaluation, specific learning disability, processing disorder, speech delay etc).

I am also providing this letter as consent for the initial evaluation of CHILD'S FIRST NAME for possible services. If this is not sufficient consent, please provide me with the consent to evaluate form promptly. I look forward to having the evaluation completed within the mandated 30 school days of receiving my consent and to convene a Team meeting within the mandated 45 days. In addition, as required, I will be looking forward to receiving the summary of evaluations 2 days prior to the Team meeting.

If you have any questions, please feel free to contact me PHONE NUMBER. Thank you for your cooperation and assistance.

Sincerely,

YOUR NAME

PHONE NUMBER

Requesting a Public School Evaluation (2): Tips for Parents

INFORMATION FOR PARENTS about Early Intervention, Public School and private evaluations for their young children

Dear Parent:

Development is never a straight line and sometimes children need additional support. At such times it can be helpful to get more information about how your child is growing and developing.

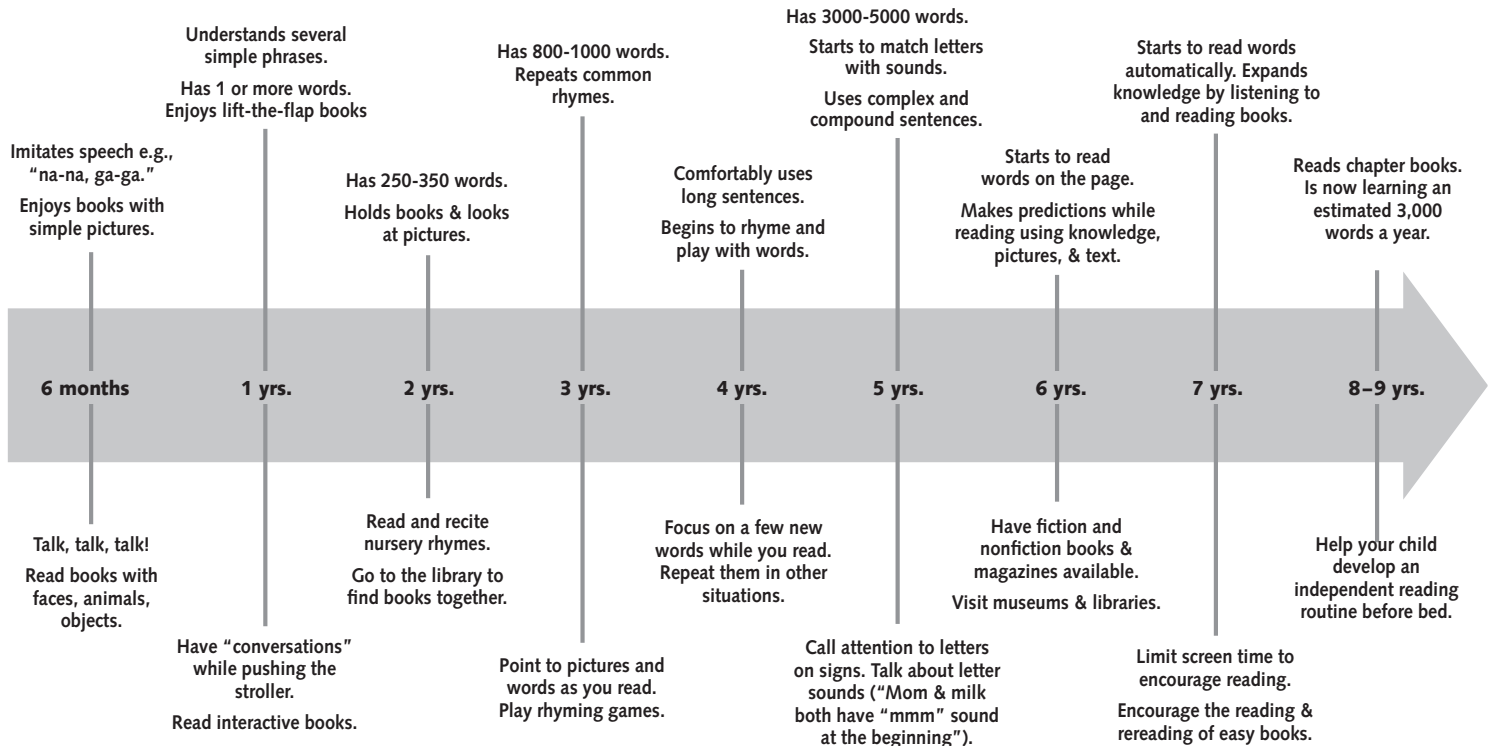
If you decide to have your child evaluated by Early Intervention (for a child under 3), the Public Schools (for a child 3 and older) or by a private clinician, keep in mind these suggestions.

- Be prepared to **describe your concerns and your vision** of what you'd like your child to be able to do.
- You can **invite a friend, relative or advocate** to come with you to the meeting where results of the evaluation are shared.
- It is often helpful to **invite your child care provider** to attend the meeting since s/he can comment on how your child behaves in a setting other than home.
- You can **request a written summary** of the evaluation and services recommended, if any, and can share it with anyone you choose, such as the child care program and physician.
- If services are recommended, you are the key person to make sure everyone shares information about goals and strategies so that your child is getting consistent help at home, in child care and in Early Intervention or Public School. To do this **sign release of information forms to allow programs and clinicians to share information with each other.**
- **Keep your pediatrician informed** about your concerns and any assistance your child is receiving.
- **If you have questions or concerns, call the person you think can help.** Everyone wants your child to succeed, and they need you to work with them.
- If your child is ineligible for services based on the evaluation and you disagree with the outcome, you have a **right to appeal.** The Federation for Children with Special Needs (fcsn.org) can advise you.

Ways Adults Can Support Children's Language and Reading

A Developing Reader's Journey to Third Grade

A reader's typical milestones



Ways adults can support children's language and reading

Source: Lesaux, N., "Turning the Page: Refocusing Massachusetts for Reading Success," Strategies for Children, 2010.

Strategies
for
children

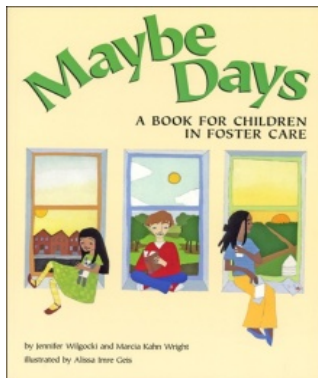
Develop a habit of talking and reading from birth to build up children's knowledge. Sing songs and play games. Elaborate on what they say to increase their language, then tell your own stories—about what happened on the bus, what you saw on the news, what you heard on the radio—and encourage them to tell theirs. Make reading a routine. Babies enjoy being held and talked to while looking at simple picture books. Toddlers like to look at pictures while lifting flaps and feeling textures and hearing rhymes. Children age 4-9 enjoy longer stories and repeated reading of favorite stories and nonfiction books. Make a point of reading chapter books out loud—listening is tough work for kids at first, but easier with practice; it is valuable for children's language growth to hear great stories that are beyond their reading ability. It is also great fun for caregivers and children alike to read together.

Books for Children about Foster Care

Compiled by Joann Grayson, Ph.D.

for Virginia Child Protection Newsletter, Volume 85

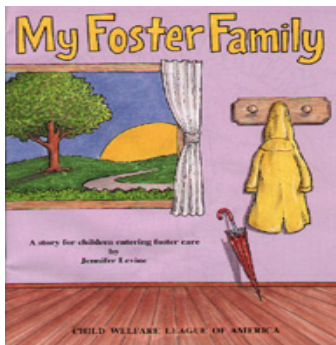
© Commonwealth of Virginia Department of Social Services



Maybe Days: A Book for Children in Foster Care by Jennifer Wilgocki, MA and Marcia Kahn Wright, PhD, 2001, 32 pages, \$9.95, ISBN 1-55798-802-1.

Available from: APA Service Center, 750 First Street, NE
Washington, DC 20002-4242
(800)-374-2721, TDD/TTY: (202)-336-6123, FAX: (202)-336-5502,
E-mail: magination@apa.org Web site:
<http://www.maginationpress.com/4418021.html>

This book discusses issues surrounding foster care. It includes some of the common questions that children ask and the different emotions they might be encountering. The book also explains the responsibilities of everyone involved in foster care: the parents; foster parents; social worker; lawyers; and judges. The story emphasizes that a child's job is to simply grow and be a child.



My Foster Family: A Story for Children Entering Foster Care by Jennifer Levine, Child Welfare League of America in Books, 1994, \$3.95, ISBN 9780878685370.

Available from: Child Welfare League of America, 2345
Crystal Drive, Suite 250, Arlington, VA 22202 (703)-412-2400
FAX: (703)-412-2401 Web site:
<http://www.cwla.org/pubs/pubdetails.asp?PUBID=5370>

This children's coloring book allows children entering foster care the opportunity to express their feelings and adjust to their new surroundings. It is intended for children between the ages of 5-11. The book provides descriptions of the logistical and emotional changes that children are likely to encounter.

Virginia Child Protection Newsletter Volume 085

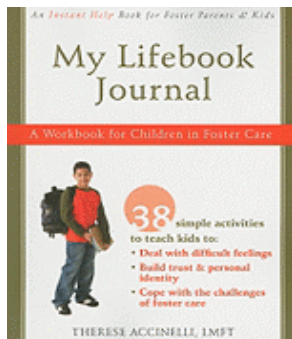
Books to Help Young Children Make Sense of Their World (2)



A Family For Sammy by Kate Gaynor, 2006, 28 pages, \$13.99.

Available from: Special Stories Publishing, Unit 13, BASE Enterprise Centre, Ladyswell Road, Mulhuddart, Dublin 15, Ireland;
Web site: <http://www.specialstories.net/FosterCare.aspx>

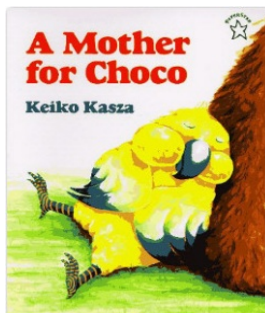
This book is designed to help explain the process of foster care to young children. The book is told through the eyes of the main character, Sammy. Sammy expresses his concerns and fears about staying with another family but then realizes that his new family is kind and caring.



My Lifebook Journal: A Workbook for Children in Foster Care by Therese Accinelli, 2008, 136 pages, \$16.95.

Available from: New Harbinger Publications, Attn: Customer Service, 5674 Shattuck Avenue Oakland, CA 94609, (800) 748-6273,
FAX : (800) 652-1613; Web site:
<http://www.ebscobooks.com/books/ProductDetails.asp?CatalogID=8432217>

This workbook provides various activities and tools to help children adjust to foster care. The worksheets help children to record their positive experiences and memories, learn to develop a sense of self, identify people who they can trust, and learn coping skills. The idea is to have children record and explore their thoughts and feelings for a few minutes every day. With these activities, resiliency and self-confidence are reinforced.

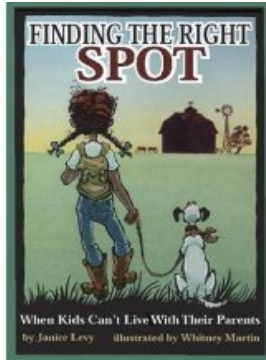


A Mother for Choco by Keiko Kasza, 1996, 32 Pages, \$5.99.

Available from: PENGUIN GROUP (USA) Inc, Academic Marketing Department 375 Hudson Street New York, NY 10014-3657, (800)-847-5515 E-mail: fran.corea@us.penguinroup.com
Web site:
<http://www.adoptshoppe.com/index.asp?PageAction=VIEWPROD&ProdID=432>

This book is intended for children ages 2-5. Choco is a little bird who wishes he had a mother and begins searching for one. He doesn't meet anyone who looks like him and doesn't think of asking Mrs. Bear. Then he realizes that Mrs. Bear begins to do things like a mother should. Choco then understands that families can come in all shapes and sizes and still be a family.

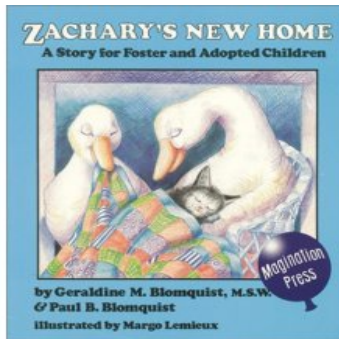
Books to Help Young Children Make Sense of Their World (3)



Finding the Right Spot: When Children Can't Live With Their Parents by Janice Levy, 2004, 48 pages \$14.95, ISBN 1-59147-073-0.

Available from: APA Service Center, 750 First Street, NE
Washington, DC 20002-4242, (800)-374-2721, (202)-336-5510,
TDD/TTY: (202)-336-6123, FAX: (202)-336-5502,
E-mail: magination@apa.org
Web site: <http://www.maginationpress.com/441A073.html>

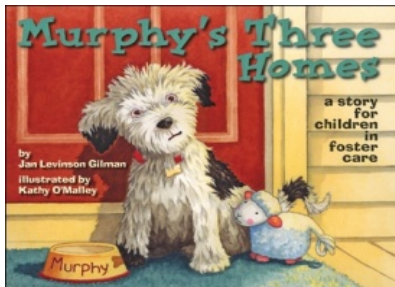
Finding the Right Spot is a story for all children who cannot live with their parents, regardless of the reasons. This story stresses feelings; resilience; loyalty; hope; disappointment; love; sadness; and anger. This story also discusses how to adjust when living away from home.



Zachary's New Home: A Story for Foster and Adopted Children by Geraldine M. Blomquist, 1990, 32 pages, \$ 9.95, ISBN: 0-945354-27-4.

Available from: APA Service Center, 750 First Street, NE
Washington, DC 20002-4242, (800)-374-2721, (202)-336-5510,
TDD/TTY: (202)-336-6123, FAX: (202)-336-5502,
E-mail: magination@apa.org
Web site: <http://www.maginationpress.com/4414274.html>

This story is about a kitten named Zachary who is forced to leave his home when his mother can no longer care for him. The story traces Zachary from the time he first enters foster care to the time when he is adopted by a family of Geese. This book targets both children in foster care and children who have been adopted.



Murphy's Three Homes: A Story for Children in Foster Care by Jan Levinson Gilman, PhD, 2008, 32 pages, \$14.95, ISBN 1-4338-0384-4.

Available from: APA Service Center, 750 First Street, NE
Washington, DC 20002-4242, (800)-374-2721, (202)-336-5510, TDD/TTY: (202)-336-6123, FAX: (202)-336-5502,
E-mail: magination@apa.org
Web site: <http://www.maginationpress.com/441B021.html>

This book uses a subtle story to help children in foster care cope. The story is about a puppy, Murphy, who is placed into a new home and is forced to deal with new things everywhere. While he is shuffled from house to house, he begins to understand his sad and angry feelings. The author also provides caregivers with various resources on how to help children cope with foster care.

Children's Book List

Being a Friend

A Rainbow of Friends by P.K. Hallinan (Ages 4-8)
Best Friends by Charlotte Labaronne (Ages 3-5)
Can You Be a Friend? by Nita Everly (Ages 3-6)
Can You Talk to Your Friends? by Nita Everly (Ages 3-6)
Care Bears Caring Contest by Nancy Parent (Ages 3-6)
Care Bears The Day Nobody Shared by Nancy Parent (Ages 3-6)
Fox Makes Friends by Adam Relf (Ages 3-5)
Gigi and Lulu's Gigantic Fight by Pamela Edwards (Ages 3-7)
Heartprints by P.K. Hallinan (Ages 3-6)
How Do Dinosaurs Play with Their Friends by Jane Yolen and Mark Teague (Ages 3-5)
How to be a Friend by Laurie Krasny Brown and Marc Brown (Ages 4-8)
Hunter's Best Friend at School by Laura Malone Elliot (Ages 4-7)
I'm a Good Friend! by David Parker (Ages 3-5)
I Can Share by Karen Katz (Ages infant-5)
I Can Cooperate! by David Parker (Ages 3-5)
I am Generous! by David Parker (Ages 2-5)
I'm Sorry by Sam McBratney (Ages 4-7)
It's Hard to Share My Teacher by Joan Singleton Prestine (Ages 5-6)
Jamberry by Bruce Degan (Ages 2-5)
Join In and Play by Cheri Meiners (Ages 3-6)
The Little Mouse, The Red Ripe Strawberry, and The Big Hungry Bear by Don & Audry Wood (Ages 2-5)
Making Friends by Fred Rogers (Ages 3-5)
Making Friends by Janine Amos (Ages 4-8)
Matthew and Tilly by Rebecca C. Jones (Ages 4-8)
Mine! Mine! Mine! By Shelly Becker (Ages 3-5)
Mine! A Backpack Baby Story by Miriam Cohen (Ages infant-2)
My Friend Bear by Jez Alborough (Ages 3-8)
My Friend and I by Lisa John-Clough (Ages 4-8)
One Lonely Sea Horse by Saxton Freymann & Joost Elffers (Ages 4-8)
Perro Grande...Perro Pequeno/Big Dog...Little Dog by P.D. Eastman (Ages 4-8)
The Rainbow Fish by Marcus Pfister (Ages 3-8)
Share and Take Turns by Cheri Meiners (Ages 5-8)
Sharing How Kindness Grows by Fran Shaw (Ages 3-5)
The Selfish Crocodile by Faustin Charles and Michael Terry (Ages 4-7)
Simon and Molly plus Hester by Lisa Jahn-Clough (Ages 5-8)
Sometimes I Share by Carol Nicklaus (Ages 4-6)
Strawberry Shortcake and the Friendship Party by Monique Z. Sephens (Ages 2-5)
Sunshine & Storm by Elisabeth Jones (Ages 3-5)
Talk and Work it Out by Cheri Meiners (Ages 3-6)
That's What a Friend Is by P.K. Hallinan (Ages 3-8)
We Are Best Friends by Alikei (Ages 4-7)



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Books to Help Young Children Make Sense of Their World (5)

Accepting Different Kinds of Friends

And Here's to You by David Elliott (Ages 4-8)
Big Al by Andrew Clements (Ages 4-8)
The Brand New Kid by Katie Couric (Ages 3-8)
Chester's Way by Kevin Henkes (Ages 5-7)
Chrysanthemum by Kevin Henkes (Ages 4-8)
Franklin's New Friend by Paulette Bourgeois (Ages 5-8)
Horace and Morris But Mostly Dolores by James Howe (Ages 4-8)
I Accept You as You Are! by David Parker (Ages 3-5)
It's Okay to Be Different by Todd Parr (Ages 3-8)
Margaret and Margarita by Lynn Reiser (Ages 5-8)

General Feelings

ABC Look at Me by Roberta Grobel Intrater (Ages infant-4)
"Baby Faces" books (most are by Roberta Grobel Intrater) (Ages infant-4)
Baby Faces by Margaret Miller (Ages infant-3)
Baby Senses Sight by Dr.S. Beaumont (ages infant -3)
Can You Tell How Someone Feels? (Early Social Behavior Book Series) by Nita Everly (Ages 3-6)
Double Dip Feelings by Barbara Cain (Ages 5-8)
The Feelings Book by Todd Parr (Ages 3-8)
Feeling Happy by Ellen Weiss (Ages infants -3)
Glad Monster, Sad Monster by Ed Emberley & Anne Miranda (Ages infant-5)
The Grouchy Ladybug by Eric Carle (Ages 1-6)
The Pout Pout Fish by Deborah Diesen (Ages 3-5)
The Three Grumpies by Tamra Wight (Ages 4-8)
Happy and Sad, Grouchy and Glad by Constance Allen (Ages 4-7)
How Are You Peeling: Foods with Moods/Vegetal como eres: Alimentos con sentimientos by Saxton Freymann (Ages 5-8)
How Do I Feel? by Norma Simon (Ages 2-7)
How Do I Feel? Como me siento? by Houghton Mifflin (Ages infant-4)
How I Feel Proud by Marcia Leonard (Ages 2-6)
How I Feel Silly by Marcia Leonard (Ages 2-6)
How Kind by Mary Murphy (ages 2-5)
I Am Happy by Steve Light (Ages 3-6)
If You're Happy and You Know it! by Jane Cabrera (Ages 3-6)
Little Teddy Bear's Happy Face Sad Face by Lynn Offerman (a first book about feelings)
Lizzy's Ups and Downs by Jessica Harper (Ages 3-9)
My Many Colored Days by Dr. Seuss (Ages 3-8)
On Monday When It Rained by Cherryl Kachenmeister (Ages 3-8)
Proud of Our Feelings by Lindsay Leghorn (Ages 4-8)
See How I Feel by Julie Aigner-Clark (Ages infant-4)
Sometimes I Feel Like a Storm Cloud by Lezlie Evans (Ages 4-8)
Smudge's Grumpy Day by Miriam Moss (Ages 3-8)
The Way I Feel by Janan Cain (Ages 4-8)
Today I Feel Silly & Other Moods That Make My Day by Jamie Lee (Ages 3-8)
The Way I Feel by Janan Cain (Ages 3-6)



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Books to Help Young Children Make Sense of Their World (6)

What Makes Me Happy? by Catherine & Laurence Anholt (Ages 3-6)
What I Look Like When I am Confused/Como me veo cuando estoy confundido
(*Let's Look at Feeling Series*) by Joanne Randolph (Ages 5-8)
When I Feel Frustrated by Marcia Leonard (Ages 2-6)
When I Feel Jealous by Marcia Leonard (Ages 2-6) feelings
Lizzy's Ups and Downs by Jessica Harper (Ages 3-9)
My Many Colored Days by Dr. Seuss (Ages 3-8)
On Monday When It Rained by Cherryl Kachenmeister (Ages 3-8)
Proud of Our Feelings by Lindsay Leghorn (Ages 4-8)
See How I Feel by Julie Aigner-Clark (Ages infant-4)
Sometimes I Feel Like a Storm Cloud by Lezlie Evans (Ages 4-8)
Smudge's Grumpy Day by Miriam Moss (Ages 3-8)
The Way I Feel by Janan Cain (Ages 4-8)
Today I Feel Silly & Other Moods That Make My Day by Jamie Lee (Ages 3-8)
The Way I Feel by Janan Cain (Ages 3-6)
What Makes Me Happy? by Catherine & Laurence Anholt (Ages 3-6)
What I Look Like When I am Confused/Como me veo cuando estoy confundido
(*Let's Look at Feeling Series*) by Joanne Randolph (Ages 5-8)
When I Feel Frustrated by Marcia Leonard (Ages 2-6)
When I Feel Jealous by Marcia Leonard (Ages 2-6)

Happy Feelings

Amadeus is Happy by Eli Cantillon (Ages 2-5)
Feeling Happy by Ellen Weiss (ages 2-5)
If You're Happy and You Know it! by David Carter (Ages 2-6)
If You're Happy and You Know It by Scholastic/Taggies book (Ages infant-2)
The Feel Good Book by Todd Parr (Ages 3-6)
Peekaboo Morning by Rachel Isadora (Ages 2-5)
When I Feel Happy by Marcia Leonard (Ages 2-6)
"What Went Right Today?" by Joan Buzick and Lindy Judd (Ages 3 – 8)

Sad Feelings

Let's Talk About Feeling Sad by Joy Wilt Berry (Ages 3-5)
Franklin's Bad Day by Paulette Bourgeois & Brenda Clark (Ages 5-8)
How I Feel Sad by Marcia Leonard (Ages 2-6)
Hurty Feelings by Helen Lester (Ages 5-8)
Knuffle Bunny by Mo Willems (Ages 3-6)
Sometimes I Feel Awful by Joan Singleton Prestine (Ages 5-8)
The Very Lonely Firefly by Eric Carle (Ages 4-7)
When I'm Feeling Sad by Trace Moroney (Ages 2-5)
When I Feel Sad by Cornelia Maude Spelman (Ages 5-7)



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Books to Help Young Children Make Sense of Their World (6)

Angry or Mad Feelings

Alexander and the Terrible, Horrible, No Good, Very Bad Day by Judith Viorst (Ages 4-8)
Andrew's Angry Words by Dorothea Lackner (Ages 4-8)
Bootsie Barker Bites by Barbara Bottner (Ages 4-8)
The Chocolate Covered Cookie Tantrum by Deborah Blementhal (Ages 5-8)
How I Feel Frustrated by Marcia Leonard (Ages 3-8)
How I Feel Angry by Marcia Leonard (Ages 2-6)
Llama Llama Mad at Mama by Anna Dewdney (Ages 2-5)
Sometimes I'm Bombaloo by Rachel Vail (Ages 3-8)
That Makes Me Mad! by Steven Kroll (Ages 4-8)
The Rain Came Down by David Shannon (Ages 4-8)
When I'm Angry by Jane Aaron (Ages 3-7)
When I'm Feeling Angry by Trace Moroney (Ages 2-5)
When I Feel Angry by Cornelia Maude Spelman (Ages 5-7)
When Sophie Gets Angry – Really, Really Angry by Molly Garrett (Ages 3-7)
Lily's Purple Plastic Purse by Kevin Henkes. (Ages 4-8)

Scared or Worried Feelings

Creepy Things are Scaring Me by Jerome and Jarrett Pumphrey (Ages 4-8)
Franklin in The Dark by Paulette Bourgeois & Brenda Clark (Ages 5-8)
How I Feel Scared by Marcia Leonard (Ages 2-6)
I Am Not Going to School Today by Robie H. Harris (Ages 4-8)
No Such Thing by Jackie French Koller (Ages 5-8)
Sam's First Day (In multiple languages) by David Mills & Lizzie Finlay (Ages 3-7)
Sheila Rae, the Brave, by Kevin Henkes (Ages 5-8)
Wemberly Worried by Kevin Henkes (Ages 5-8)
When I'm Feeling Scared by Trace Moroney (Ages 2-5)
When I Feel Scared by Cornelia Maude Spelman (Ages 5-7)

Caring About Others and Empathy

Bear Feels Sick by Karma Wilson and Jane Chapman (Ages 3-5)
Can You Tell How Someone Feels by Nita Everly (ages 3-6)
Understand and Care by Cheri Meiners (Ages 3-6)
When I Care about Others by Cornelia Maude Spelman (Ages 5-7)

Problem Solving

Don't Let the Pigeon Drive the Bus by Mo Willems (Ages 2-7)
Don't Let the Pigeon Stay Up Late! by Mo Willems (Ages 2-7)
I Did It, I'm Sorry by Caralyn Buehner (Ages 5-8)
It Wasn't My Fault by Helen Lester (Ages 4-7)
Talk and Work it Out by Cheri Meiners (Ages 4-8)



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Books to Help Young Children Make Sense of Their World (7)

Self Confidence

ABC I like Me by Nancy Carlson (Ages 4-6)
Amazing Grace by Mary Hoffman (Ages 4-8)
Arthur's Nose, by Marc Brown (Ages 3-8)
The Blue Ribbon Day by Katie Couric (Ages 4-8)
Can You Keep Trying by Nita Everly (Ages 3-6)
I Can Do It Myself (A Sesame Street Series) by Emily Perl Kingsley (Ages 2-4)
I'm in Charge of Me!, by David Parker (Ages 3-5)
I am Responsible!, by David Parker (Ages 3-5)
The Little Engine that Could by Watty Piper (Ages 3-7)
Susan Laughs by Jeanne Willis (Ages 4-7)
Too Loud Lilly by Sophia Laguna (Ages 4-7)
Try and Stick With It by Cheri Meiners (Ages 4-8)
26 Big Things Little Hands Can Do by Coleen Paratore (Ages 1-6)
The Very Clumsy Click Beetle by Eric Carle (Ages 3-7)
Whistle for Willie/Sebale a Willie by Erza Jack Keats (Ages 4-7))
You Can Do It, Sam by Amy Hest (Ages 2-6)

Good Behavior Expectations

Can You Listen with Your Eyes? by Nita Everly (Ages 3-6)
Can You Use a Good Voice? by Nita Everly (Ages 3-6)
David Goes to School by David Shannon (Ages 3-8)
David Gets in Trouble by David Shannon (Ages 3-8)
Excuse Me!: A Little Book of Manners by Karen Katz (Ages infant-5)
Feet Are Not for Kicking (available in board book) by Elizabeth Verdick (Ages 2-4)
Hands are Not for Hitting (available in board book) by Martine Agassi (Ages 2-8)
Hands Can by Cheryl Willis Hudson (ages 1-5)
I Tell the Truth! by David Parker (Ages 3-5)
I Show Respect! by David Parker (Ages 3-5)
Know and Follow Rules by Cheri Meiners (Ages 3-6)
Listen and Learn by Cheri Meiners (Ages 3-6)
No Biting by Karen Katz (Ages infant-5)
No David by David Shannon (Ages 3-8)
No Hitting by Karen Katz (Ages infant-5)
Please Play Safe! Penguin's Guide to Playground Safety by Margery Cuyler (Ages 2-5)
26 Big Things Small Hands Can Do by Coleen Paratore (Ages 3-5)
Quiet and Loud by Leslie Patricelli (Ages 1-3)
Words Are Not for Hurting by Elizabeth Verdick (Ages 3-6)



The Center on the Social and Emotional
Foundations for Early Learning



Administration for
Children & Families



Office of
Head Start



Child Care
Bureau

Source: The Center on the Social and Emotional Foundations for Early Learning

Books to Help Young Children Make Sense of Their World (8)

Angry or Mad Feelings

Alexander and the Terrible, Horrible, No Good, Very Bad Day by Judith Viorst (Ages 4-8)
Andrew's Angry Words by Dorothea Lackner (Ages 4-8)
Bootsie Barker Bites by Barbara Bottner (Ages 4-8)
The Chocolate Covered Cookie Tantrum by Deborah Blementhal (Ages 5-8)
How I Feel Frustrated by Marcia Leonard (Ages 3-8)
How I Feel Angry by Marcia Leonard (Ages 2-6)
Llama Llama Mad at Mama by Anna Dewdney (Ages 2-5)
Sometimes I'm Bombaloo by Rachel Vail (Ages 3-8)
That Makes Me Mad! by Steven Kroll (Ages 4-8)
The Rain Came Down by David Shannon (Ages 4-8)
When I'm Angry by Jane Aaron (Ages 3-7)
When I'm Feeling Angry by Trace Moroney (Ages 2-5)
When I Feel Angry by Cornelia Maude Spelman (Ages 5-7)
When Sophie Gets Angry – Really, Really Angry by Molly Garrett (Ages 3-7)
Lily's Purple Plastic Purse by Kevin Henkes. (Ages 4-8)

Scared or Worried Feelings

Creepy Things are Scaring Me by Jerome and Jarrett Pumphrey (Ages 4-8)
Franklin in The Dark by Paulette Bourgeois & Brenda Clark (Ages 5-8)
How I Feel Scared by Marcia Leonard (Ages 2-6)
I Am Not Going to School Today by Robie H. Harris (Ages 4-8)
No Such Thing by Jackie French Koller (Ages 5-8)
Sam's First Day (In multiple languages) by David Mills & Lizzie Finlay (Ages 3-7)
Sheila Rae, the Brave, by Kevin Henkes (Ages 5-8)
Wemberly Worried by Kevin Henkes (Ages 5-8)
When I'm Feeling Scared by Trace Moroney (Ages 2-5)
When I Feel Scared by Cornelia Maude Spelman (Ages 5-7)

Caring About Others and Empathy

Bear Feels Sick by Karma Wilson and Jane Chapman (Ages 3-5)
Can You Tell How Someone Feels by Nita Everly (ages 3-6)
Understand and Care by Cheri Meiners (Ages 3-6)
When I Care about Others by Cornelia Maude Spelman (Ages 5-7)

Problem Solving

Don't Let the Pigeon Drive the Bus by Mo Willems (Ages 2-7)
Don't Let the Pigeon Stay Up Late! by Mo Willems (Ages 2-7)
I Did It, I'm Sorry by Caralyn Buehner (Ages 5-8)
It Wasn't My Fault by Helen Lester (Ages 4-7)
Talk and Work it Out by Cheri Meiners (Ages 4-8)



The Center on the Social and Emotional
Foundations for Early Learning



Administration for
Children & Families



Office of
Head Start



Child Care
Bureau

Source: The Center on the Social and Emotional Foundations for Early Learning

Books to Help Young Children Make Sense of Their World (9)

OREGON STATE UNIVERSITY Extension Service



Children's Book List

for children raised by grandparents and/or children who have lost a loved one

The following books deal with children raised by grandparents and/or children who have lost a loved one.

Aarvy Aardvark Finds Hope Donna O'Toole. 1998. An aardvark's delayed grief over the loss of family begins to heal through the support of a caring friend. For all ages.

Abuela Arthur Dorros. Illustrated by Elisa Kleven. 1995. While riding on a bus with her grandmother, a little girl imagines they are carried up in the sky and fly over the sights of New York City. For ages four to eight. In English with Spanish phrases.

Abuela's Weave Omar S. Castaneda. 1993. A young Guatemalan girl and her grandmother weave some special creations which they hope to sell at the market. For ages four to eight.

Elephant in the Living Room: The Children's Book Jill Hastings & Marion Typpo. 1994. This book helps children from alcoholic homes learn about alcoholism, and teaches new ways to handle feelings. A companion book to *Elephant in the Living Room: A Leader's Guide for Helping Children of Alcoholics*. For ages seven to twelve.

A Lei for Tutu Rebecca Fellows. Illustrated by Linda Finch. 1998. Nahoa and her grandmother plan to make a particularly beautiful lei for Lei Day. When grandmother becomes ill and is taken to the hospital, Nahoa devises a special plan. For ages four to eight.

Belle Prater's Boy Ruth White. 1996. When Woodrow's mother disappears suddenly, he moves to his grandparents' home in a small Virginia town. He befriends his cousin and together they find the strength to face the terrible losses and fears in their lives. For young adults.

Can You Do This Old Badger? Eve Bunting. Illustrated by LeUyen Pham. 2000. Although Old Badger cannot do some things as easily as he used to, he can still teach Little Badger the many things he knows about finding good things to eat and staying safe and happy. For ages four to eight.

Dinosaurs Divorce: A Guide for Changing Families Laurie Krasny Brown & Marc Brown. 1988. Dinosaur characters depict the range of experiences and feelings encountered by children whose parents have divorced. For ages five to twelve.

Do I Have a Daddy? A Story About a Single-Parent Child Jeanne Warren Lindsay. Illustrated by Jami Moffett. 2000. This story provides a model for how to respond to children's questions about a parent they have never seen. For ages four to eight.

Daddy, Will You Miss Me? Wendy McCormick. Illustrated by Jennifer Eachus. 2002. A boy and his father think of many different ways to be in touch while the daddy spends a month in Africa. For ages four to eight.

Books to Help Young Children Make Sense of Their World (10)

Everett Anderson's Goodbye Lucille Clifton. *Illustrated by Ann Grifalconi. 1988.* Everett has a difficult time coming to terms with his grief after his father dies. For ages four to eight.

Good-bye Daddy! Brigitte Weninger. *Illustrated by Alan Marks. 1995.* After spending the day with his daddy, a young bear is sad and angry that his father has to leave. The bear comes to learn that even when a father has to live in another home, the love and caring never go away. Ages four to eight.

Grandmother's Adobe Dollhouse Mary Lou Smith. *Illustrated by Ann Blackstone. 1998.* A tour of Grandmother's dollhouse provides information about the architecture, art, food, and culture of New Mexico to her grandson. For all ages.

Grandmother's Nursery Rhymes. Nelly Palacio Jaramillo. *Illustrated by Elivia Savadler. 1999.* A collection of lullabies, tongue twisters and riddles from South America, written in English and Spanish. For ages four to eight.

Grandpa, Is Everything Black Bad? Sandy Lynne Holman. *Illustrated by Lela Kometiani.* An African-American boy learns about his African heritage and learns to be proud of his dark skin. Ages five to eight.

Grandpa's Garden Shea Darian. *Illustrated by Karlyn Holman. 1996.* Every Saturday Grandpa and granddaughter work in the garden, sharing words and thoughts. The lessons learned in the garden strengthen the granddaughter when Grandpa becomes ill. For ages four to eight.

It's Okay to Be Different Todd Parr. 2001. There are many ways to be different and all of them are okay. For ages four to eight.

Keeping Up with Grandma John Winch. 2000. When Grandma decides that it is time to have fun outdoors, Grandpa has trouble keeping up with her. For ages four to eight.

Kele's Secret Tololwa Mollel. *Illustrated by Catherine Stock. 1997.* A young African boy who lives with his grandparents on their coffee farm follows a hen named Kele in order to find out where she is hiding her eggs. For ages four to eight.

Kids and Grandparents: An Activity Book Ann Love & Jane Drave. *Illustrated by Heather Collins. 2000.* A collection of games, crafts, recipes, and activities to help grandparents and grandchildren stay connected and build on their special relationship. For ages four to twelve.

Let's Talk About Living with a Grandparent Susan Kent. 2003. Provides an idea of what it is like to live with a grandparent and some hints for ways to improve the situation. Part of the "Let's Talk Library." For ages four to eight.

Love is a Family Roma Downey. *Illustrated by Justine Gasquet. 2001.* Lily worries that she will be the only kid in her class who brings just one person to Family Fun Night. It turns out that there are many kinds of families, including grandparents raising a grandson. For ages four to eight.

Book list for children raised by grandparents and/or children who have lost a loved one

Books to Help Young Children Make Sense of Their World (11)

Mei-Mei Loves the Morning Margaret Holloway Tsubakiyama. Illustrated by Cornelius Van Wright and Ying-Hwa Hu. 1999. A little girl and her grandfather spend the morning at the park in a big city in China. For ages four to eight.

Nonna Jennifer Bartoli & Joan E Drescher. 1975. A boy tells the story of his grandmother, portraying how young children respond to the death of a loved one. Out of print, but used copies are available.

Our Granny Margaret Wild. Illustrated by Julie Vivas. 1998. A celebration of grandmothers of all shapes and sizes! For ages four to eight.

Robert Lives With His Grandparents Martha Whitmore Hickman. Illustrated by Tim Hinton. 1995. Robert's parents are divorced and he lives with his grandparents. When his grandmother decides to attend Parents Day at his school, he is afraid of what the other kids will think of him. Ages four to eight.

Saying Good-Bye to Grandma Jane Resh Thomas. Illustrated by Marcia Sewall. 1988. When her grandma dies, seven-year-old Suzie and her parents attend the funeral. Addresses many aspects of loss. For ages five to eight.

Secret of the Peaceful Warrior: A Story about Courage and Love Dan Millan & T. Taylor Bruce. Illustrated by T. Taylor Bruce. 1991. A young boy harassed by the school bully learns to resolve conflicts peacefully and to live as a "peaceful warrior." For ages nine to twelve.

The Button Box Margaret Reid & Sarah Chamberlain. Illustrated by Sarah Chamberlain. 1995. A little boy explores the treasures in his grandmother's button box. For ages four to eight.

The Day Gogo Went to Vote Elinor Batezat Sisulu. Illustrated by Sharon Wilson. 1999. Six-year-old Thembi and her 100 year old grandmother go together to vote on the day when black South Africans are allowed to vote for the first time. For ages four to eight.

The Hickory Chair Lisa Rowe Fraustino. Illustrated by Benny Andrews. 2001. A blind boy remembers a loving relationship with his grandmother and the gift she left him after her death. For ages four to eight.

The Saddest Time Norma Simon. Jackie Rogers, photographer. 1987. Losing a loved one is the subject of these three gentle stories. For ages four to eight.

The Tenth Good Thing About Barney Judith Viorst. Illustrated by Erik Blegvad. 1987. When his cat dies, a boy tries to think of ten good things to say about his pet at the funeral. For all ages.

Through Grandpa's Eyes Patricia MacLachlan. Illustrated by Deborah Kogan Ray. 1983. Grandpa is blind, but his grandson John learns about new sounds, smells and ways of doing everyday things by "seeing" the world as Grandpa does. For ages four to eight.

Book list for children raised by grandparents and/or children who have lost a loved one

Books to Help Young Children Make Sense of Their World (12)

Today I Feel Silly & Other Moods That Make My Day Jamie Lee Curtis. Illustrated by Laura Cornell. 1998. A child's emotions range from silliness to anger to excitement, coloring and changing each day. Ages four to eight.

What! Cried Granny: An Almost Bedtime Story Kate Lum. Illustrated by Adrian Johnson. 1999. Patrick's first sleepover at his Granny's house is quite an adventure! For ages four to eight.

What Grandmas Do Best, What Grandpas Do Best Laura Numeroff. Illustrated by Lynn Munsinger. 2000. Grandparents can do many things but best of all, they give you lots of love. For preschoolers.

When A Friend Dies: A Book for Teens About Grieving and Healing Marilyn Gootman. Illustrated by Deborah Prothrow-Stith. 1999. Sensitively written and sensible. For teenagers.

When Sophie Gets Angry—Really, Really Angry... Molly Garrett Bang. 1999. People handle anger in different ways. When Sophie gets angry she climbs her favorite tree. For ages four to eight.

You are My I Love You Maryann K. Cusimano. Illustrated by Satomi Ichikawa. 2001. Gentle verses about the love between parent and child. For ages three to seven.

You Hold Me and I'll Hold You Jo Carson. Illustrated by Annie Cannon. 1992. When her great aunt dies, a little girl finds comfort at the memorial service by being held and in holding her father. For ages four to eight.

Zenon Kar Spaceball Star (Zenon: Girl of the 21st Century, #2) Marilyn Sadler. Illustrated by Roger Bollen. 2001. Zenon creates trouble at her space station home somewhere in the Milky Way, and her parents send her to her grandparents' farm on Earth for the summer. For ages four to eight.

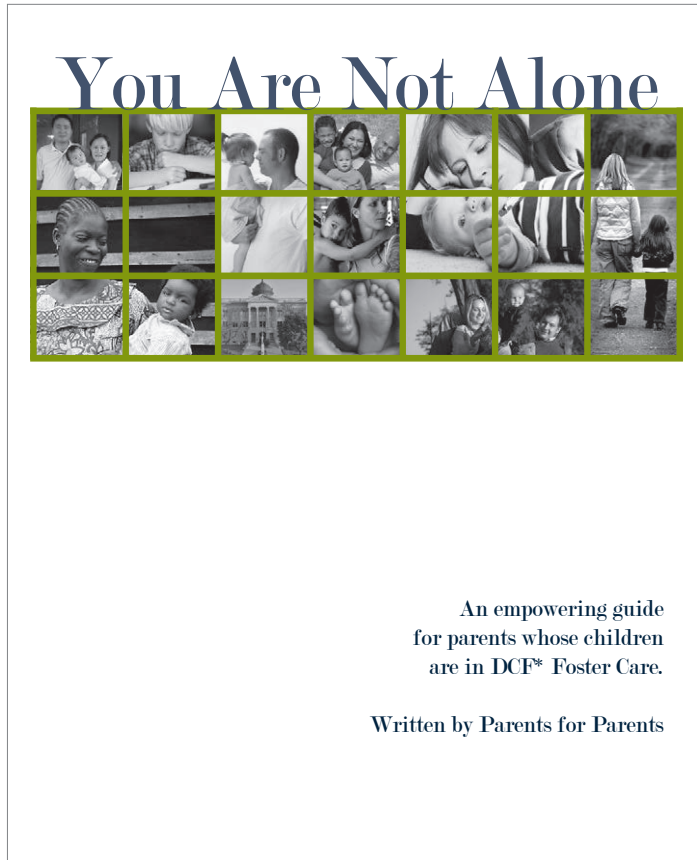
Book list for children raised by grandparents and/or children who have lost a loved one

Oregon State
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Extension Service

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You Are Not Alone: Guide to the DCF System in MA



For parents whose children are in DCF custody, Parents Helping Parents offers a guide titled “You Are Not Alone: An Empowering Guide for Parents Whose Children are in DCF Foster Care”.

A group of 12 parents came together to share what they learned about DCF and the Juvenile Court system when their children were removed by DCF.

The Guide is available in PDF format in both English and Spanish. Both versions can be downloaded at:

www.parentshelpingparents.org/#!news/cqna

The English version of the guide is reproduced in Chapter 5 of this Toolkit (Item 5-A).

Source:

The Roundtable of Support, Inc. and Family Nurturing Center of Massachusetts, Inc.
©2010 Parents Helping Parents

www.parentshelpingparents.org

Learn More

- 8-A SCSC System Change Recommendations Report
Resources
- 8-B SCSC System Change Recommendations Report
Glossary
- 8-C Five Numbers to Remember about Early Childhood
- 8-D Adverse Childhood Experiences
- 8-E Protective Factors in Child Welfare
- 8-F Is This the Right Place for My Child?
(Indicators of High Quality Child Care)
- 8-G Child Care Providers' Role in Child Abuse Prevention
- 8-H Early Childhood Mental Health Toolkit Link

CHILD WELFARE
TOOLKIT



FOR EARLY CHILDHOOD PROFESSIONALS





+ Appendix A: Resources

SCSC Early Childhood Train-the-Trainer Series: ***Promoting Infant and Toddler Resiliency through Trauma-Informed Practice***

For Early Childhood Educators

This 2013 train-the-trainer series for early childhood educators includes video of four 2-hour sessions (edited videos are shorter), each structured around an interactive PowerPoint presentation. Large and small group discussions, vignettes and case sharing, video clips and handouts supplement the PowerPoint for each session. The series was designed to be used by administrators or supervisors to train staff, but is also appropriate for self-guided learning.

A parallel series is available for child welfare professionals, as is an additional cross-training session that provides a structure to bring early childhood and child welfare staff together to build relationships and increase mutual understanding, with a goal of improved collaboration between the child welfare and early childhood systems.

Session Titles:

1. What is Infant and Early Childhood Mental Health?
2. Brain Development and the Impact of Trauma
3. Attachment and the Impact of Trauma
4. Infant and Early Childhood Mental Health Best Practices: Effective Collaboration and Supporting Resiliency

Training Content:

- Promotes understanding of infant and toddler mental health and access to resources to train early childhood educators in trauma-informed practice that supports the social-emotional development of infants and toddlers
- Explains typical social-emotional development of infants and toddlers and how to recognize common areas of concern
- Provides an overview of early brain development and the effects of trauma and toxic stress on the developing brain
- Teaches participants how to recognize healthy attachment and understand the impact of attachment disorders
- Offers strategies for identification and support of effective interventions by early educators that can minimize the adverse effects of trauma and toxic stress and promote resiliency in infants, toddlers and their families

Components of each session:

- The PowerPoint Presentation
- Video
- Trainer's Guide
- Bibliography
- Handouts

SCSC Train-the-Trainer
resources may be found at:
collaborative.org/early-childhood/scsc

**SCSC Early Childhood Train-the-Trainer Series:
*Promoting Resiliency in Families with Infants, Toddlers and
Preschool-aged Children through Trauma-Informed Child Welfare Practice***

For Child Welfare Professionals

This 2013 train-the-trainer series for child welfare professionals includes video of four 2-hour sessions (edited videos are shorter), each structured around an interactive PowerPoint presentation. Large and small group discussions, vignettes and case sharing, video clips and handouts supplement the PowerPoint for each session. The series was designed to be used by administrators or supervisors to train caseworkers and other staff, but is also appropriate for self-guided learning.

A parallel series is available for early educators, as is an additional cross-training session that provides a structure to bring early childhood and child welfare staff together to build relationships and increase mutual understanding, with a goal of improved collaboration between the child welfare and early childhood systems.

Session Titles:

1. What is Infant and Early Childhood Mental Health?
2. Brain Development and the Impact of Trauma
3. Attachment and the Impact of Trauma
4. Infant and Early Childhood Mental Health Best Practices: Effective Collaboration and Supporting Resiliency

Training Content:

- Enables participants to train staff and colleagues in trauma-informed practice that supports the social-emotional development of infants, toddlers, and preschool-aged children
- Provides an in-depth look at infant and early childhood mental health
- Explores typical early social-emotional development and identifies common areas of concern
- Describes healthy attachment to caregivers and the effects of attachment disorders
- Promotes understanding of early brain development and the effects of trauma and toxic stress on the developing brain
- Explains the impact of trauma and toxic stress on very young children and offers effective strategies and interventions to minimize adverse effects and promote resiliency
- Provides best practice strategies for working with very young children and their families in a child welfare setting

Components of each session:

- The PowerPoint Presentation
- Video
- Trainer's Guide
- Bibliography
- Handouts

SCSC Train-the-Trainer
resources may be found at:
collaborative.org/early-childhood/scsc

SCSC Cross-Training Session to Improve Collaboration between Early Educators and Child Welfare Staff

Provided are a PowerPoint presentation and Training Guide designed to be used with a multi-disciplinary group of early educators and child welfare professionals, ideally with equal representation from each discipline. This two-hour cross-training session was the final session in two SCSC Train-the-Trainer series offered separately to each discipline in 2013. The session is built around case vignettes of infants, toddlers and preschool-aged children involved with both the early education and child welfare systems. Through small-group exercises, early educators and child welfare professionals are encouraged to share their roles and perspectives and explore together the possibilities and benefits of improved collaboration.

SCSC Early Childhood/Child Welfare Toolkit for Early Educators

(in development – expected to be available in December, 2014)

This toolkit for early educators will be a best practices guide to effective collaboration with DCF, the child welfare agency in Massachusetts.

SCSC Early Childhood/Child Welfare Toolkit for DCF/Child Welfare Professionals

(in development – expected to be available in December, 2014)

This toolkit for DCF staff will be a best practices guide for child welfare casework with children birth to five in Massachusetts, with additional emphasis on effective collaboration with early education/child development programs and services.

Assessment Resources

Ages and Stages Questionnaires (ASQ)

The ASQ Third Edition (ASQ-3) and ASQ-Social Emotional (ASQ:SE) are developmental screening tools appropriate for screening children from 1 month to 5 ½ years of age. The tools are based on research and are both reliable and valid. The ASQ-3 uses drawings and simple directions to help parents elicit and indicate children's language, personal-social, motor, and cognition skills. The ASQ:SE helps screen for emotional and behavioral problems. Both tools are available in English and Spanish. (from Zero to Three, referenced in Appendix D)

agesandstages.com

Additional assessment and screening resources for parents and professionals can be found at the Brazelton Touchpoints Center and Watch Me Thrive websites:

www.brazeltontouchpoints.org

www.acf.hhs.gov/programs/ecd/watch-me-thrive

Resource Websites

These are just a few of the many websites that contain valuable resources for parents and professionals who care for and provide services to vulnerable young children and their families:

www.brazeltontouchpoints.org

Brazelton Touchpoints Center is dedicated to supporting optimal child development for all children. Resources for parents and professionals available.

csefel.vanderbilt.edu

The Center for Social and Emotional Foundations of Early Learning (CSEFEL) promotes the social-emotional development and school readiness of young children birth to age 5. Free resources in Spanish and English for families and training modules for early educators and trainers/coaches are available.

circleofsecurity.net

Circle of Security International is a relationship based early intervention program designed to enhance attachment security between parents and children. Free handouts designed to enhance parenting education are available.

developingchild.harvard.edu

The Center for the Developing Child at Harvard University provides materials accessible to the lay reader about the science of early childhood, including brain development, trauma and toxic stress.

www.mass.gov/eohhs/gov/departments/dcf

The Massachusetts Department of Children and Families is the state child welfare agency. Information is available about child abuse and neglect reporting, statistics, and family services.

www.mass.gov/edu/government/departments-and-boards/departments-of-early-education-and-care

The Massachusetts Department of Early Education and Care provides information about accessing the mixed delivery early care and education system in MA, and also offers parenting resources for parents of young children.

www.acf.hhs.gov/programs/ohs

Office of Head Start provides fact sheets and research about early learning, parent engagement and related topics.

healthrecovery.org

Institute for Health and Recovery specializes in resources for youth, parents, and professionals on topics related to substance abuse, violence/trauma, mental health, and HIV/AIDS. Materials are available at low cost on the website.

naeyc.org

National Association for the Education of Young Children is a member organization that advocates on behalf of young children and sells publications and resources for early childhood professionals.

nctsnet.org/

National Child Traumatic Stress Network is committed to improving access to and quality of services for traumatized children. Free resources for parents and professionals are available.

www.acf.hhs.gov/programs/ecd/watch-me-thrive

Watch me Thrive is a new child development resource for families and early educators that provides free resources to help parents and educators with developmental screening and supporting optimal early development.

zerotothree.org

Zero to Three is a national, nonprofit organization that provides parents, professionals and policymakers the knowledge and know-how to nurture early development. A wide array of free resources can be accessed through the website.



Appendix D: Glossary

Zero to Three Definitions

Child Abuse Prevention and Treatment Act (CAPTA)

CAPTA is the key federal legislation addressing child abuse and neglect. It provides federal funding to states in support of... [child welfare] activities and also provides grants . . . for demonstration programs and projects... CAPTA requires state early intervention and child welfare systems to establish coordinated procedures for the referral of substantiated cases of abused, neglected, or illegal drug-exposed infants and toddlers to Part C services. www.childwelfare.gov/search/search_results.cfm?q=CAPTA

Child and Family Services Improvement and Innovation Act (2011)

The Child and Family Services Improvement and Innovation Act instituted a new requirement for states to describe in their child welfare plans how they promote permanency for, and address the developmental needs of, young children in their care. Specifically, state plans must "include a description of the activities that the State has undertaken to reduce the length of time children who have not attained 5 years of age without a permanent family, and the activities the State undertakes to address the developmental needs of such children who receive benefits under this part or part E." 14 The Act also requires states to outline how emotional trauma associated with a child's maltreatment and removal from home will be monitored and treated, and to design services and activities that facilitate contact between young children and their parents and siblings as a component of time-limited family reunification services... www.gpo.gov/fdsys/pkg/PLAW-112publ34/pdf/PLAW-112publ34.pdf

Concurrent Planning

Seeks to promote timely permanence for children in foster care by considering reunification and other permanency options at the earliest possible point after a child's entry into foster care. The process includes: systems that institutionalize the approach, clarity and services for birth parents, training and support for caseworkers, processes for recruiting and training families to foster children in concurrent planning cases and adopt if that is the outcome, and active promotion by the court. www.childwelfare.gov/permanency/overview/concurrent.cfm

Differential Response

In traditional child protective service systems without differential response, there is only one response to all reports. Child welfare workers investigate the allegation with a resulting formal disposition indicating whether maltreatment occurred. Research indicates that this single approach is not effective in all types of reports of maltreatment. 16 In differential response, child protective services offer both traditional investigations and

The definitions on these two pages are excerpted from the Glossary in Zero to Three's "A Developmental Approach to Child Welfare Services for Infants, Toddlers, and their Families—A Self-Assessment Tool for States and Counties Administering Child Welfare Services."

www.zerotothree.org/public-policy/webinars-conference-calls/final-cw-self-assessment-tool.pdf

Note: Additional definitions relevant to these recommendations are listed following those obtained from Zero to Three.

assessment alternatives to families reported for child abuse and neglect, depending on the severity of the allegation and other considerations... For high-risk reports, an investigation generally ensues. For low- and moderate-risk cases with no immediate safety concerns, a family assessment is conducted to gauge the family's needs and strengths and refers them on to appropriate community-based resources.

www.childwelfare.gov/pubs/issue_briefs/differential_response/

Dyadic Therapy

Dyadic therapy is an intervention approach provided to infants and young children with symptoms of emotional disorders. Therapy includes the child and the parent and focuses on rebuilding a healthy and secure relationship between them. Research suggests that this type of therapy is useful in helping the parent and child to regain trust, develop a secure attachment, work through trauma and fears, and improve parenting skills. 17

Family-Centered Practice

Family-centered practice is a way of working with families, both formally and informally, across service systems to enhance their capacity to care for and protect their children. It focuses on the needs and welfare of children within the context of their families and communities. Family-centered practice recognizes the strengths of family relationships and builds on these strengths to achieve optimal outcomes. Family is defined broadly to include birth, blended, kinship, and foster and adoptive families. <https://www.childwelfare.gov/famcentered>

Foster-Adopt Home Placements (also called legal risk placements)

When a child is placed with a foster-adopt family, typically the child's permanency options are being evaluated through concurrent planning in two directions: adoption and family reunification. The child is placed in the home of a specially trained prospective adoptive family, who will work with the child during family reunification efforts but will adopt the child in the event that family reunification is not successful.

Kinship Care

Kinship care refers to placements of children with relatives or, in some jurisdictions, close family friends (often referred to as fictive kin). Relatives are the preferred placement for children who must be removed from their birth parents, as this kind of placement maintains the children's connections with their families. Kinship care is often considered a type of family preservation service.

<https://www.childwelfare.gov/outofhome/kinship>

Part C of the Individuals with Disabilities Education Act

Part C is the Early Intervention Program for Infants and Toddlers with Disabilities. It is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for children from birth to 2 years old who have developmental delays or who are at risk of developing a delay or special need that may affect their development or impede their education, and their families...

idea.ed.gov/part-c/search/new

Pre-Removal Conference

Pre-removal conferences are initiated by and held at the child welfare agency. At these meetings, mediated by a trained facilitator, the investigative social worker and the worker who will take the case after the investigation talk with the parent(s) about the reasons for removal, the family's strengths and challenges, the services that could be initiated immediately, and the special needs of the child(ren). This allows parents to be seen as the experts about their child(ren) and to know that the child welfare workers are in their corner. Relatives and other members of the parents' support system are also invited to participate.

Protective Factors

The Center for the Study of Social Policy has identified five protective factors that can ameliorate risk of child abuse and neglect:

- Parental resilience—the capacity to cope with all types of challenges.
- Social connections—positive relationships with friends, family members, neighbors, and others who can provide concrete and emotional supports to parents.
- Knowledge of parenting and child development—accurate information about raising children and appropriate expectations for their behaviors.
- Concrete support in times of need—financial security and access to informal and formal supports.
- Social and emotional competence of children—the ability of children to interact positively and articulate their feelings.

www.cssp.org/reform/strengthening-families

Quality Early Learning and Development Programs

Quality early learning programs offer the promise of a solid future by providing our youngest children with nurturance, support for early learning and language development, preparation for school, and the opportunity for all infants and toddlers to reach their full potential. The quality of care for infants and toddlers in an early learning program ultimately boils down to the quality of the relationship between the care provider and the child:

skilled and stable providers promote positive development. A secure relationship between the infant and the caregiver can complement the relationship between parents and young children and facilitate early learning and social development. Young children whose caregivers provide ample verbal and cognitive stimulation, who are sensitive and responsive, and who give them generous amounts of attention and support are more likely to be advanced in all aspects of development compared with children who fail to receive these important inputs.

www.zerotothree.org/

public-policy/policy-toolkit/child_caremar5singles.pdf

Secure Attachment

Research demonstrates that forming secure attachments to a few caring and responsive adults is a primary developmental milestone for babies in the first year of life. Infants and toddlers who are able to develop secure attachments are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments. 19

Trauma-Informed Care

Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may aggravate.

www.samhsa.gov/nctic/trauma.asp

Trauma-Informed Supervision

The key to making child- and youth-serving systems more trauma-informed is professionals who understand the impact of trauma on child development and can address trauma and minimize any additional negative effects. In doing so, it is important that practitioners are provided with the opportunity to talk through their own personal reactions to very troubling family trauma and learn how to cope and manage professional and personal stress, often called vicarious or secondary trauma. Trauma-informed supervision provides a concrete way for supporting child welfare professionals.

www.childwelfare.gov/pubs/braindevtrauma.pdf

Visit Coaching

Visit coaching is fundamentally different from supervised visits. Instead of merely watching the family, the coach is actively involved in supporting them to demonstrate their best parenting skills and make each visit fun for the children; the coach's intention is to facilitate safe reunification by helping parents demonstrate their skills at meeting their children's needs. Visit coaching can be effective immediately after removal and/or as an aftercare practice as children begin extended visits prior to case closing. 20

14 Child and Family Services Improvement and Innovation Act of 2011, 112th Cong., H.R. 2883, www.gpo.gov/fdsys/pkg/PLAW-112publ34/pdf/PLAW-112publ34.pdf.

16 Cohen, Cole, and Szrom, A Call to Action on Behalf of Maltreated Infants and Toddlers.

17 Julie Cohen, Cindy Oser, and Kelsey Quigley, Making It Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health. ZERO TO THREE, 2012, www.zerotothree.org.

19 National Research Council and Institute of Medicine, From Neurons to Neighborhoods.

20 Marty Beyer, "Visit Coaching: Building on Family Strengths to Meet Children's Needs." *Juvenile and Family Court Journal* 59, no.1 (2008): 47–60.

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Appendix D: Glossary (continued)

Additional Definitions from Sources Other Than Zero to Three

Child Well-Being

Well-being, or “overall satisfaction with life,” is measured in different ways for different purposes. The CDC refers to the following as adding up to a person’s well-being: “quality of relationships, positive emotions and resilience, the realization of their potential . . .” (www.cdc.gov/hrqol/wellbeing.htm)

In a child welfare/ infant and early childhood mental health context, the goal of child well-being refers to laying the foundation for long-term happiness and success through meeting the child’s physical and social-emotional needs for nurturing, safety, secure attachment, and consistency/continuity of responsive caregiving relationships.

Early Childhood Mental Health

(synonymous with infant and early childhood mental health)

“The developing capacity of infants, toddlers and young children to experience, manage and express emotions; form close, secure relationships; and actively explore the environment and learn. . . essentially synonymous with healthy social and emotional development.” (Vanderbilt University, csefel.vanderbilt.edu/documents/rs_emhc.pdf —adapted from Zero to Three)

Early Childhood Mental Health Consultation (ECMH)

A professional consultant with early childhood and mental health expertise “working with early care and education staff, programs and families to improve their ability to prevent, identify and respond to mental health issues among the children in their care.” (Georgetown University, gucchd.georgetown.edu/67637.html) Note: The SCSC Project piloted and recommends the use of IECMH consultation with child welfare staff in addition to early educators and parents of children in early learning programs.

Mentoring/Consultation Component (for training follow-up)

After participating in a training program, trainees receive follow-up to assist them to integrate the training content into their practice. A mentoring model would provide regular access to individual or small group meetings with a mentor who could model and support best practice. An alternative is to ensure that trainees receive regular consultation with a professional who has relevant expertise, such as an Infant and Early Childhood Mental Health (IECMH) Consultant

Permanency Planning

“The goal of permanency planning is to provide a child with a safe, stable environment in which to grow up, while in the care of a nurturing caregiver who is committed to a lifelong relationship with that child. A sense of urgency exists for every child who is not in a permanent home. Permanency Planning:

- Starts at first contact;
- Continues throughout the lifetime of the child’s case until permanency is achieved;
- Secures a safe, stable, and permanent home for the child as soon as possible;
- Protects the child developmentally;
- Protects primary attachments, or
- Creates new attachments; and
- Preserves cultural and family connections”

(Permanency Planning Practice Guide for Social Workers, Children’s Administration, August, 2006 www.dshs.wa.gov/pdf/ca/PermPlanGuide.pdf)

Social-Emotional Development

See early childhood mental health, above.

Strengths-Based Approach

“An individualized, strengths-based approach refers to policies, practice methods, and strategies that identify and draw upon the strengths of children, families, and communities. Strengths-based practice involves a shift from a deficit approach, which emphasizes problems and pathology, to a positive partnership with the family. The approach acknowledges each child and family’s unique set of strengths and challenges, and engages the family as a partner in developing and implementing the service plan.” (Child Welfare Information Gateway, www.childwelfare.gov/pubs/acloserlook/strengthsbased/strengthsbased1.cfm)

Toxic Stress

“Toxic stress refers to the disruption in brain architecture and other organ systems that occurs with strong, frequent or prolonged adversity. It comes from children being repeatedly exposed to very difficult situations in their neighborhoods or home—from witnessing or experiencing violence or trauma on a regular basis to having a family member with an untreated mental health or substance abuse problem.” (www.centerforyouthwellness.org/toxic-stress)

Transition Planning

Typically refers to the planning process that enables a child with disabilities to transition between early intervention services and the public schools. In this context, it refers to the planning process to enable young children in the child welfare system to transition successfully between living at home and in out-of-home placements, and between placements when there is more than one. Transitions should be kept to an absolute minimum for very young children, but, when necessary, should happen planfully, at a pace and in a manner appropriate to the child’s developmental stage and special needs.

FIVE NUMBERS TO REMEMBER ABOUT EARLY CHILDHOOD DEVELOPMENT

700

700 PER SECOND

18

18 MONTHS

90-100

90-100%

3:1

3:1 ODDS

4-9

4-9 DOLLARS

This feature highlights five numbers to remember about the development of young children. Learn how the numbers illustrate such concepts as the importance of early childhood to the learning, behavior, and health of later life and why getting things right the first time is easier and more effective than trying to fix them later. This feature is also available in a web-based slideshow format at http://developingchild.harvard.edu/resources/multimedia/interactive_features/five-numbers/

For more resources from the Center on the Developing Child at Harvard University visit <http://developingchild.harvard.edu/resources/>

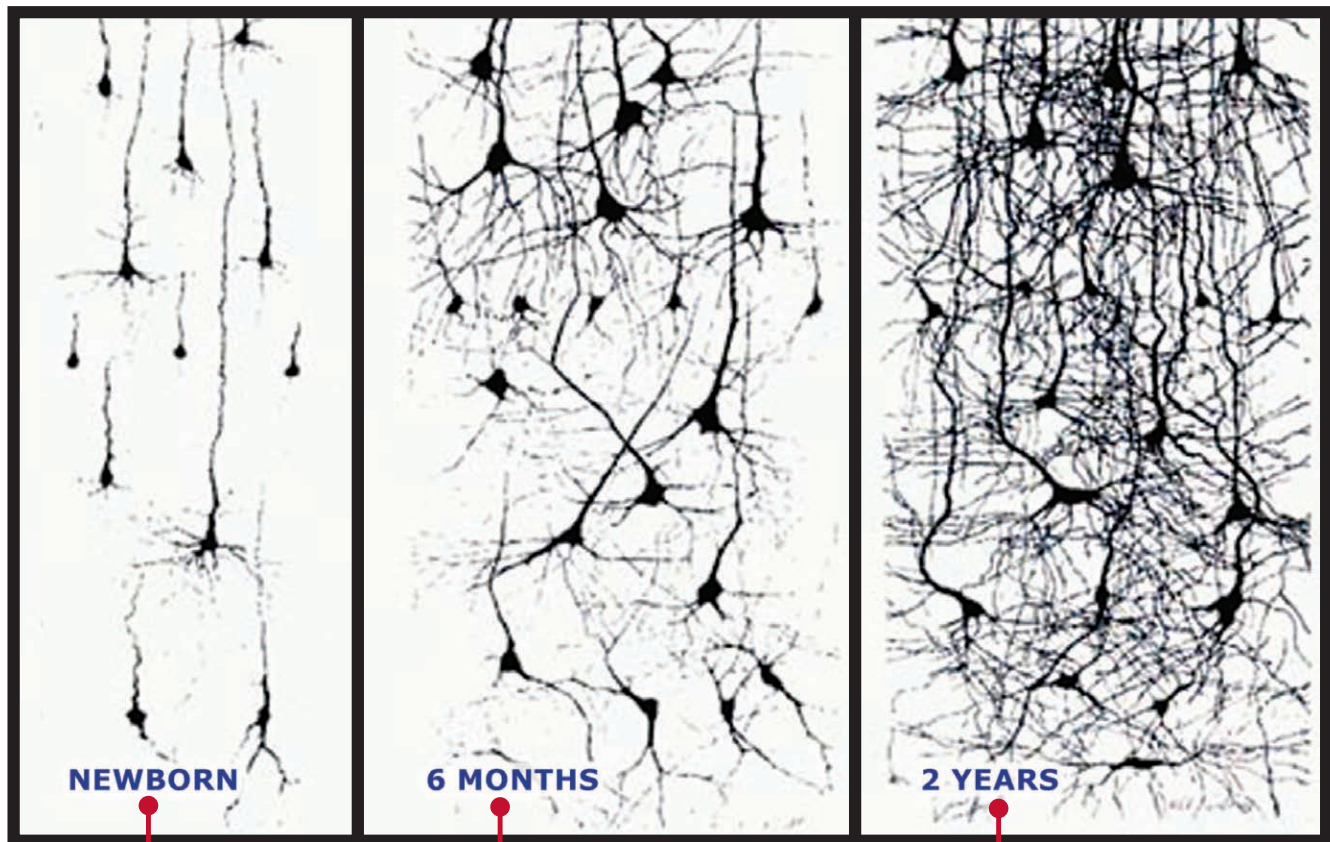
www.developingchild.harvard.edu

Center on the Developing Child  HARVARD UNIVERSITY

Source: Center on the Developing Child at Harvard University | www.developingchild.harvard.edu

FIVE NUMBERS TO REMEMBER ABOUT EARLY CHILDHOOD DEVELOPMENT

700 700 NEW NEURAL CONNECTIONS
PER SECOND



1

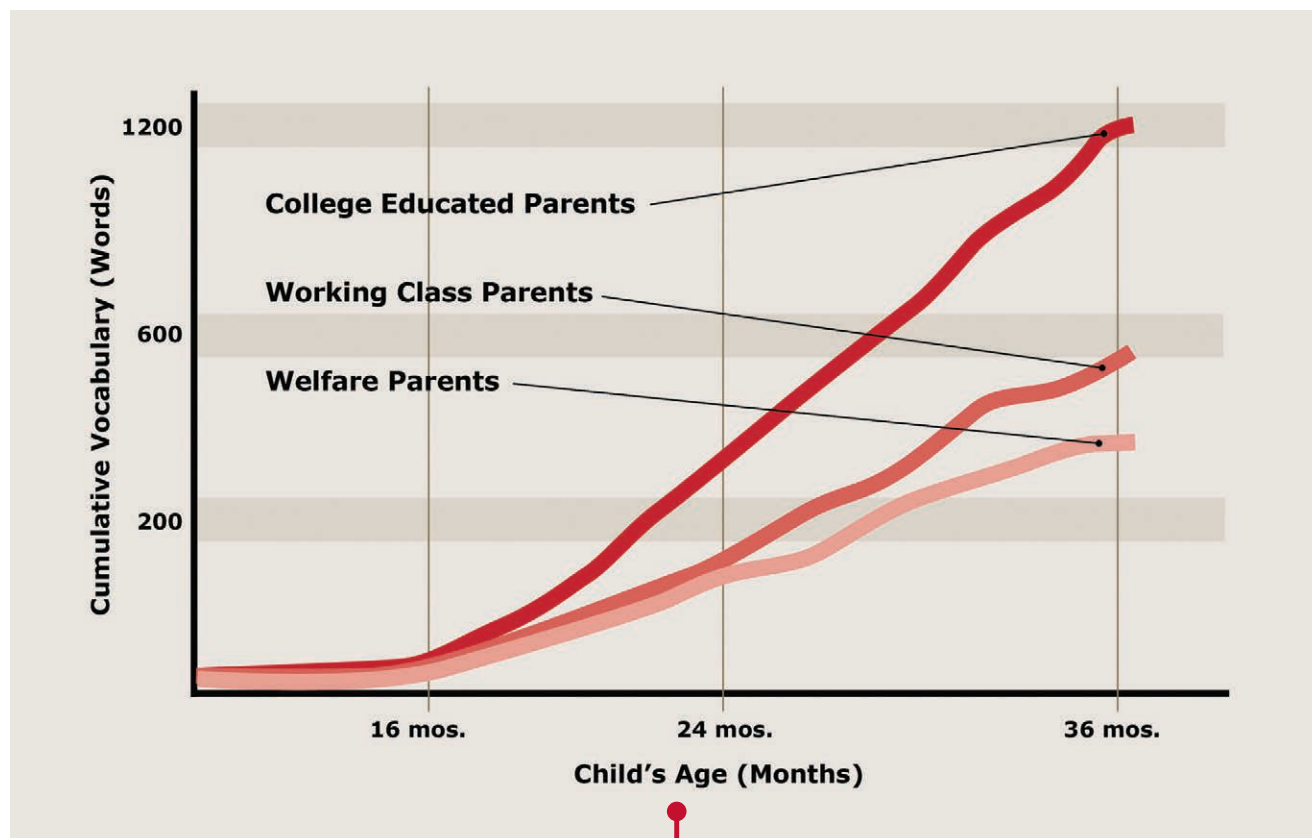
The early years matter because, in the first few years of life, 700 new neural connections are formed every second. Neural connections are formed through the interaction of genes and a baby's environment and experiences, especially "serve and return" interaction with adults, or what developmental researchers call contingent reciprocity. These are the connections that build brain architecture – the foundation upon which all later learning, behavior, and health depend.

Image source: Conel, J.L. The postnatal development of the human cerebral cortex. Cambridge, Mass: Harvard University Press, 1959

FIVE NUMBERS TO REMEMBER ABOUT EARLY CHILDHOOD DEVELOPMENT

18

18 MONTHS: AGE AT WHICH DISPARITIES IN VOCABULARY BEGIN TO APPEAR



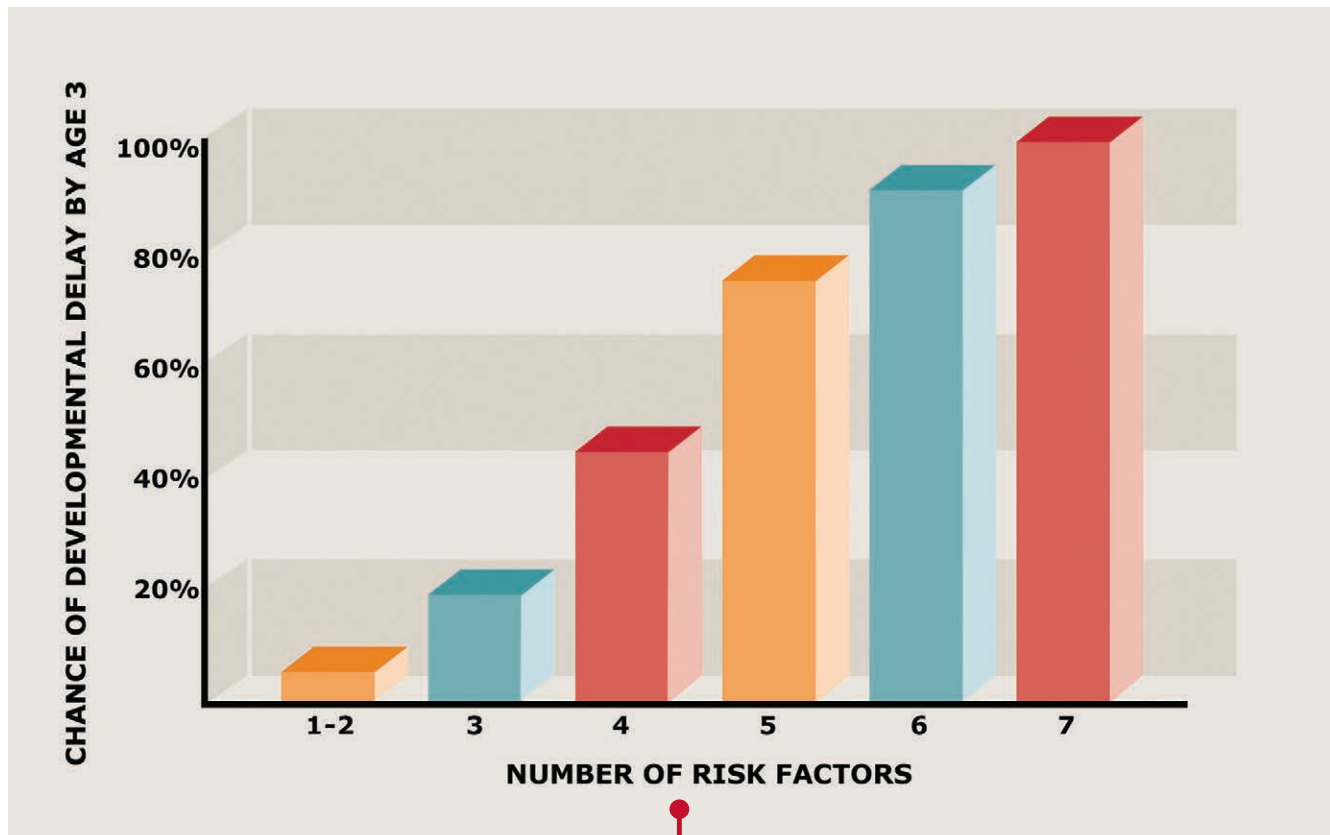
2

Early experiences and the environments in which children develop in their earliest years can have lasting impact on later success in school and life. Barriers to children's educational achievement start early, and continue to grow without intervention. Differences in the size of children's vocabulary first appear at 18 months of age, based on whether they were born into a family with high education and income or low education and income. By age 3, children with college-educated parents or primary caregivers had vocabularies 2 to 3 times larger than those whose parents had not completed high school. By the time these children reach school, they are already behind their peers unless they are engaged in a language-rich environment early in life.

Source: Hart, B., & Risley, T. (1995). Meaningful differences in the everyday experiences of young American children. Baltimore, MD: Brookes.

FIVE NUMBERS TO REMEMBER ABOUT EARLY CHILDHOOD DEVELOPMENT

90-100 90-100% CHANCE OF
DEVELOPMENTAL DELAYS
WHEN CHILDREN EXPERIENCE 6-7 RISK FACTORS



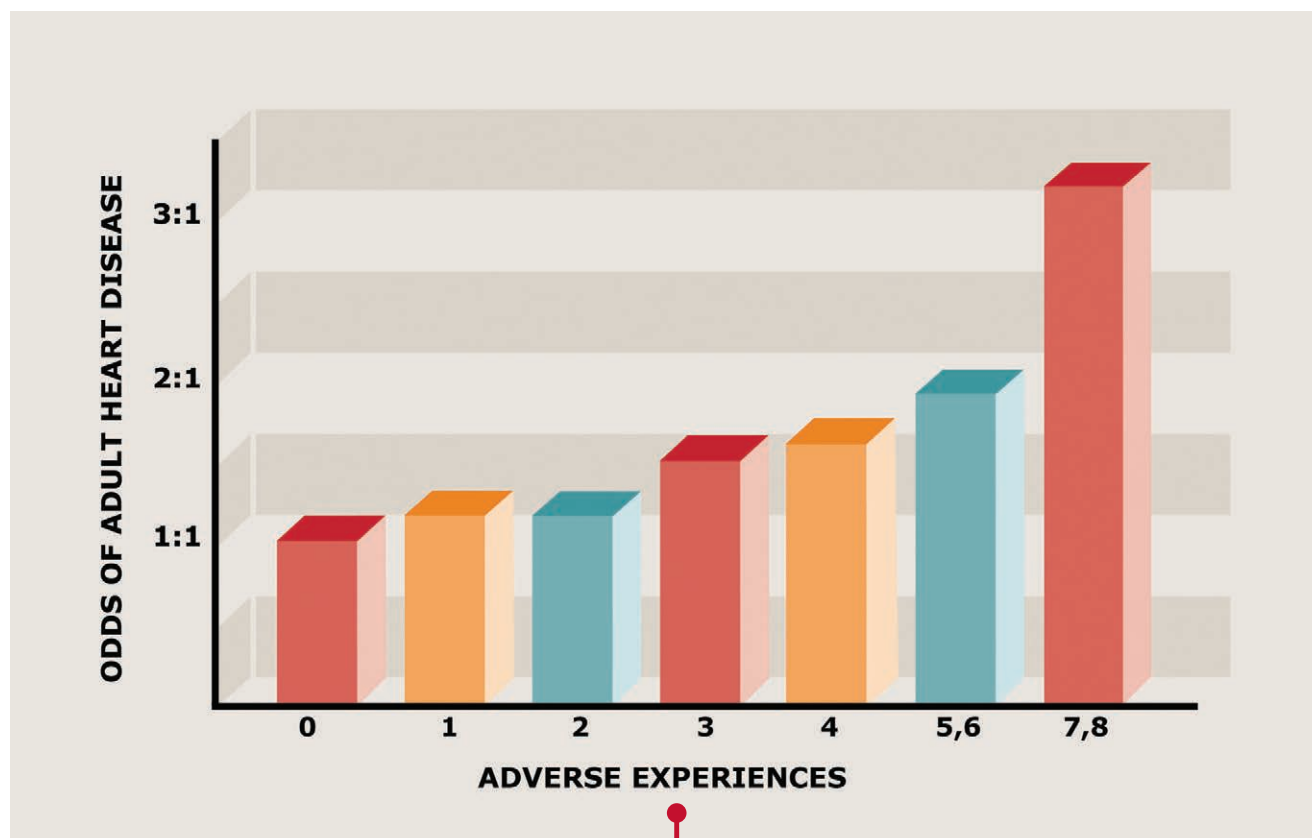
3

Significant adversity impairs development in the first three years of life—and the more adversity a child faces, the greater the odds of a developmental delay. Indeed, risk factors such as poverty, caregiver mental illness, child maltreatment, single parent, and low maternal education have a cumulative impact: in this study, maltreated children exposed to as many as 6 additional risks face a 90-100% likelihood of having one or more delays in their cognitive, language, or emotional development.

Source: Barth et al. (2008)

FIVE NUMBERS TO REMEMBER ABOUT EARLY CHILDHOOD DEVELOPMENT

3:1 3:1 ODDS OF ADULT HEART DISEASE
AFTER 7-8 ADVERSE CHILDHOOD EXPERIENCES



4

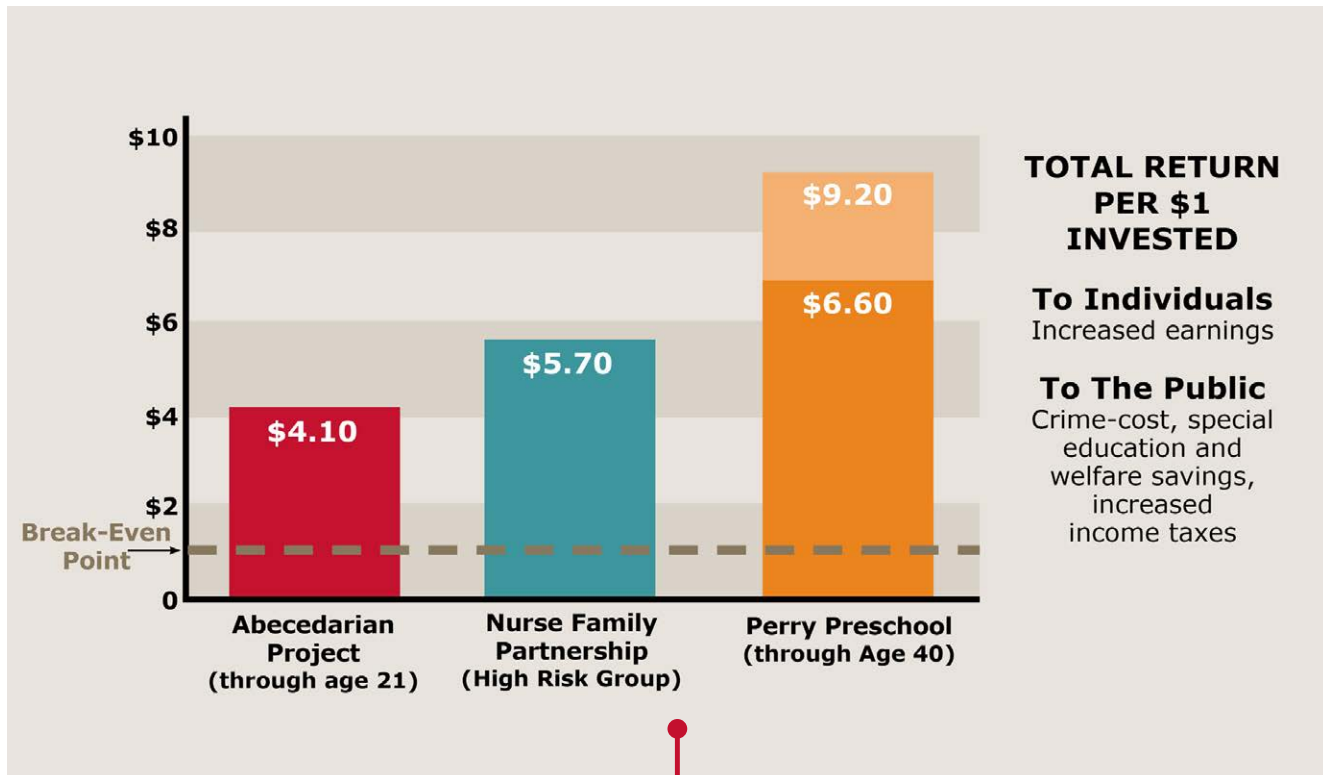
Early experiences actually get into the body, with lifelong effects—not just on cognitive and emotional development, but on long term physical health as well. A growing body of evidence now links significant adversity in childhood to increased risk of a range of adult health problems, including diabetes, hypertension, stroke, obesity, and some forms of cancer. This graph shows that adults who recall having 7 or 8 serious adverse experiences in childhood are 3 times more likely to have cardiovascular disease as an adult. And children between birth and three years of age are the most likely age group to experience some form of maltreatment—16 out of every thousand children experience it.

Source: Dong et al. (2004)

FIVE NUMBERS TO REMEMBER ABOUT EARLY CHILDHOOD DEVELOPMENT

4-9

**\$4 - \$9 IN RETURNS FOR EVERY DOLLAR
INVESTED IN EARLY CHILDHOOD PROGRAMS**

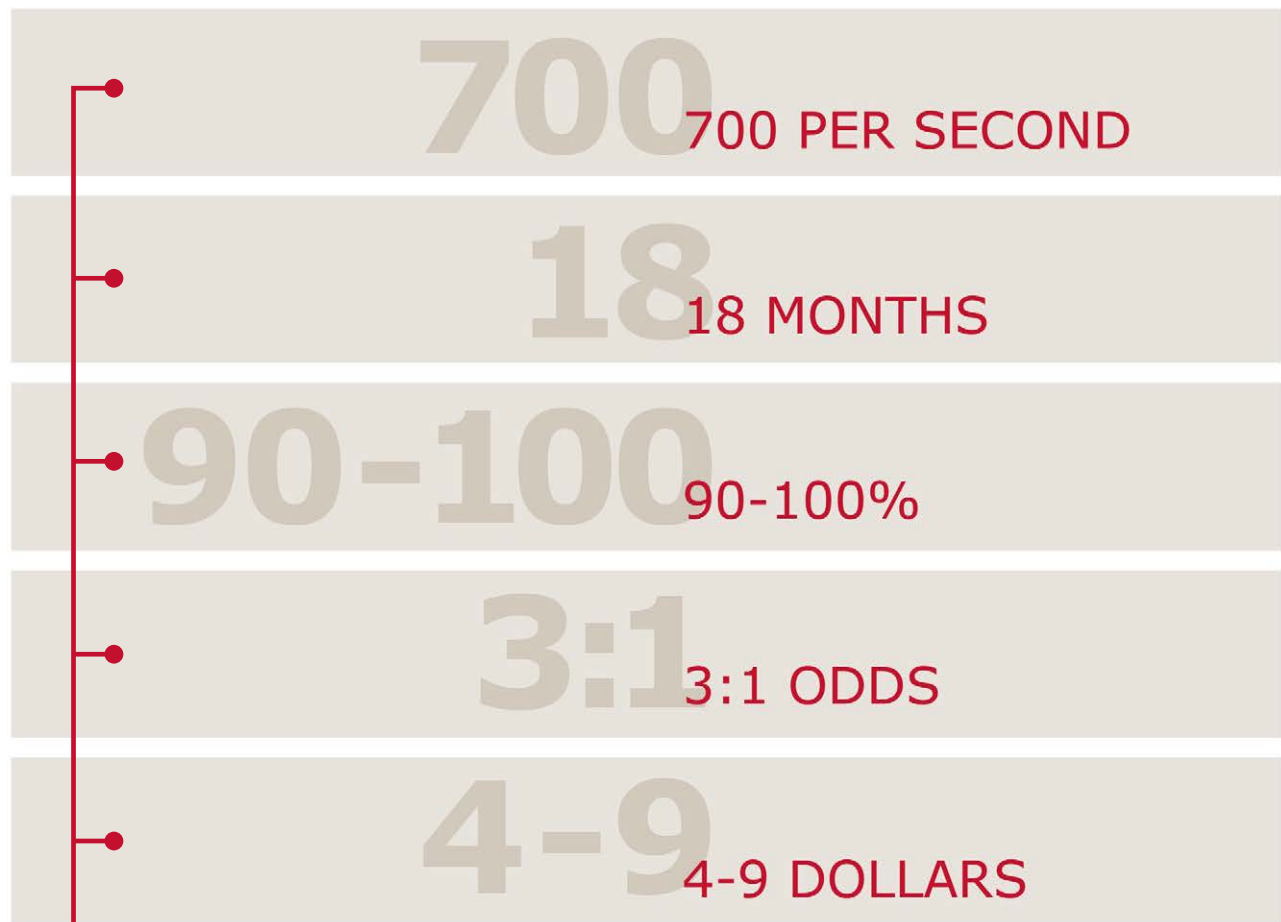


5

Providing young children with a healthy environment in which to learn and grow is not only good for their development—economists have also shown that high-quality early childhood programs bring impressive returns on investment to the public. Three of the most rigorous long-term studies found a range of returns between \$4 and \$9 for every dollar invested in early learning programs for low-income children. Program participants followed into adulthood benefited from increased earnings while the public saw returns in the form of reduced special education, welfare, and crime costs, and increased tax revenues from program participants later in life.

Sources: Masse, L. and Barnett, W.S., A Benefit Cost Analysis of the Abecedarian Early Childhood Intervention (2002); Karoly et al., Early Childhood Interventions: Proven Results, Future Promise (2005); Heckman et al., The Effect of the Perry Preschool Program on the Cognitive and Non-Cognitive Skills of its Participants (2009)

WHAT THESE FIVE NUMBERS TELL US



1. Getting things right the first time is easier and more effective than trying to fix them later.
2. Early childhood matters because experiences early in life can have a lasting impact on later learning, behavior, and health.
3. Highly specialized interventions are needed as early as possible for children experiencing toxic stress.
4. Early life experiences actually get under the skin and into the body, with lifelong effects on adult physical and mental health.
5. All of society benefits from investments in early childhood programs.

Adverse Childhood Experiences (ACEs)

From the ACEs research, ACEs include:

- Physical child abuse by a parent or other adult in the household:
frequent hitting, slapping, pushing, burning or using objects to create physical harm, etc.
- Emotional child abuse by a parent or other adult in the household:
name calling, shaming, belittling, pervasive criticism, humiliation, frequent yelling, swearing, etc.
- Child sexual abuse by an adult or person at least 5 years older:
all forms, including fondling, exposure to pornography, all forms of adults touching children's private parts and children being asked to touch adults' private parts, etc.
- Child neglect by parents or adult caregivers:
chronic hunger, inadequate adult supervision, inadequate clothing, medical neglect, educational neglect, emotional neglect, etc.
- Parental substance abuse, all types, and substance abuse by anyone living in the household
- Loss of a parent due to death, divorce, abandonment or other reasons
- Intimate partner/domestic violence: witnessing or other forms of awareness of interpersonal violence occurring in the home, including physical violence, use of weapons in the home, and threats and other emotional forms of violence
- Household member mentally ill, depressed, or committed suicide
- Household member in prison

Adverse Childhood Experiences (2)

The higher the ACE score, the more likely it is that there will be long-term, possibly lifelong, consequences that affect a child's physical and mental health and wellbeing.

For example, children with an ACE score of 4 as compared with those whose score is 0 are predicted to be 12 times more likely to have negative health outcomes and a variety of chronic health challenges in adulthood. They are much more likely to suffer depression, to be an IV drug user, and to attempt suicide. BUT, if they receive appropriate and effective services early in life, these negative outcomes will become less likely, and may be able to be prevented altogether.

The higher the ACE score, the more important it is to take immediate action to prevent long-term negative consequences.

What the DCF Social Worker can do to prevent long-term harm:

- **Refer the child for free developmental screening** by an early intervention program (REACH, locally) or public school after age 3 **and follow up** to make sure that any barriers to successful screening are eliminated and that the family engages with recommended services.
- **Refer for assessment and therapeutic services to specialized early childhood mental health services** that use evidence-based modalities to promote healthy attachments, improved parent-child attunement and positive parenting skills.
- **Do everything possible to keep placement changes to an absolute minimum and maintain children's relationships with primary caregivers** when out-of-home placement or placement changes are unavoidable.
- Help the family **enroll the child in a high quality early education/child care setting**, either in a center or family child care home and **maintain frequent contact with early educators**. Research shows that high quality early education/child care is a strong protective factor that will improve long-term outcomes for traumatized young children and their families. Head Start is free for eligible families and can prioritize children involved with DCF and foster children.

Adverse Childhood Experiences (3)

ACE survey screening questions:

Asked of adults; answers apply to situations and events that occurred before the age of 18.

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
No___If Yes, enter 1 __
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
No___If Yes, enter 1 __
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
No___If Yes, enter 1 __
6. Was a biological parent ever lost to you through divorce, abandonment, or other reason ?
No___If Yes, enter 1 __
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
No___If Yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
No___If Yes, enter 1 __
10. Did a household member go to prison?
No___If Yes, enter 1 __

Now add up your "Yes" answers: ____ This is your ACE Score.



ISSUE BRIEF

February 2014

Protective Factors Approaches in Child Welfare

This issue brief provides a succinct overview of protective factors approaches to the prevention and treatment of child abuse and neglect. It is designed to help policymakers, administrators, child welfare and related professionals, service providers, advocates, and other interested individuals understand the concepts of risk and protective factors in families and communities and learn ways in which building protective factors can help to lessen risks for child abuse and neglect.

What Are Risk and Protective Factors?

Risk factors refer to the stressful conditions, events, or circumstances (e.g., maternal depression, substance abuse, family violence, persistent poverty) that increase a family's chances for poor outcomes, including child abuse and neglect. Protective factors are conditions or attributes of individuals, families, communities, or the larger society that mitigate risk and promote healthy development and well-being. Put simply, they are the strengths that help to buffer and support families at risk.

WHAT'S INSIDE

What are risk and protective factors?

Why is a protective factors approach important?

Using protective factors in child maltreatment

Mapping connections across protective factors approaches

Individual protective factors

Relational protective factors

Societal or community protective factors

Putting protective factors into practice

Conclusion

Resources



Children's Bureau/ACYF/ACF/HHS
800.394.3366 | Email: info@childwelfare.gov | <https://www.childwelfare.gov>



Source: Child Welfare Information Gateway | www.childwelfare.gov

Why Is a Protective Factors Approach Important?

Traditionally, child maltreatment prevention and intervention strategies have focused exclusively on risk factors and their elimination. We now know that changing the balance between risk and protective factors so that protective factors outweigh risk factors is a more effective prevention and intervention strategy. Helping children and families build resilience and develop skills, characteristics, knowledge, and relationships that offset risk exposure can contribute to both short- and long-term positive outcomes.

Using a protective factors approach can be a positive way to engage families because it focuses on families' strengths and what they are doing right. Focusing exclusively on risk factors with families can leave families feeling stigmatized or unfairly judged. Also, a protective factors approach can provide a strong platform for building collaborative partnerships with other service providers—like child care—that are not as familiar or comfortable with a risk paradigm as a basis for engaging families.

Using Protective Factors in Child Maltreatment

The emphasis on protective factors continues to grow, and today they are used by practitioners, policymakers, and researchers to improve child, family, and community well-being. Currently, there are several key protective factors approaches in use, including the following:

- Strengthening Families™ and Youth Thrive™ were developed by the Center for the Study of Social Policy (CSSP).
- Essentials for Childhood is an approach developed by the Centers for Disease Control and Prevention (CDC).
- The Administration on Children, Youth and Families (ACYF), Administration for Children and Families, U.S. Department of Health and Human Services (HHS) is currently working on an approach that identifies protective factors specifically relevant across the populations served by ACYF.

This brief aligns and interconnects the information across these protective factors approaches.

Strengthening Families

Strengthening Families is focused on building five protective factors that are associated in the research literature with lower rates of child abuse and neglect and with optimal child development:

- Parental Resilience
- Social Connections
- Knowledge of Parenting and Child Development
- Concrete Support in Times of Need
- Social-Emotional Competence of Children

Strengthening Families is the most well-established and broadly used protective factors approach in the field of child abuse and neglect prevention. In addition to the research literature, the development of the Strengthening Families approach was supported by:¹

- A national study of exemplary practice
- A 2-year, seven-State pilot study
- Structured learning from a national network of implementers
- Learning from four research studies being conducted under the ACYF-funded National Quality Improvement Center on Early Childhood

More than 40 States have initiated statewide Strengthening Families efforts, and a majority of all States are using Strengthening Families for child abuse and neglect prevention programming. It is also being used in multiple other sectors, including early childhood, child welfare services, family support, and home visiting, to name a few. Because of its longstanding application in the field, Strengthening Families is also supported by a wide range of implementation tools and materials, as well as active learning communities of implementers. More information on Strengthening Families can be found at <http://www.StrengtheningFamilies.net>.

¹ More information on this work can be found at the following link: <http://www.cssp.org/reform/strengthening-families/resources/Research-Behind-Strengthening-Families-2012.pptx>

Youth Thrive

The Youth Thrive protective factors approach focuses on adolescents, with a particular focus on youth receiving child welfare services. This approach describes how youth can be supported by parents and practitioners in ways that advance healthy development and well-being and reduce the impact of negative life experiences. There are five protective factors in the Youth Thrive framework:

- Youth Resilience
- Social Connections
- Knowledge of Adolescent Development
- Concrete Support in Times of Need
- Cognitive and Social-Emotional Competence

A national study of exemplary practice is underway to learn from programs that are building the Youth Thrive protective factors into their practice with youth facing challenging circumstances. New Jersey is piloting the application of Youth Thrive to the youth services provided for youth involved with child welfare. More Youth Thrive implementation tools will be available to the field in coming years.

Essentials for Childhood

The CDC's National Center for Injury Prevention and Control has defined three critical qualities of relationships and environments that can reduce the occurrence and negative effects of child maltreatment and other adverse childhood experiences:

- **Safety:** The extent to which a child is free from fear and secure from physical or psychological harm within his or her social and physical environment
- **Stability:** The degree of predictability and consistency in a child's social, emotional, and physical environment
- **Nurturing:** The extent to which a parent or caregiver is available and able to sensitively and consistently respond to and meet the needs of his or her child

CDC's Essentials for Childhood focuses on four goals that are critical for creating the context for safe, stable, nurturing relationships and environments:

- Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment
- Use data to inform actions
- Create the context for healthy children and families though norms change and programs
- Create the context for healthy children and families through policies

While each individual goal is important, the four goals together are more likely to build the comprehensive foundation of safe, stable, and nurturing relationships and environments for children. CDC has funded five State health departments to implement the Essentials for Childhood framework. The work of these grantees should provide additional implementation tools and resources for those interested in comprehensive strategies to promote safe, stable, and nurturing relationships and environments for all children. More information on Essentials for Childhood can be found here: <http://www.cdc.gov/violenceprevention/childmaltreatment/essentials/>

ACYF Literature Review on Protective Factors

The Children's Bureau, within ACYF, has long supported a focus on protective factors. Through its work to support programs, research, and monitoring systems that prevent child abuse and neglect, the Children's Bureau has integrated key elements of Strengthening Families' protective factors framework into its ongoing prevention work through the Office on Child Abuse and Neglect. Based on feedback from the field, the Children's Bureau also incorporated a sixth protective factor—nurturing and attachment—for prevention efforts and has been infusing this protective factor in its work.² (A child's early experience of being nurtured and developing a bond with a caring adult affects all aspects of behavior and development.)

Broadening this approach, in 2012, ACYF commissioned a literature review and expert consultation project to

² For example, see work from the FRIENDS National Resource Center on the Protective Factors Survey at <http://friendsnrc.org/protective-factors-survey>.

understand the strength of evidence that exists for protective factors for the populations it serves: youth in or transitioning out of foster care, children/youth exposed to domestic violence, victims of child abuse and neglect, pregnant and parenting youth, and runaway and homeless youth. One key finding from the 2012 review was the lack of available research on protective factors for a number of ACYF target populations. Other key findings showed that the needs of extremely vulnerable children are not so very different from those of other at-risk children, suggesting that the general literature on at-risk populations might be a good place to identify potential protective factors and interventions for ACYF populations. In addition, protective factors need to be built into all domains of the social ecology—individual, family, and community/society—in order for these children, youth, and families to thrive (see below).

ACYF identified 10 protective factors,³ with the strongest level of evidence, across these domains:

- Self-Regulation
- Relational Skills
- Problem-Solving Skills
- Involvement in Positive Activities
- Parenting Competencies
- Caring Adults
- Positive Peers
- Positive Community
- Positive School Environments
- Economic Opportunities

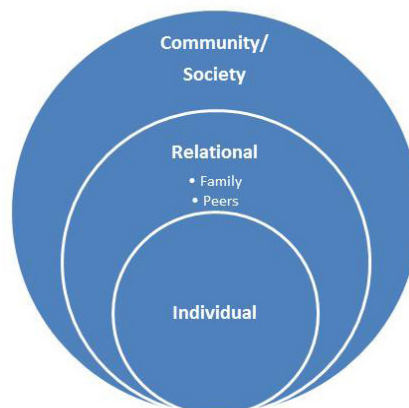
The full literature review and more detailed information about protective factors for each of the specific populations is available at <http://www.dsgonline.com/ACYF>.

³ These 10 factors apply to all the populations served by ACYF. The full literature review includes a separate list of relevant factors that are specific to each ACYF population (i.e., youth in or transitioning out of foster care, children/youth exposed to domestic violence, victims of child abuse and neglect, pregnant and parenting youth, and runaway and homeless youth).

Mapping Connections Across Protective Factors Approaches

Each of the described approaches synthesizes a broad range of existing literature in order to identify a discrete set of protective factors. In the process, they align and group research findings that are linked to the definition of the protective factor. Often, definitions overlap so that a certain study, for example, might be cited in one approach to support the importance of social-emotional competence in children and in another approach to support the importance of self-regulation in children.

This section of the brief compares the definitional language used by each approach in order to better understand the overlap and alignment. The social ecological framework is used to organize this comparison. Each approach's protective factors are placed in individual, relational, and social/community domains.



What Is Social Ecological Theory?

Social ecological theory examines how the experiences of individuals are shaped and interact with the structures and systems around them. Most social ecological theory uses concentric rings to illustrate how individuals are shaped by the environments closest to them.

Individual Protective Factors

The ACYF review, Youth Thrive, and Strengthening Families each address individual protective factors. Overall, there is good agreement among these approaches that children and youth's internal skills provide a strong platform for their overall well-being and positive outcomes. The internal skills associated with positive outcomes include:

- Regulation of emotion and action
- Ability to connect and interact effectively with others
- Ability to proactively respond to challenging circumstances and plan for life in ways that head off adversity

The chart below digs deeper into how the protective factors under each approach connect.

Table 1: Individual Protective Factors		
ACYF	Strengthening Families	Youth Thrive
Self-Regulation: a youth's ability to manage or control emotions and behaviors Relational Skills: (1) a youth's ability to form positive bonds and connections and (2) interpersonal skills such as communication, conflict resolution, and self-efficacy in conflict situations	Social-Emotional Competence in Young Children: the ability of the children to recognize their own and others' emotions, take the perspective of others, and use their emerging cognitive skills to think about appropriate and inappropriate ways of acting	Social, Emotional, and Cognitive Competence of Youth: the interrelated components of cognitive and social-emotional competence, including self-regulation, future orientation, planning, positive self-concept, self-esteem, self-efficacy, self-compassion, personal responsibility, character strengths, and positive emotions
Problem-Solving Skills: a youth's adaptive functioning skills and ability to solve problems, including general problem-solving skills, self-efficacy in conflict situations, higher daily living scores, decision-making skills, planning skills, adaptive functioning skills, and task-oriented coping skills		Youth Resilience: the ability of youth to call forth their inner strength to positively meet challenges, manage adversities, heal the effects of trauma, and thrive, given their unique characteristics, goals, and circumstances
Involvement in Positive Activities: engagement in and/or achievement in school, extracurricular activities, employment, training, apprenticeships, or the military		Social Connections: the need for youth to be constructively engaged in social institutions—like schools, religious communities and recreational facilities—that are safe, stable, and equitable
		Concrete Supports in Times of Need: helping youth to identify, find, and receive concrete supports to help ensure they receive the basic necessities everyone deserves in order to grow and thrive
		Knowledge of Youth Development: the benefit that young people themselves can gain from increasing their knowledge and understanding about adolescent development

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Relational Protective Factors

All four of the protective factors approaches address relational protective factors. Essentials for Childhood, developed by the CDC, puts the development of safe, stable, and nurturing relationships with the caregiving and broader environment at the heart of its protective factors. Strengthening Families focuses largely on the importance of the parental relationship and the building of parental protective factors as a pathway to optimal development and lower rates of child abuse and neglect for young children. Youth Thrive looks at the importance of social connections as an important protective factor for youth. The results of ACYF's literature review point to the importance of nurturing by parents and other adults as well as positive peer relationships. Overall, the following conclusions can be drawn:

- Relationships matter.
- It is the quality of these relationships that matter.
- The parental relationship is particularly important, and investments that build parents' skills, capacity, and ability to nurture are an important pathway to positive child outcomes.

Table 2: Relational Protective Factors			
ACYF	CDC	Strengthening Families	Youth Thrive
Parenting Competencies: parenting skills (e.g., parental monitoring and discipline, prenatal care, and setting clear standards and developmentally appropriate limits)	Create the context for healthy children and families through norms change and programs: implement evidence-based programs for parents that support development of skills to provide safe, stable, and nurturing relationships for their children; promote positive community norms about parenting programs and acceptable parenting behaviors; make it easy for parents and caregivers to participate in parenting programs	Knowledge of Parenting and Child Development: parent's willingness to seek and ability to apply knowledge of parenting and child development	Knowledge of Youth Development: parents and other adults work to increase their knowledge and understanding about adolescent development
Parenting Competencies: positive parent-child interactions (e.g., close relationship between parent and child, sensitive parenting, support, caring)		Social Emotional Competence of Children: a parent's ability to nurture children's social emotional skills Parental Resilience: the capacity of parents to maintain stability, be calm, and provide nurturing support, despite difficult or challenging circumstances	

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Table 2: Relational Protective Factors

ACYF	CDC	Strengthening Families	Youth Thrive
Caring Adults: refers to caring adults beyond the nuclear family, such as mentors, home visitors (especially for pregnant and parenting teens), older extended family members, or individuals in the community	Promote the community norm that we all share responsibility for the well-being of children		<p>Youth Resilience: this is aided by a trusting relationship with a caring, encouraging, and competent adult who provides positive guidance and promotes high expectations</p> <p>Social Connections: the need that youth have for people inside and outside of their family who care about them; who can be nonjudgmental listeners; to whom they can turn for well-informed guidance and advice; who encourage them and promote high expectations; and who set developmentally appropriate limits, rules, and monitoring</p>
Positive Peers: friendships with peers, support from friends, or positive peer norms			Social Connections: youth's peer relationships that provide social, emotional, and instrumental support
		Concrete Supports in Times of Need: access for parents to concrete supports and services (e.g., housing, food, transportation) that address needs and help to minimize the stress caused by very difficult challenges and adversity	

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Societal or Community Protective Factors

While the ACYF approach is the only one that looks specifically at community-level protective factors, the other three explicitly address questions about the type of systemic, societal, and community-level changes that are needed in order to support their protective factors approaches. In general, all three approaches agree that,

- To more broadly ensure that all children and families have opportunities to build protective factors not only requires changes in services, but also broader societal shifts that will impact both communities and institutions.

Table 3: Societal or Community Protective Factors

ACYF	CDC	Strengthening Families	Youth Thrive
Positive Community: neighborhood advantage or quality, religious service attendance, living in a safe and higher quality environment, a caring community, social cohesion, and positive community norms	Raise awareness and commitment to support safe, stable, nurturing relationships and environments: adopt the vision of ensuring this for every child, raise awareness in support of the vision, partner with others to unite behind the vision Create the context for healthy children and families through norms change and programs: promote the community norm that we all share the responsibility for the well-being of children; promote positive community norms about parenting programs and acceptable parenting behaviors Create the context for healthy children and families through policies: Identify and assess which organizational and regulatory policies, laws, and ordinances may positively impact the lives of children and families; provide decision makers and community leaders with information on the benefits of evidence-based strategies and rigorous evaluation	Parents' constructive and supportive social connections —that is, relationships with family members, friends, neighbors, co-workers, community members and service providers.	Social Connections: the need for youth to be constructively engaged in social institutions—like schools, religious communities, and recreational facilities—that are safe, stable and equitable
Positive School Environments: the existence of supportive programming in schools			

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Table 3: Societal or Community Protective Factors

ACYF	CDC	Strengthening Families	Youth Thrive
Economic Opportunities: household income and socioeconomic status; a youth's self-perceived resources; employment, apprenticeship, coursework, and/or military involvement; and placement in a foster care setting (from a poor setting)			

Putting Protective Factors Into Practice

A number of jurisdictions are already applying protective factors approaches. The following are some examples:

- Since 2009, the Idaho Children's Trust Fund has required all child abuse and neglect prevention grantees to demonstrate how they are building protective factors into their work. Grantees are also asked to use the Protective Factors Survey developed by the FRIENDS National Resource Center to evaluate their programs to establish consistent measurement of outcomes related to protective factors. The Idaho Children's Trust provides ongoing training and technical assistance to all grantees, including a Strengthening Families Training Institute that brings in best practices from around the country. <http://idahochildrenstrustfund.idaho.gov/neglect.asp>
- In Kansas, Sedgwick and Marion Counties have used a protective factors framework to organize local planning and to guide collaboration. The protective factors have allowed local partnerships to expand to include representation from law enforcement, hospitals, faith-based organizations, and the business community. The process has led to development of strategic plans, a focus on data-driven decision-making, implementation of new programming—such as the Period of PURPLE Crying—and increased public awareness, including community positive parenting calendars. <http://www.cssp.org/reform/strengthening-families/national-network/2012-state-profiles/Kansas-2012.pdf>

In 2012, New Jersey created the Task Force on Helping Youth Thrive in Placement (HYTIP). The task force has been charged with completing a comprehensive and critical analysis of current practice and policies surrounding adolescents and youth in out-of-home care settings using the protective and promotive factors outlined in the Youth Thrive Framework. This analysis will be used to inform specific changes in policies and practices. <http://www.state.nj.us/dcf/providers/notices/nonprofit/youth.html>

In Philadelphia, the adoption of a protective factors approach is one part of Improving Outcomes for Children (IOC), a comprehensive restructuring of the approach to serving children and families when abuse and neglect has occurred. The IOC is building new partnerships between the Department of Human Services (DHS), which will continue to maintain oversight and investigative responsibilities, and community umbrella agencies (CUAs) that will be responsible for the day-to-day casework with families. A protective factors approach will provide a common framework for practice for both CUA and DHS staff.

- Training:** All staff in direct contact with children and families will receive training on Strengthening Families. In addition, Charting the Course, the 10-module foundation training for all individuals who will be holding a child welfare caseload is being adapted so workers can clearly see how to build

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protective factors through their existing practice with families.

- **Practice Guidelines:** Practice guidelines for the CUAs have the protective factors approach integrated into them.
- **Staffing:** Each CUA will have two dedicated staff positions that will be responsible for helping to connect families to resources, activities, and supports that will enhance their protective factors. In addition, supervisory materials and tools are being developed to help supervisors coach workers on how to work with families using a protective factors approach.
- **Resources for Parents:** Capacity is being built within each CUA to host parent cafés—parent-to-parent conversations around protective factors. <http://dynamicsights.com/dhs/ioc/>

Conclusion

The growing recognition of protective factors as a critical aspect of all work for and with children and families is long overdue. The strong consistency and overlap between this established, ongoing, and new work also underscores the salience of this strength-based approach across many disciplines. There is a powerful synergy between what research demonstrates children need in order to thrive and avoid bad outcomes and what the family support and child maltreatment prevention practice community has been working toward for many years. More work still needs to be done, including the following:

- Continue to expand the research base on protective factors and ensure that new research continues to inform the approaches being used in the field.
- Develop more valid and reliable tools and instruments to measure protective factor capacities in individuals, families, and communities.

- Continue to develop the body of implementation resources that support the ability of those that work with children and families to take these ideas and incorporate them into everyday practice.
- Promote the widespread adoption, implementation, and sustainability of protective factors approaches into the systems and services that support children and families.

Resources

- Strengthening Families information is available on the CSSP website: <http://www.cssp.org/reform/strengthening-families> (State-specific information can be found at <http://www.cssp.org/reform/strengthening-families/around-the-nation/states>.)
- Youth Thrive information is available on the CSSP website: <http://www.cssp.org/reform/child-welfare/youth-thrive>
- Essentials for Childhood information is available on the CDC website: <http://www.cdc.gov/ViolencePrevention/childmaltreatment/essentials/index.html>
- Information on the ACYF protective factors, as it becomes available, can be found on the Child Welfare Information Gateway web section on Preventing Child Abuse and Neglect: <https://www.childwelfare.gov/preventing/>

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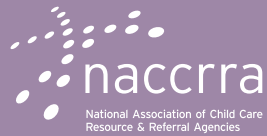


U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau



Is This the Right Place for My Child?

38 Research-Based Indicators of High-Quality Child Care



National Association of Child Care Resource & Referral Agencies
3101 Wilson Boulevard, Suite 350, Arlington, VA 22201
Phone (703) 341-4100 Fax (703) 341-4101 www.naccrra.org
347-1101 (May 2008)



Source: National Association of Child Care Resources and Referral Agencies | www.naccrra.org

[illegible]

Will my child be supervised?

Are children watched at all times, including when they are sleeping?¹⁵

Are adults warm and welcoming? Do they pay individual attention to each child?⁴⁰

Are positive guidance techniques used?

Do adults avoid yelling, spanking, and other negative punishments?¹⁶

Are the caregiver/teacher-to-child ratios appropriate and do they follow the recommended guidelines:

- ▶ One caregiver per 3 or 4 infants
- ▶ One caregiver per 3 or 4 young toddlers
- ▶ One caregiver per 4 to 6 older toddlers
- ▶ One caregiver per 6 to 9 preschoolers¹⁹

Have the adults been trained to care for children?

If a center:

- Does the director have a degree and some experience in caring for children?^{27/28/29}
- Do the teachers have a credential^{***} or Associate's degree and experience in caring for children?^{27/28/29}

If a family child care home:

- Has the provider had specific training on children's development and experience caring for children?³⁰

Is there always someone present who has current CPR and first aid training?³²

Are the adults continuing to receive training on caring for children?³³

Have the adults been trained on child abuse prevention and how to report suspected cases?^{12/13}

Will my child be able to grow and learn?

For older children, are there specific areas for different kinds of play (books, blocks, puzzles, art, etc.)?²¹

For infants and toddlers, are there toys that “do something” when the child plays with them?⁴¹

Is the play space organized and are materials easy-to-use? Are some materials available at all times?²¹

Are there daily or weekly activity plans available? Have the adults planned experiences for the children to enjoy? Will the activities help children learn?²²

Do the adults talk with the children during the day? Do they engage them in conversations? Ask questions, when appropriate?⁴³

Do the adults read to children at least twice a day or encourage them to read, if they can read?⁴³

Is this a safe and healthy place for my child?

Do adults and children wash their hands (before eating or handling food, or after using the bathroom, changing diapers, touching body fluids or eating, etc.)?⁴

Are diaper changing surfaces cleaned and sanitized after each use?⁵

Do all of the children enrolled have the required immunizations?⁶

Are medicines labeled and out of children's reach?⁷

Are adults trained to give medicines and keep records of medications?⁷

Are surfaces used to serve food cleaned and sanitized?

Are the food and beverages served to children nutritious, and are they stored, prepared, and served in the right way to keep children growing and healthy?

Are cleaning supplies and other poisonous materials locked up, out of children's reach?⁸

Is there a plan to follow if a child is injured, sick or lost?⁹

Place a check in the box if the program meets your expectations.

Are first aid kits readily available?¹⁰

Is there a plan for responding to disasters (fire, flood, etc.)?¹¹

Has a satisfactory criminal history background check been conducted on each adult present?

► Was the check based on fingerprints?¹⁴

Have all the adults who are left alone with children had background and criminal screenings?¹³

In a center:

► Are two adults with each group of children most of the time?

In a home:

► Are family members left alone with children only in emergencies?

Is the outdoor play area a safe place for children to play?³⁹

► Is it checked each morning for hazards before children use it?²³

- Is the equipment the right size and type for the age of the children who use it?²⁴
- In center-based programs, is the playground area surrounded by a fence at least 4 feet tall?²⁵

► Is the equipment placed on mulch, sand, or rubber matting?²³

► Is the equipment in good condition?³⁹

Is the number of children in each group limited?

► In family child care homes and centers, children are in groups of no more than**

- 6-8 infants
- 6-12 younger toddlers
- 8-12 older toddlers
- 12-20 preschoolers
- 20-24 school-agers²⁰

Is the program set up to promote quality?

Does the program have the highest level of licensing offered by the state?⁴²

Are there written personnel policies and job descriptions?¹⁷

Are parents and staff asked to evaluate the program?³⁷

Are staff evaluated each year; do providers do a self-assessment?¹⁸

Is there a written annual training plan for staff professional development?³³

Is the program evaluated each year by someone outside the program?³⁸

Is the program accredited by a national organization?³⁶

Does the program work with parents?

Will I be welcome any time my child is in care?¹

Is parents' feedback sought and used in making program improvements?

Will I be given a copy of the program's policies?²

Are annual conferences held with parents?³

Notes:

These questions are based on research about child care; you can read the research findings on the NACCRRA website under “Questions for Parents to Ask” at <http://www.naccrra.org>. Research-based indicators can only describe quality. Parents should base their decisions on actual observations.

* These are the adult-to-child ratios and group sizes recommended by the National Association for the Education of Young Children. Ratios are lowered when there are one or more children who may need additional help to fully participate in a program due to a disability, or other factors.

** Group sizes are considered the maximum number of children to be in a group, regardless of the number of adult staff.

*** Individuals working in child care can earn a Child Development Associate credential.

For help finding child care in your area, contact Child Care Aware, a Program of NACCRRA at 1-800-424-2246 or www.childcareaware.org.

For information about other AAP publications visit:
www.aap.org

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Is This the Right Place for My Child? 38 Research-Based Indicators of High-Quality Child-Care



Is This the Right Place for My Child?

38 Research-Based Indicators of High-Quality Child Care

(A Checklist for Parents)

Choosing Child Care

Choosing care for your child while you work or attend school is one of the most important decisions you will make as a parent. Unfortunately in most areas there isn't a "consumer report" on the best care available. The National Association of Child Care Resource & Referral Agencies (NACCRRA) through the Child Care Aware Program helps parents find licensed care (www.childcareaware.org). Because licensing and regulations vary widely, parents need more to go on. This guide helps parents understand how to better judge quality.

In addition, some states have quality rating systems to help parents with this decision. Parents can learn if their state has a quality rating system on the National Child Care Information Center website: www.nccic.org/pubs/qrs-defsystems.html. The National Association for the Education of Young Children (NAEYC) provides a list of their accredited child care centers on their website (www.naeyc.org) as does the National Accreditation Commission (NAC) For Early Care and Education Programs (www.naccp.org) and the National Early Childhood Program

Accreditation (NECPA) (www.necpa.net). The National Association of Family Child Care (NAFCC) lists accredited family child care providers at www.nafcc.org. However, only a small percentage of child care programs in the United States are accredited by any organization or part of a quality rating system.

After using these and other resources, parents should visit the programs they are considering. Included, is a checklist parents can use to evaluate child care programs. This checklist is based on research on what is important to children's health, safety and development. Research-based indicators can only describe quality. Parents should base their decisions on actual observations. Following the checklist are suggested ways to find the information you are seeking. High-quality programs will want you to have all the information you need to choose the best child care for your child and family. NACCRRA produced this guide to help parents with their search for high-quality child care.

The Quality Indicators listed in this guide are based on research about what is important in order for children to be protected and well-cared for in a group child care setting. Each indicator is followed by a short

explanation of why it is important. This is followed by what to look for and ask to find out if the program you are considering will be a safe, healthy and happy place for your child. The term "director" is used to refer to the person in charge of a child care center or the provider operating a family child care home. The term "program staff" is used to refer to individuals providing care in centers or family child care homes. It isn't necessary to ask all of the questions or make all of the observations suggested; they are only provided as a resource to help you evaluate the programs you are considering for your child.

NACCRRA, the National Association of Child Care Resource & Referral Agencies, is our nation's leading voice for child care. We work with more than 800 state and local Child Care Resource & Referral agencies to ensure that families in every local community have access to high-quality, affordable child care. To achieve our mission, we lead projects that increase the quality and availability of child care, offer comprehensive training to child care professionals, undertake groundbreaking research, and advocate child care policies that positively impact the lives of children and families.



Is This the Right Place for My Child?

Will my child be supervised?

*Are children watched at all times, including when they are sleeping?*¹⁵

If your child is supervised at all times he or she is less likely to be injured, as well as more likely to be engaged in activities that promote learning. It is especially important that caregivers check on infants while they are sleeping because of the risk of Sudden Infant Death Syndrome (SIDS). Also, if adults closely supervise children outdoors, children are less likely to be injured.

- ▶ Observe the program staff when the children are outdoors. Do the adults stay close to the children and intervene when children engage in risky activities?
- ▶ If possible, visit the program when children are resting or sleeping as well as when they are awake. During rest time are the children where the adults can see them? Do the adults check on the children frequently?

Are adults warm and welcoming? Do they pay individual attention to each child?

Children grow and learn when they feel cared about and comfortable. When adults pay attention to children they can respond to their individual needs, extend their learning, engage them in activities, and offer materials and information.

- ▶ Observe the adults.
 - Do they smile and talk to you? Do they smile and talk to your child? How do they act with the other children?
 - Do they interact with individual children as well as the group of children?
 - Do they respond when children make requests?
 - Do they offer materials and information to extend children's play?
 - Do they encourage and support children's efforts?
 - Do they comfort children who need comforted?



Are positive guidance techniques used? Do adults avoid yelling, spanking, and other negative punishments?⁶

Children learn how to behave through adult example and encouragement. Positive guidance techniques include:

- ▶ Setting limits for the child. “Keep the paint on the paper.”
- ▶ Giving reasons for rules and limits. “If you eat lunch now you won’t be hungry later.”
- ▶ Changing something about the situation. For example, moving a breakable item out of a toddler’s reach.
- ▶ Ignoring behavior when it is appropriate to do so. For example, not responding when a child whines for something he or she wants.
- ▶ Redirecting the child’s behavior. “Ride your bike on the path, not on the grass.”
- ▶ Using consequences. “If you leave the paint out you won’t be able to use it tomorrow.”

Yelling, spanking, and other negative punishments provide a bad example for children and may harm the child in other ways.

- ▶ Ask the program director to see the program’s guidance policies. Look for prohibitions against negative punishments and examples of positive techniques such as those listed above.

- ▶ Observe the program staff to see what techniques they use when children misbehave. Watch for use of negative punishments (yelling, hitting, twisting arms, ridiculing, criticizing, threatening, etc.) Expect to see the positive techniques listed above.
- ▶ Ask the program staff, “What do you do when children don’t follow the rules?” and “What do you do when children misbehave?” and “How are children punished when they don’t behave?”
- ▶ Ask the program staff, “How is time out used?” Expect to hear that time out is used to help children relax, not as a punishment.

Are the caregiver/teacher-to-child ratios appropriate and do they follow these recommended guidelines:

- ▶ ***One caregiver per three or four infants?***
- ▶ ***One caregiver per three or four young toddlers?***
- ▶ ***One caregiver per four to six older toddlers?***
- ▶ ***One caregiver per six to nine preschoolers?⁹***

When each adult is responsible for fewer children, your child can be provided with more one-on-one attention. Attention is crucial to your child’s social and emotional development. It also helps adults get to know your child and plan activities based on his or her learning needs and interests. (In some states, programs are allowed to have each adult care for more children while the children are asleep or resting.)

- ▶ Ask the program director, “How many children is each adult responsible for?” Compare his or her answer to the information above.

- Observe to see how many children each adult is providing care for during the day.

Is the number of children in each group limited? In family child care homes and centers, children are in groups of no more than:**

- *six to eight infants*
- *six to 12 younger toddlers*
- *eight to 12 older toddlers*
- *12 to 20 preschoolers*
- *20 to 24 school-agers*²⁰

Small group sizes ensure your child will receive one-on-one attention and are part of a group that is easier to manage. Small group sizes are particularly important for young children who need more individual attention and can become overwhelmed in large groups.

- Ask the program director how many children are in each group. Compare his or her answers to the information above.
- Observe to see the size of the groups in which children receive care. Compare the group sizes to the information above.
- If the group in which your child will receive care includes one or more children with special needs, look to see if the program has adjusted the number of children in the group so that all of the children's needs are met.

Have the adults been trained to care for children?

If a center,

- ***Does the director have a degree and some experience in caring for children?***²⁶
- ***Do the teachers each have a credential*** or Associate's degree and experience in caring for children?***^{27/28/29}

If a family child care home,

- ***Has the provider had specific training on children's development and experience caring for children?***³⁰

Staff education is the best predictor of the quality of an early childhood program. Adults with training in early childhood education provide higher quality programs for your child, implement more appropriate activities, and do a better job of preparing your child for school.

Managing a child care program is a challenging task that requires both early childhood and business management knowledge. Experience putting this knowledge to work enhances the child care program's quality.

Experience helps adults gain knowledge of early childhood programs and effective strategies for caring for and educating your child. Experience, combined with training and education, increases the quality of early childhood programs.

- Ask the center director, "Do you have a college degree?" and "What field is your degree in?" Listen for early childhood education, child development or a related field.
- Ask the center director, "How much experience do you have managing a child care program?"
- Ask the center director, "How many staff do you have? How many of them have a degree in early childhood education or a related field? How many of them have an Associate's degree in early childhood education or a related field? How many of them have their CDA (Child Development Associate Credential)?"
- Ask the family child care provider, "How much training have you had in early childhood education? Did the training include information on the development of children's social and emotional behavior, thinking, and language?" and "How many years of experience do you have providing child care?"

Is there always someone present who has current CPR and first aid training?³²

If adults are trained in emergency first aid and infant/toddler CPR they will know how to handle medical emergencies and react appropriately in case your child has a medical emergency.

- Ask the program director, "Who in the program has current certification in CPR and first aid?" and "Is there always someone on duty in the program with current certification in CPR and first aid?"
- Check the program's job descriptions to find out if certification in CPR and first aid are required.
- Ask to see copies of the program staff's or provider's first aid and CPR cards.

Are the adults continuing to receive training on caring for children?²³

If the adults caring for your child continue to receive training, they will know new information about how to protect your child's health and safety, for example, how to reduce the incidence of Sudden Infant Death Syndrome. They will also know how to promote children's development, for example, the newest research on how children learn to read and write.

- ▶ Ask the program staff, "When was the last time you attended training on early childhood education?"
- ▶ Ask the program director, "Are staff required to attend training each year?" and "Are staff funded to attend training each year?"
- ▶ Review the program's annual training plan to find out how much training staff members or providers receive each year.

Have the adults been trained on child abuse prevention and how to report suspected child abuse?²³

Caregivers who are trained in identifying and reporting child abuse will know how to respond if they suspect a child has been mistreated.

- ▶ Ask the program staff, "Have you been trained on how to identify and report child abuse?" and "If you suspect a child has been abused, who would you report it to?"
- ▶ Ask the program director, "Are the staff and volunteers trained on how to identify and report child abuse?" and "What is included in this training?"

Will my child be able to grow and learn?

For children three and older, are there specific areas for different kinds of play (books, blocks, puzzles, art materials, etc)?²¹

Your child will learn different concepts and skills in different interest areas (blocks, books, puzzles, art materials, music, science and math). Interest areas that are organized and orderly will help your child make choices about what to play with and where to put materials away. The areas may have different names such as library (instead of books), manipulatives (instead of puzzles), construction (instead of blocks), etc. In a family child care home the areas may be set up each day or left permanently in place.

- ▶ Look to see there are areas with different kinds of toys and materials. Expect to see an area with books, art materials, blocks and other construction toys such as trucks, and puzzles and other small manipulatives such as Legos. You may also see a science and math area and a music area.
- ▶ Check to see if the areas include a variety of toys and other materials.
- ▶ Ask the program staff, "How often do you add new materials to the areas or rotate the materials in the areas?" Expect new or different materials will be added at least monthly.
- ▶ In a family child care home, look to see that infants and toddlers are protected from small items that could cause choking.

For infants and toddlers, are there toys that "do something" when the child plays with them?⁴¹

Infants are interested in looking at toys, touching them with their hands and mouth, fitting pieces of things together, and making sense of their world. Infants need bright-colored toys of many textures. They need toys to look at, feel, chew on, hold, and drop. As they begin to walk or crawl they enjoy push-pull toys and balls.

In the second year of life, toddlers have the physical skills that make it easier for them to play and learn. Busy toddlers need toys for physical play – walking, climbing, pushing and riding – and ones that encourage experimentation and manipulation.

- ▶ For infants look to see if the program has:
 - balls
 - grasping toys
 - stacking and nesting toys
 - toys to look at, feel, and chew on
- ▶ For toddlers look to see if the program has:
 - equipment for climbing
 - riding toys
 - balls
 - large interlocking blocks and puzzles
 - water and sand for sensory play

Is the play space organized and are materials easy-to-use? Are materials available at all times?²¹

If the play areas are organized and orderly your child will be able to make choices about what



materials to play with and will be able to put toys away after playing with them. Materials should be organized by type on shelves or in containers. If shelves and containers are labeled with a picture or drawing of the materials it is easier for children to know where they belong.

- ▶ Look to see if the materials are organized by type (blocks, puzzles, dolls, art materials, dress-up clothes, etc.)? Are the spaces and containers labeled with a picture or drawing of the materials?
- ▶ Does the space seem organized? If you were a child wanting to play dress-up or wanting to do a puzzle, would you know where to look?
- ▶ Are the materials arranged in an orderly way or are they jumbled and disorganized?
- ▶ Are some materials available at all times and easy for children to reach?

Are there daily or weekly activity plans available? Are there planned experiences for the children to enjoy? Will the activities help children learn?²²

Children benefit when adults plan activities for them. If the daily activities reflect your child's interests and needs it increases the likelihood your child will benefit from the experiences. He or she will also benefit more if the activities are ones they enjoy and are planned to help them learn and develop. If the program plans a variety of activities it increases the potential that all of the children's needs will be met.

- ▶ Ask to see the program's daily or weekly plans. Check to see if the plans include a variety of activities – art, music, outdoor play, reading, dramatic play, science, and math.
- ▶ Ask the program director, "Do you have a planned curriculum? If so, what is it?"
- ▶ Look to see if the children seem to be enjoying the activities that are being offered and are actively engaged in them.
- ▶ Ask the program staff, "How do you decide which activities to offer?" Expect to hear the activities are based on the children's interests and needs.

Do the adults talk with children during the day? Do they engage them in conversation? Do they ask questions, when appropriate?

Adults can help promote children's language development by talking with them during the day. Research has shown that early exposure to language leads to greater language skills as children grow older. The more caregivers and parents talk to children while they are caring for and playing with them, the more effectively children will learn to communicate.

- ▶ Observe the adults with the children:
 - Do they talk with babies and toddlers while they are handling daily routines?
 - Do they turn babies' sounds into words?
 - Do they provide words to help children label things?

- Do they encourage toddlers to use words?
- Do they add words to expand children's vocabulary?
- Do they talk with older children when doing so will extend their thinking and play?
- Do they engage preschoolers and older children in conversations?
- Do they avoid asking older children questions to which the adult already knows the answer?

Do the adults read to children at least twice a day or encourage them to read, if they can read?

Reading aloud provides your child with sounds to imitate and helps them develop phonemic awareness (the ability to hear sounds) – an important prereading skill. Reading also helps build your child's vocabulary and increases their understanding of feelings, objects, and events. When adults read to them children get the message that reading is important. A child's reading skills are important to success in school and life.

- ▶ Check the program's schedule to see if reading is included at least twice a day.
- ▶ Ask the program staff, "How often do you read to the children?" Expect to hear "at least twice a day" or more. Sometimes programs read books but don't include it on the schedule.
- ▶ Look around for children's books. If few or no books are available, it may be a sign that reading is not valued by the program.

Is this a safe and healthy place for my child?

Do adults and children wash their hands (before eating or handling food and after using the bathroom, changing diapers, touching bodily fluids, or eating)?⁴

Germs can be passed easily from child to child. Washing hands often and well reduces the chance that germs will be passed along and that your child will get sick.

- ▶ Observe the adults. Do they wash the children's hands and their hands after using the bathroom, changing diapers, before serving foods, after handling animals, etc.?
- ▶ Are handwashing signs posted in center bathrooms?
- ▶ Are the supplies (water, soap, paper towels) needed for handwashing near sinks and diaper-changing areas?

- ▶ Ask the program staff "When do you wash your hands during the day?" and "When do you wash the children's hands?"
- ▶ Are the food and beverages served to children nutritious, and are they stored, prepared, and served in the right way to keep children growing and healthy?

Are the diaper-changing surfaces cleaned and sanitized after each use?⁵

Germs can be passed easily among children, particularly at the diaper-changing table. Cleaning and disinfecting the diaper-changing surface after each change reduces the chance that germs will be transmitted and your child will get sick.

- ▶ Observe the adults. Do they clean and sanitize the diaper-changing surface with a bleach water solution and a disposable towel after changing each child?
- ▶ Is the surface used for changing diapers easy to sanitize? Couches, beds, etc., can't be easily sanitized.
- ▶ Are the supplies (bleach water solution/paper towels) needed to clean and sanitize the diaper-changing table located near the area, but not where children can reach them?
- ▶ Ask the program staff, "What procedures do you follow during diaper changing to keep children healthy?" Listen for evidence that they sanitize the diaper-changing surface.

Do all the children enrolled have the required immunizations?⁶

Children who are up-to-date on their immunizations are less likely to get or pass along diseases. When all the children in a program are healthy this reduces the risk of your child getting sick.

- ▶ Ask the program staff, "Which immunizations do you require children to have?"
- ▶ Check to be sure that the program requires children to have the immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). If you want to know what those immunizations are, look on this website: http://www.cdc.gov/nip/recs/child_sched_pocket_fold.pdf.

- ▶ Ask the program staff, “How does the program keep track of whether or not children have the required immunizations?”

Are medicines labeled and out of children’s reach?⁷

This will help your child receive the right medication at the right time in the right amount and prevent your child from receiving someone else’s medication by accident. Children can be harmed by ingesting other children’s medications or too much of any medication.

Are adults trained to give medicines and keep records of medications?⁷

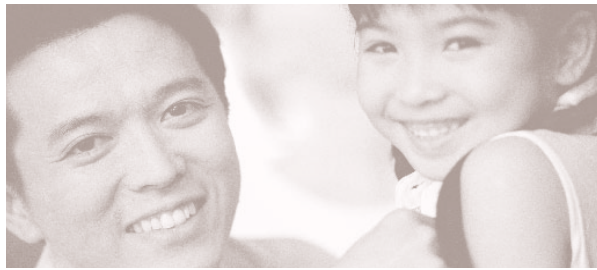
Caregivers should be trained in how to read labels on medicines and how to give medicine to children. This will help ensure your child receives medicines when needed and does not receive medicines that are not needed. Children can be harmed by ingesting other children’s medications or too much of any medication.

- ▶ Ask the program director, “Do the staff receive training on giving medicines?”
- ▶ Ask the program staff, “Do you give prescription medicines?” and “Do you require a doctor’s directions to give prescription medicines?” and “Do you give non-prescription medicines?” and “Do you require a parent’s approval to give non-prescription medicines?”
- ▶ Observe to see if staff make a written record when they give a child a medicine.

Are cleaning supplies and other poisonous materials locked up, out of children’s reach?⁸

Accidental poisoning is a leading cause of injury and death among young children. Many cleaning supplies are poisonous when ingested in any amount. Storing all hazardous substances out of reach will ensure your child is not harmed.

- ▶ Observe to see where cleaning supplies and other poisonous materials are stored. Are they stored where children can’t reach them?
- ▶ Check to see if the janitor’s closets are locked. Most of them contain supplies that would be dangerous to children.
- ▶ Look to see that cleaning supplies and food are not stored together. Storing food and cleaning supplies together can result in accidental poisoning.



- ▶ Ask the program staff, especially the janitor and cooks, “How do you keep children away from poisonous materials?”

Is there a plan to follow if a child is injured, sick or lost?⁹

Child care programs with emergency plans respond better when an emergency arises. The program should have information on each child in care so that they can contact the parents or another trusted individual if a child becomes injured, sick or lost. The staff should be trained on how to contact emergency medical services and the police.

- ▶ Ask the program staff, “What would you do if my child were injured or became ill?” Expect to hear they would contact you and know how to contact emergency medical services.
- ▶ Ask the program staff, “What would you do if my child was missing?” Expect to hear they would contact the police immediately before starting to search and contacting you.
- ▶ Be sure the program has a phone. Check near the phones to see if the numbers for fire, police, and emergency medical services are listed.
- ▶ Ask the program director, “What information do you collect so you are prepared to handle emergencies involving my child?” Expect to hear they collect your home, cell, and work phone numbers and backup phone numbers from other people you would trust to make decisions about your child.

Are first aid kits readily available?¹⁰

If your child gets hurt, having first aid supplies nearby will ensure he or she gets basic medical attention more quickly.

- ▶ Ask to see the program’s first aid kit. Some programs keep a kit in each room; some have a kit in the office.

- ▶ Check to see if the kit contains items such as first-aid instructions, disposable, non-porous gloves, soap or hydrogen peroxide, tweezers, bandage tape, sterile gauze, scissors, a baby-safe thermometer.

Is there a plan for responding to disasters (fire, flood, etc.)?¹¹

An emergency plan that is practiced regularly will increase the likelihood caregivers and children will act appropriately in an emergency. Programs should have an emergency plan and the staff and children should practice it regularly. The plan should be practiced during different times of the day – especially when the children are sleeping, eating, and outside. The program’s plan should include what to do during the types of disasters (hurricanes, tornadoes, winter storms, etc.) most often experienced in the area, as well as terrorist attacks.

- ▶ Ask the program staff, “What would you do if there was a fire?” Expect to hear that they would evacuate the children from the facility and then call 9-1-1.
- ▶ Look to see if there are two ways out of most areas. Check to see the paths to exit the facility in an emergency are posted in each room in a center and at least one place in a family child care home.
- ▶ Ask the program director to see the program’s emergency plan. Check to see if it includes information on the types of weather events experienced in the area.
- ▶ Ask the program staff, “Do you practice for emergencies like a fire?” and “How often do you involve the children in these practices?” and “What types of weather events are you prepared for?”
- ▶ Ask the program staff, “What would you do if there was a terrorist attack?”

Has a satisfactory criminal history background check been conducted on each adult present? Was the check based on fingerprints?¹⁴

Having adults with favorable background checks helps ensure people with criminal backgrounds are not caring for your child, reducing the risk of child abuse. These checks are more valid if they are based on fingerprints. Sometimes these checks take some time to be processed; adults who have not had their background check returned should always be closely supervised by someone who has been cleared. Checks

should be completed on all adults who have contact with children including bus drivers, janitors, clerks, etc.

- ▶ Ask the program director, “Is a criminal history background check conducted on all staff and volunteers and adult family members (if a family child care home)?” and “Are the checks based on fingerprints?”
- ▶ Ask the program director, “Are adults allowed to be alone with children while you are waiting for their background check to be completed?” and “How will you ensure my child will not be alone with someone without a completed background check?”
- ▶ Ask the program director, “Are there any adults around the program who have been arrested or convicted of a crime involving violence or children?”

Have all the adults who are left alone with children had background and criminal screenings?¹³

The rare occasions when abuse occurs in child care centers typically happen when caregivers are left alone with children. Making sure center caregivers can be seen at all times greatly reduces this risk. In family child care homes the provider often will be alone with the children. The greater risk in homes is when other family members or visitors are left alone with children.

- ▶ In centers, look to see that at least two adults are with each group of children most of the time.
- ▶ Ask the program director, “What precautions do you take to reduce the potential for child abuse in your program?” Expect to hear that the program avoids having one adult alone with children whenever possible.
- ▶ In family child care homes, ask the provider, “Will my child ever be left alone with your family members or guests?” Expect to hear this would only occur in an emergency or if a family member is an approved and trained substitute.

Is the outdoor play area a safe place for children to play?

- ▶ Is it checked each morning for hazards before children use it?²³
- ▶ Is the equipment the right size and type for the age of the children who use it?²⁴
- ▶ Is the outdoor area surrounded by a fence or other barrier at least 4 feet tall if there is traffic or there are other hazards nearby?²⁵



- Is the equipment in good condition?³⁹
- Is the equipment placed on mulch, sand, or rubber mats?²³

The most common place for children to be injured is on the playground or yard.

If there is traffic or there are other hazards near the outdoor area there should be a barrier at least 4 feet high surrounding the area. The barrier could be a fence, hedge, or other protection.

If the outdoor area is checked daily for broken glass, metal pieces, etc. cuts and other injuries can be avoided. Children can also be injured if the play equipment is broken or splintered or missing important parts.

Most injuries on playgrounds occur when children fall. Children can get hurt if they fall from play equipment that is too high or has handholds, steps or other parts that are too big for them. Having soft surfaces under play equipment cushions the child's fall. The materials used to cushion children's falls should be 9 to 12 inches deep.

- Walk around the outdoor area; look for broken glass, metal pieces, or other debris that could injure a child. Check the equipment for missing or broken parts that could result in children falling. If there is traffic or there are other hazards nearby, is there a fence or other barrier to protect children from injury? Is the barrier high enough to keep children inside?

- Check the playground equipment. Is it the right size for your child? Does it have impact-altering materials under it? Are the materials 9-12 inches deep? Are the materials still in place where the slide ends, where children drag their feet when swinging, and in other high-use areas?

- Ask the program director, "How often is the outdoor area and equipment checked?" and "When is the cushioning material under the outdoor equipment replenished?"

Is the program set up to promote quality?

Does the program have the highest level of licensing offered by the state?⁴²

Some states offer different approval levels for child care programs. For example, family child care programs may be registered or licensed. In some states, if the family child care provider is a relative of the children in care or cares for fewer than a specific number of children, he or she is not required to be registered or licensed.

If a child care program chooses to be licensed, even if not required to be, this may indicate the program is interested in providing good care for your child. Some states have a quality rating system for child care programs and rate programs based on various quality criteria. If the program has earned a high rating in the state's quality rating system this is usually an indication that the program is providing higher quality child care.



- ▶ Ask the program director, “Is this program licensed by the state?” If it isn’t licensed ask, “Why isn’t it licensed?” If the answer is that the program isn’t required to be licensed, ask “Have you considered becoming licensed anyway?”
- ▶ Ask the program director, “Has this program received the highest quality rating given by the state?” If the answer is “no”, ask “Why didn’t the program receive the highest quality rating?” The answer may be that the state doesn’t offer quality ratings.
- ▶ Ask the program director, “Do you ask the parents how the program could be improved?” and “Do you ask the staff how the program should be improved?”
- ▶ Ask the program staff, “Are you asked to provide input on how the program could be improved?”
- ▶ Ask other parents, “Are you asked to provide input on how well the program is doing?”
- ▶ Ask to see the results of any surveys parents and staff have been asked to complete.

Are there written personnel policies and job descriptions?²⁷

Written personnel policies and job descriptions reflect a program’s professionalism and expectations of staff. Written policies also help staff know what is expected of them, resulting in program’s running more effectively.

- ▶ Ask to see a center’s personnel policies and job descriptions for staff.
- ▶ In a family child care home, ask to see the personnel policies and job descriptions for any assistants and substitutes.

Are parents and staff asked to evaluate the program?²⁸

Child care programs should regularly seek ways to improve the quality of the care they offer. Asking parents and staff for feedback and using the results to make improvements shows the program is responsive to your and other parents’ input.

Are staff evaluated each year; do providers do a self-assessment?²⁸

Annual evaluations provide feedback to staff on their performance and provide an opportunity for staff to identify areas of strength and areas for improvement. This feedback can improve job performance, enhancing the overall operation of the program.

- ▶ Ask the program director, “Are staff evaluated each year?” and “Are the results of staff evaluations shared with the individual staff members?”
- ▶ Ask family child care providers, “Do you do a self-assessment each year?” and “How do you use the results of the self-assessment?”
- ▶ Ask program staff, “Are you evaluated each year?” and “Are the results of your annual evaluation shared with you?”

***Is there a written annual training plan for staff professional development?*³³**

A written training plan individualized for each staff member or provider helps adults get the training they need to do the best job possible of educating and caring for your child.

- ▶ Ask to see the center's training plan for staff professional development. Check to see that staff are provided opportunities to continue to learn about how to help children develop and learn.
- ▶ Ask the family child care provider to see his or her training plan for the year. Check to see that he or she plans to participate in training on how to help children develop and learn.
- ▶ Ask program staff, "Is there a written annual training plan for professional development?" and "Is the plan followed?"

***Is the program evaluated each year by someone outside the program?*³⁸**

Having an outside "pair of eyes" look at the child care program each year helps ensure it will be a good place for your child. Someone who is not in the program every day can spot health or safety hazards missed by those who are there every day. An objective observation by someone who is not in the program everyday can spot healthy or safety hazards missed by those who are there everyday. Outside evaluators can also offer suggestions on how to improve the program and make it a better place for children to grow and learn.

- ▶ Ask the program director, "How often are you inspected by the state?" and "Are you visited by any other outside group?"
- ▶ If the program has been inspected in the last year, ask "What were the results of your latest inspection?"

***Is the program accredited by a national organization?*³⁶**

National accreditation is a process that typically requires self-study, feedback from families, and a validation visit by an outside organization. Participating in this process increases program quality. The stamp of approval of an outside organization means the program has received feedback on its performance by an outside entity. Accrediting agencies include the National Association for the Education of Young Children, National Association for Family Child Care, National After School Association, National Early Childhood

Program Accreditation and National Accreditation Commission for Early Care and Education Programs.

- ▶ Ask the program director, "Is this program accredited?" If the program is not accredited, ask "Why hasn't the program sought accreditation?" and "Does the program plan to become accredited?"
- ▶ Look for a certificate or other display indicating that the program is accredited.

Does the program work with parents?

***Will I be welcome any time my child is in care?*¹**

As a parent you should always feel welcome in the program. You should always have access to your child and where they are receiving care at any time. Programs may recommend that you not visit during rest time or other specific times, but you should be able to visit during those times if you choose to do so.

- ▶ Ask the program director, "Will I be able to visit the program at all times?"
- ▶ Ask other parents, "Are you able to visit the program whenever you want to?"

***Is parents' feedback sought and used in making program improvements?*¹**

Your input should be welcome. Programs have the needs of many different families to balance, but you should always feel listened to and encouraged to express your opinions.

- ▶ Ask other parents, "Is parent input asked for and accepted?"





- ▶ Ask the program director, “How does the program get input from parents?” and “What are some examples of changes that have been made based on parent input?”

Will I be given a copy of the program’s policies?²

Well-managed programs operate using a set of policies and procedures. This information may be made available to parents in a parent handbook. This usually means the program has thought through the needs and interests of parents and will be more responsive to their needs.

- ▶ Ask to see a copy of the program’s policies.
- ▶ Ask for a copy of the program’s parent handbook.
- ▶ Ask parents, “Have you been given a copy of the program’s policies?”
- ▶ As the program director, “Will I be given a copy of the program’s policies?”

Are annual conferences held with parents? Are parents involved in other ways?³⁰

Parent conferences allow you to visit with your child’s teacher or caregiver in a focused way about your child’s development and progress, and to share goals for the future. These conferences can be invaluable for establishing relationships and developing shared plans for educating and caring for your child. Staff and providers should talk with parents about their child’s day and how to ease transitions between home and child care and child care and school.

- ▶ Ask the program director, “Are parent conferences held?” and “How often?”
- ▶ Ask the program staff, “Do you have planned conferences with parents?”
- ▶ Ask other parents, “Are annual conferences held with parents?”
- ▶ Ask the program director, “How will the person caring for my child keep me informed about my child’s day?”
- ▶ Ask the program director, “What will the program do to help my child adjust to child care? and “What will the program do to help my child transition to school?”

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Is This the Right Place for My Child?

38 Research-Based Indicators of High-Quality Child Care

Acknowledgements

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About NACCRRA:

NACCRRA, the National Association of Child Care Resource & Referral Agencies, is our nation's leading voice for child care. We work with more than 800 state and local Child Care Resource & Referral agencies to ensure that families in every local community have access to high-quality, affordable child care. To achieve our mission, we lead projects that increase the quality and availability of child care, offer comprehensive training to child care professionals, undertake groundbreaking research, and advocate child care policies that positively impact the lives of children and families. To learn more about NACCRRA and how you can join us in ensuring access to high-quality child care for all families, visit www.naccrra.org.

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Child Care Providers' Role in Child Abuse Prevention

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The Role of Child Care Providers in Child Abuse Prevention

Nancy L. Seibel, Linda G. Gillespie, and Tabitha Temple

Abstract:

Child care providers are likely to be the professionals who most frequently interact with families with young children. Thus, infant and toddler child care providers are uniquely positioned to recognize and respond to families' needs for information and support. This article describes knowledge, skills, and strategies that support child care providers in creating effective partnerships with parents that enhance program quality, build protective factors for families, and help to reduce the risk of child maltreatment.

The full article may be viewed online at:

main.zerotothree.org/site/DocServer/28-6-nSeibel.pdf?docID=12461

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Early Childhood Mental Health Toolkit Link

The *Early Childhood Mental Health Toolkit: Integrating Mental Health Services into the Pediatric Medical Home* is a comprehensive collection of tools and tips for incorporating early childhood mental health personnel and practices into the pediatric primary care setting.

Topics addressed include:

- Building a Core Team to Champion Children's Social and Emotional Health
- Providing Family Centered Care for Children's Social and Emotional Health
- Creating Medical Home Systems to Support Mental Health Integration
- Financing and Sustaining the Early Childhood Mental Health Model of Integrated Care

PDFs and additional information are available at the Partnership for Early Childhood Mental Health website:

ecmhatters.org

The Early Childhood Mental Health Partnership is a partnership between the MA Executive Office of Health and Human Services, the MA Department of Public Health and the Boston Public Health Commission. The partnership's goal is to build a strong system of early childhood mental health services statewide, starting with a pilot effort in Boston. The partnership is particularly committed to the integration of early childhood mental health in the pediatric medical home.



SYSTEM
CHANGE for
SUCCESSFUL
CHILDREN