Child and Family Team Meeting Facilitator Guide

Special Considerations for Infants and Children Birth to 5 Years of Age

1a. Early childhood is characterized by rapid and significant development.

Infants and young children grow at a faster rate than any other time in their life. By age three, the brain is about 80% of the size and organization it will be when the child is fully grown. Babies strive to meet physical, social and emotional milestones in their development, learning the skills needed for life-long relationships and well-being. Feeling safe within their environment provides the foundation for meeting developmental milestones, future learning, developing healthy relationships, communication, behavior and physical health. If a responsive caregiver provides the nurturing needed to support healthy development, then the child will trust the world enough to explore and grow.

It is important to understand what "typical" development looks like. It's easy to assume that, for example, a child who does not cry or test limits is somehow "normal." Each developmental path is unique, and milestone achievement will vary in timing. Development consists of several physical milestones, but it is imperative to understand development in the context of socialization and emotional regulation; early difficulties with emotional regulation can impact developmental milestones in a variety of ways.

CFT participants should be collectively informed of any issues related to development. Several screening tools are available for professionals and parents, and screening should be used with parental involvement whenever possible. Parental incapacity, unless severe, does not limit the ability to report an infant or child's development. Parental involvement greatly benefits engagement and education for the child, creates a common language and empowers parents to remain actively involved.

Consider adapting CFT Meeting frequency to a pace consistent with the developmental and intervention needs of a child who is changing and developing quickly.

Child Welfare workers are experts in child protection and family systems. Early childhood specialists are experts in development, intervention and resources. While there is often shared knowledge between the two fields of practice, team members should incorporate those working directly with the child to advance that child's development.

As a team, decide if the presence of the child is beneficial. For example, CFT Meetings are not productive if the child's presence distracts parents from the focus of the meeting or if they view the meeting as another opportunity for a visit. Promoting a young child's voice and choice can be tricky. Babies will need others to advocate for their needs, and children who can articulate their choices should be included but also engaged in an age-appropriate manner.

If considering bringing a baby to the CFT meeting, it is important to be mindful of dynamics between the CFT participants. Consider the impact of an infant or young

child preferring to be with the resource family over a parent who has not had adequate time to develop a relationship. At this age, it is recommended identifying a specific intent or benefit for a child to be included. The key question to ask: **Will everyone be able to focus on objectives and services if the child is present?**

Resource parents and parents should always be present, and difficulty finding adequate alternate care should be considered ahead of time.

1b. Early childhood trauma can have an impact for life.

Trauma – neglect, parental absence or incapacity, exposure to domestic violence, abuse, and subsequent removal from parents – during these early years can impact brain architecture. The situation becomes detrimental when the traumatic experience is not mitigated by nurturing and reassurance from a trusted adult. Trauma can cause the child to perceive the world as an unsafe place to explore and learn, resulting in an inability to develop to full potential. **Recognizing the impact that trauma has had on a developing brain is critical to find the right treatment and support for that child's development.** The brain grows so rapidly and is so reliant upon a sequential process that the impact of trauma can be lifelong. **Research has shown that neglect is one of the most damaging forms of child maltreatment, and domestic violence, even while in utero, can harm brain development**.

A baby's or young child's response to trauma is different than the responses of older children. A baby cannot talk about the trauma, but a baby does create different kinds of memories associated with the trauma (images, sensory memories like smell, sounds, and feelings of fear).

"Trauma does not just 'affect' children, it literally changes the wiring of the brain." Jack Shonkoff, MD, Director, Harvard Center for the Developing Child.

Traumatic memories for babies and young children are implicit not explicit, and therefore behaviors associated with trauma can be difficult to understand. There are interventions to help children manage responses to traumatic memory triggers and learn new responses that are healthier and less disruptive to the course of development.

Early identification is extremely important to initiate appropriate intervention. Trauma impacts a developing child in a variety of ways, often in social and emotional development. It is important to use screening tools appropriate to recognize concerns in these areas.

2. Participants specific to meeting the needs of infants and young children 0-5

Participants in the CFT meeting should include those relevant and involved in the baby's or young child's life. The most obvious participants are the parents, resource parents, child welfare social worker and facilitator for the CFT meeting. Other participants could include:

Occupational Therapist (OT): Helps babies and young children experiencing delays or disabilities with extra support for skill-building and sensory issues.

Speech Therapist: Works to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication

and swallowing disorders in infants and children.
Audiologist: Screens and tests hearing and devise treatments to improve hearing.

Pediatric Physical Therapist (PT): Treats infant, child and adolescent patients who have conditions that limit their physical abilities.

Public Health Nurse: Promotes and enhances the physical, mental, dental and developmental well-being of children in the child welfare system.

Infant Mental Health Specialists: Works to support the emotional and behavioral health and development of infants, toddlers and parents in a range of settings.

Mental Health Service Provider: Works with children and families to provide and coordinate mental health services to support healthy family dynamics and behavioral health.

Preschool Teacher: Instructs children from ages 2 to 5 in their first structured learning experience.

Day Care Provider: Provides regular care for the baby or young children.

Head Start Program: Promotes school readiness of children ages zero to five by supporting their development in a comprehensive way.

Early Start: Evaluates infants and toddlers diagnosed with developmental delay or disabilities or who are at risk for developmental delay or disabilities.

Visitation Coach/Monitor: Supervises and supports visits between parents and baby/young children.

CASA: Court Appointed Special Advocate, provides advocacy for child in court.

Others: There may be other significant people involved with the baby/young child identified as important family supports who should be considered for the Child and Family Team.

3. Screening, assessment tools and Well-Child Exam review screening tools

Screening tools determine if a concern exists or if there are indications for a more comprehensive assessment. Some well-known screening tools include the Ages and Stages Questionnaire (ASQ3) and the Ages, Stages Questionnaire – Social Emotional 2 (ASQ-SE2), Parents' Evaluation of Developmental Status (PEDS) and the Bayley III. Please note, ASQ and ASQ-SE2 look at different domains. Screening tools are used in a variety of different ways, so it is important to know what was used and the frequency of screenings. Screening for concerns is recommended to be regular and on-going. **A child who is screened and does not have areas of concern should continue to be screened based on the periodicity of the specific tool**.

A compendium of screening tools is available here:
https://www.acf.hhs.gov/sites/default/files/opre/compendium_2013_508_compliant_final_2_5_2014.pdf
A list by the American Academy of Pediatrics is below:
https://screeningtime.org/star-center/#/screening-tools

Assessment Options

Assessments take a closer look at concerns identified by a screening and are completed by a professional in the associated field who is trained on how to administer the assessment tools. County Mental Health or Behavioral Health Departments offer a full assessment of mental health needs, but this will vary in each county. Below are some examples of assessments/assessment tools:

- Comprehensive Mental Health Assessment (Behavioral Health)
- Diagnosis: DC: 0-5 crosswalk to DMS –5 and ICD -10 or DSM 5 (done by Behavioral Health/Therapists)
- Child & Adolescent Needs & Strengths Assessment (CANS)
- Nursing Child Assessment Satellite Training (NCAST) Parent Child Interaction Teaching and Feeding Scales
- Child Behavioral Check List for 3-5 years (CBCL)
- Sensory Profile (Pearson)
- Treatment Outcome Package (TOP)
- Regional Center Evaluation/Assessment

Other assessments include a Peer/Parent Partner evaluation of parent-child interaction/relationship and ongoing assessment updates from a treatment provider if the child receives treatment using a therapeutic model designed specifically to treat the parent-child relationship, such as Child-Parent Psychotherapy (CPP); Parent-Child Interaction Therapy (PCIT); WisdomPath Way Reparative Parenting Model (WPW); Circle of Security; Positive Parenting Program (PPP).

Well-Child Exams

Routine medical exams are recommended after birth at the following intervals: 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 2 ½ years, 3 years, 4 years and 5 years. Pediatricians will assess and observe the child for a range of developmental processes and milestones. The 2017 Bright Futures Guide, American Academy of Pediatrics, is available at the link below: https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_POCKETGUIDE.pdf

4. Supporting relationships with the birth parents

Babies and young children will have some experience with their mother and father, even in utero. **Successful reunification for babies and young children requires special considerations; the relationships need to be supported and nurtured at a frequency relevant to the baby or young child's developmental stage and status.** Here are some of those considerations:

i. Visitation or "Family Time" in a home-like setting
   - Comforting and calming for both the birth parents and the child.
   - Birth parents have an opportunity to learn and practice new parenting skills and/or demonstrate safe parenting skills as well as participate in the child's activities of daily living.
   - Birth parents have the opportunity to play with the baby or young child.
   - Birth parents are supported in planning appropriate activities with the baby or young child during visits.

ii. Inclusion in services, planning for return and decision-making while in care
    - When possible and appropriate, birth parents should be involved in the child's activities of daily living.
    - Parents help make decisions for their child
    - Parents are empowered during the process
iii. Education on trauma and development
iv. Understanding a parent's own trauma history and service needs
    - http://www.nctsn.org/trauma-types/complex-trauma/effects-of-complex-trauma
v. Build culturally relevant plans
vi. Transition planning (visits and reunification)
    - Transition planning and practice applies to any move from one caregiver to another caregiver, including to or from a birth parent.
    - Any change in primary caregiver can be traumatic.
    - https://www.advokids.org/childhood-mental-health/transitions/

5. Concurrent Planning

Concurrent Planning is an important process to assure that the baby or young child will have a nurturing and consistent relationship to support development. Concurrent Planning was designed to reduce the possibility of multiple placements and disruptions for the young child, and this age range is viewed as more likely to be adopted. This factor can exert a strong influence for both birth families and resource families going through this process with a baby or young child.

Communicating the legal requirement to have a plan if reunification fails can have the unintended consequence of creating a barrier for trust between the parents and resource parent. It is recommended to schedule a time and place to discuss this openly and honestly, either during the CFT Meeting or when deemed appropriate. Pre-planning may be required to avoid misunderstandings. It can result in efforts to support the birth family being minimized and leave a resource family feeling angry and frustrated.

Ideally, the team fosters a positive connection between the birth parents and the resource parents. Resource parents can be very influential and helpful to birth parents who are working to reunify, and birth parents can share important information about the child with resource parents to support good care.

Management of the parallel process of concurrent planning for both birth parent and resource families

i. Think about having an ice breaker meeting so birth parent and resource parent can meet and get to know one another and avoid misunderstandings.
ii. Strategize ways to prevent or address possible interference with reunification.
iii. Be mindful of counterproductive planning.
iv. Plan for how parents and resource parents can communicate with each other.

6. Logistical Considerations

Logistical considerations may arise, such as problems with transportation or a need for interpretation/translation when there are differences in the primary language of Child and Family Team members. Child care may be a concern not only for the baby or young child, but also for siblings or foster siblings. Other considerations include being sure that all necessary releases are secured for the CFT participants and that there is an understanding about how information is shared between CFT participants (e.g. birth parents and resource parents, other service providers and birth parents and resource parents). Guiding the team at the beginning of the CFT meeting process can be helpful for creating agreements to address the above considerations and to avoid experiencing these are problems in the future.

Resources/Links

Center for Disease Control (CDC), Child Development. This is a great resource for information on developmental milestones that for parents and resource families. There are specific activities that support development in each domain and at every age range. There are also tips for effective parenting and a range of other related areas.
https://www.cdc.gov/ncbddd/childdevelopment/facts.html

Center for Child Development at Harvard. This is a resource for video clips describing the developing brain and the impact child maltreatment and stress can have. Exercise caution in the timing and need to share this resource with birth families. Be aware of the guilt and/or shame it could trigger as well at the realization of their own history or early childhood trauma.
http://developingchild.harvard.edu/

Early Start. This is the California Department of Developmental Services portal to understand the eligible requirements, local service providers and Resource Centers. For families whose infants or toddlers have a developmental delay, disability or an established risk condition with a high probability of delay may be eligible to receive an "Early Start" in California.
http://www.dds.ca.gov/EarlyStart/index.cfm

Regional centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and support for individuals with developmental disabilities. There are offices throughout California that help individuals and their families find and access the many services available to them.
http://www.dds.ca.gov/RC/index.cfm

Family Resource Centers (FRCs) actively work in partnership with regional centers and education agencies and help many parents, families and children get information about early intervention services and how to navigate the Early Start system. California's FRCs are staffed by parents who have children with special needs and provide information and parent-to-parent support. Each FRC is unique, reflecting the needs of their community. They may operate as independent sites or be based in regional centers, local education agencies, public health facilities, hospitals or homes. Support services are available in many languages and are culturally responsive to the needs of the individual family.
http://www.dds.ca.gov/RC/index.cfm

The National Child Traumatic Stress Network (NCTSN) is a great resource for learning more about trauma and how it impacts children. There are many resources available on the website for professionals and parents. https://www.nctsn.org/

Child Trauma Academy: CTA is a not-for-profit organization based in Houston, Texas working to improve the lives of high-risk children through direct service, research and education. By creating biologically informed child-and-family respectful practice, programs and policy, CTA seeks to help maltreated and traumatized children. http://childtrauma.org/nmt-model/

First 5 of California: First 5 California is dedicated to improving the lives of California's young children and their families through a comprehensive system of education, health services, childcare, and other crucial programs. Since its creation, First 5 California has brought these critical services to millions of parents, caregivers, and children ages 0 to 5, and strives to reach thousands more every day. www.ccfc.ca.gov

Head Start: Head Start offers parents opportunities and support for growth, so that they can identify their own strengths, needs and interests, and find their own solutions. The objective of Family Partnerships is to support parents as they identify and meet their own goals, nurture the development of their children in the context of their family and culture, and advocate for communities that are supportive of children and families of all cultures. The building of trusting, collaborative relationships between parents and staff allows them to share with and to learn from one another. www.caheadstart.org

UC DAVIS EXTENSION
CENTER FOR HUMAN SERVICES
Resource Center for Family-Focused Practice