Babies and Toddlers in Court Systems: Beginning a Discussion in Indiana

Introduction

Nationally, infants and toddlers are over-represented in the child welfare system. They are also more likely than older children to sustain significant and long-lasting effects when involved in the system. Exposure to trauma is particularly concerning and can lead to life-long physical and behavioral health consequences (Anda et al., 2006). In Indiana, a great proportion of the substantiated child maltreatment, such as abuse and severe neglect, occurs with children younger than 6 years of age. During 2009, there were 20,346 substantiated cases of neglect in Indiana. Of these cases, over half (11,449, or 56.3%) were with infants and children under 6. In terms of abuse, 1 in 5 cases of substantiated sexual abuse in 2009 (806 of 4247, or 19.0%) and 2 in 5 cases of substantiated physical abuse (1,097 of 2,890, or 38.0%) occurred with infants and children younger than 6 years of age (Indiana Department of Child Services, 2010).

Exposure to maltreatment, which includes abuse, severe neglect, and witnessing violence against others, leads to poor regulation in infants and toddlers, which can lead to developmental delays and difficult behavior. Although these changes in development and behavior can be traced to changes in brain structure and function, recovery is possible (Schore, 2010; Lieberman & Van Horn, 2008). Maltreated and traumatized infants and children require stability and safety to allow for a return to normal development, including physical and emotional well-being and the ability to engage in positive relationship building. In 2009, a total of 14,931 Indiana youth were identified as a Child in Need of Services (CHINS) on June 30, 2009 (Indiana Department of Child Services, 2010). Of these youth under court supervision, approximately 3 in 10 (29.8%) remained living in their home, 1 in 5 (21.3%) were placed with a relative, over 1 in 3 (37.0%) were placed in foster care, and 1 in 8 (12.0%) were placed in residential care or elsewhere (e.g., out-of-state placements). Decision-making by professionals and volunteers serving court systems must be informed by science and best-practice guidelines so that maximal positive effects occur (Cohen, Cole, & Szrom, 2012).

Ongoing experience and research has identified steps legal systems can take to address the effects of adverse experiences. These steps include reducing the number of placements a young child undergoes and ensuring that developmental and behavioral interventions and therapies are provided to the children, parents and other caregivers. In many states, “court team” approaches allow judges, lawyers, mental health workers and other professionals to coordinate care, resulting in infants and toddlers being provided targeted, effective and integrated services (Katz, Lederman, & Osofsky, 2011). Although there are some excellent local partnerships intended to address the developmental and

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behavioral needs of the youngest children in care and their families, there is currently no statewide approach.

This project was designed to survey professionals working in and with the court systems in Indiana to gain information about their understanding of the effects of trauma and maltreatment specifically with infants and toddlers, including the professional's decisions related to assessment, intervention, and placement for very young children. This project's intention is to provide a beginning point for discussion about the experiences of very young children in care and to identify potential gaps in knowledge of these key professionals and volunteers who make decisions that impact the lives and development of these children.

Method

Four vignettes were developed to represent common experiences of young children who have court involvement. Topics addressed at least one time across the four vignettes included: substantiated physical abuse, neglect, witnessing domestic violence, divorce, removal from home, foster care and kinship care, multiple placement, visitation, and decisions made by professionals related to assessment, intervention, and visitation for infants and children ages 12 to 20 months. Each vignette included questions to tap the respondent's knowledge of expected behaviors or responses when a young child is in the situation and appropriate next steps and decisions. Experts with experience in child welfare, including mental health workers, attorneys, and child welfare workers reviewed the vignettes and questions to provide input regarding their accuracy and representativeness of the kind of situations that are encountered.

Email requests were sent to representatives of state agencies including First Steps, Head Start, Bureau of Child Development, Department of Child Services, Division of Mental Health and Addiction, and to other involved partners including foster care agencies, CASA and Guardian Ad Litem representatives, and individual mental health professionals. The request invited the participants to go to the Survey Monkey link to complete the survey and also to forward the request to other potential participants.

Participants

Table 1 provides an overview of the demographic information about the respondents who answered this survey. A total of 151 completed surveys were collected. Participants were largely female (90.1%), Caucasian (87.7%), and highly experienced. More than half (58.2%) reported having more than 8 years' experience in court and legal systems and over one-third reported more than 10 years' experience in their present job (33.1%). With regard to working with young children, 76.0% and 70.6% reported having more than 8 years' experience with children ages 3-5 and birth-2 years, respectively. Over half of the participants reported having a college degree (52.6%) and another 44.8% reported holding an advanced degree (such as a master's).

Most participants reported primary affiliation with the Department of Child Services (71.1%), and 7.9% worked within a mental health center. Respondents affiliated with First Steps made up 3.9% of the total, and Head Start or Early Head Start and social service agencies both represented 2.6% of participants. CASA or GAL, juvenile court, foster parent, Healthy Families were represented by less than 1% each.

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Table 1
Demographic Information of Survey Participants (N = 151).

	Percent
Gender	
Female	90.9
Male	9.9
Race	
Caucasian	87.7
Black	9.0
Other	3.3
Hispanic / Latino	2.0
Level of education	
Associates degree	1.3
Bachelors degree	52.6
Advanced degree (masters, doctorate)	44.8
Other	1.3
Years of experience with infants (birth-2 years)	
0-2 years	9.2
3-5 years	11.8
6-8 years	8.5
More than 8 years	70.6
Years of experience with toddlers (3-5 years)	
0-2 years	6.5
3-5 years	8.4
6-8 years	9.1
More than 8 years	76.0
Years at current job	
Less than 1 year	13.0
1-5 years	32.5
6-10 years	21.4
More than 10 years	33.1
Years of experience with court / legal system	
0-2 years	19.0
3-5 years	11.8
6-8 years	11.1
More than 8 years	58.2
Primary affiliation	
Department of Child Services	71.1
Mental health center	7.9
Part C – First Steps	3.9
Social service agency	2.6
Head Start / Early Head Start	2.6
Juvenile Court	0.7
Other	11.2

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Findings

Vignette 1: Physical abuse

Table 2 provides an overview of responses to questions about the physical abuse vignette. Participants were asked to choose the three most likely behaviors foster parents would observe in a 12 month old with a history of substantiated physical abuse. The abuse was perpetrated by the mother's boyfriend and was found during a routine doctor's visit. The top three behaviors selected by respondents were: self-soothing behavior (rocking, sucking thumb), irritable and whiney mood, and trouble falling or staying asleep. Regression in behavior was the only other item selected by over half of the respondents. Few participants reported that regression in language or feeding issues were likely.

Table 2
Physical abuse vignette (N = 151).

	Percent
Most likely observed behavior (participants selected top 3)	
Self-soothing behavior	66.7
Irritable mood	65.3
Sleep difficulties	51.4
Behavior regression	50.7
Aggression	40.3
Language regression	15.3
Walking regression	7.6
Picky eater	1.2
Overeating	0.0
Most likely outcome without treatment	
Will impact future relationships	86.2
Resolve within two months	11.0
Return to normal behavior within week	2.8
Relive abuse indefinitely	0.0
Attachment demonstrated with:	
Foster mother	81.0
Case worker	15.5
Biological mother	3.5
Most effective recommendation to build mother-child relationship	
Mother to perform caregiving tasks during visits	77.6
Play therapy for child to treat Reactive Attachment Disorder	9.8
Mother to bring objects from home during visits	8.4
No foster parent participation in visits	4.2

When asked to choose a likely outcome for the child in the absence of treatment, 86.2% recognized that a trauma experience could result in brain based changes that would affect future events and experiences. Over one in 10 respondents (11.0%) stated the child would forget the trauma within two months, while another 2.8% felt that the child would not remember the event at all, and return to normal behavior within a week. No respondents felt the child would relive the abuse indefinitely.

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The next part of the vignette described behaviors of the child, now 14 months, during a supervised visitation with her mother. In the vignette, the child warmed up to the mother after play. When the foster mother left the room, however, the child stopped playing and assumed a sober expression, requesting to be held by the caseworker. Participants were asked to indicate to which woman attachment behaviors were demonstrated and to select from a list of strategies which one would best strengthen the relationship between the infant and mother. Although the majority indicated that attachment behaviors were shown with the foster mother (81%), over 1 in 8 respondents (15.5%) indicated that attachment behavior was best demonstrated toward the caseworker, and a few respondents (3.5%) indicated that the attachment was best displayed toward the mother. With regard to an effective recommendation to support the parent-child relationship, over 3 in 4 participants (77.6%) chose encouraging the mother to perform caregiving tasks during visits. Nearly 1 in 10 respondents (9.8%) suggested play therapy for Reactive Attachment Disorder was most appropriate, and approximately 1 in 12 respondents (8.4%) suggested that the mother bring objects from home to show the child.

Vignette 2: Multiple placements & neglect

Table 3 provides responses from questions related to the vignette that addressed multiple placements and neglect. This vignette involves a 20 month old boy who lived with his father while his mother was incarcerated for drug offenses. The father had a history of psychiatric disorder, learning problems, and alcohol abuse. The child was removed from the father after neglect was substantiated—the infant was found wandering the neighborhood, and the home was inappropriate. The child initially was placed with a family member, but soon experienced two foster care placements, all within a month. The boy was described to cry while in the first non-family foster placement and to be withdrawn with “empty eyes” in the second foster placement. The father was unable to visit. Participants were asked to select from a list any evaluations that would be recommended. Approximately 4 of every 5 respondents indicated that the child should have assessments for developmental delays (81.3%), reactive attachment/bonding (81.3%) and social emotional well-being (78.7%). Nearly 3 in 10 respondents suggested an evaluation for possible earlier physical abuse (29.7%) and another 1 in 10 suggested evaluation for substances (11.6%). Very few respondents (1.3%) felt that no additional assessments were indicated.

Respondents were then asked to choose the single most likely explanation for the child’s reactions in the second foster home (withdraw) and to indicate the best treatment. Approximately 1 in 3 respondents indicated the best reason for his behavior was grief from the loss of the caregiver who made him feel safe (33.6%), and a similar number felt the best reason was reactive attachment disorder (30.7%). A traumatic response to removal from the placement with a familiar family member was chosen by 17.5% of respondents, and a grief response or depression from removal from his father was selected by 13.9%. Approximately 1 in 20 respondents (4.4%) indicated that the behavior was most likely due to a broken bond with his first foster parents. Most participants suggested that the best intervention would be a stable home with supports to the foster parents (85.4%). A little over thirteen percent (13.1%) suggested an immediate return to the father with weekly visits and drug screen. Very few suggested another move to more experienced foster parents.

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Table 3
Multiple placements & neglect vignette (N = 151).

	Percent
Additional assessments indicated (Participants selected all indicated)	
Developmental evaluation	81.3
Reactive attachment / bonding	81.3
Social / emotional well-being	78.7
Evaluation for earlier physical abuse	29.7
Substance abuse of infant	11.6
No additional evaluations indicated	1.3
Best explanation of reaction to second foster home	
Removed from caregiver who made him feel safe	33.6
Reactive Attachment Disorder	30.7
Traumatic response to removal from aunt	17.5
Grief response / depression	13.9
Broken bond from first foster parents	4.4
Best treatment approach	
Provide training and stay with current foster family	85.4
Return immediately to father	13.1
Placed in home with experienced foster parents, children	1.5

Vignette 3: Witness to domestic violence

Table 4 provides responses related to the vignette which described a 14 month old girl whose parents often had serious violent disagreements resulting in one or the other parent injured and/or leaving. The family was also frequently homeless, leading to her being cared for by various family members, neighbors, and acquaintances. This child was placed in emergency foster care after witnessing a physical argument that led to police involvement. Signs of neglect were observed, including lice. Similar to the first vignette, participants were asked to select the three most likely behaviors the foster parents would observe in the child. Being easily startled was most often selected (66.7% of respondents), followed by withdrawn (50.8%) and self-soothing behaviors (43.2%). Aggression when upset (36.4%), irritable mood (34.1%) and sleep problems (31.8%) were the next most frequently chosen observed behaviors.

Regression in the child's behavior was selected by about 1 in 5 respondents (22.7%); however, regression in language (4.5%) was rarely chosen and regression in walking was never considered. Few respondents also selected overeating (3.0%), and being picky eater was never chosen.

Participants were asked to identify the best initial visitation schedule given the social and emotional needs of the child, assuming a permanency plan of reunification. Almost all respondents selected frequent visits in a neutral setting during which parents would provide caregiving (92.4%). Very few respondents suggested visits be deferred until parents improved their own communication (6.8%), and less than one percent suggested regular weekly visits with overnight stays (0.8%). No respondents felt weekly, all-day visits were appropriate.

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Table 4
Witness to domestic violence vignette (N = 151).

	Percent
Most likely observed behavior (participants selected top 3)	
Easily startled	66.7
Quiet / withdrawn	50.8
Self-soothing behavior	43.2
Aggression	36.4
Irritable mood	34.1
Sleep difficulties	31.8
Behavior regression	22.7
Fear of police	6.8
Language regression	4.5
Overeating	3.0
Walking regression	0.0
Picky eater	0.0
Recommended initial visitation schedule based on reunification goal	
Frequent, short visits in neutral setting	92.4
Postpone visitation until parents improve communication	6.8
Regular weekly overnight visitation	0.8
All-day visits weekly	0.0

Vignette 4: Parental separation / divorce

Table 5 provides responses related to a parental separation and divorce vignette. This last vignette involved a 14 month old child born after her parents had separated. The parents had an amiable relationship after their separation; the child lived with the mother and visited the father one evening per week and every Sunday. The father now requested a change to visits one week each month in his new home, as he planned to move out of state. He planned for the child to be cared for by his sister during his work hours. During an evaluation, the child interacted with both parents. When she had a minor injury, she went to her mother for comfort, but quickly returned to playing with both parents.

Table 5
Parental separation / divorce vignette (N = 151).

	Percent
Should visitations with father for 1 week each month occur?	
Yes, bonding needs to occur with both parents	91.5
No, it is more important to maintain primary bond	8.5
Overnight visits	
Age of child is important consideration	53.5
Level of conflict between parents is important	42.6
Overnight visits should not occur	3.2
None of the above	15.5

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Most respondents felt that the father's request should be honored to promote bonding with both parents (91.5%). Less than 1 in 10 (8.5%) chose maintaining the current schedule on the basis of avoiding disruption to the child's relationship with her mother (the primary caregiver). Participants were also asked to choose one of four statements about overnight visits. Just over half of the respondents (53.5%) indicated that the age of the child was not important as long as the child was familiar with the parent, and another 4 in 10 respondents (42.5%) chose that the level of conflict the child observed between parents was important. Very few respondents (3.2%) agreed that overnight visits should never occur for children under the age of two years. Approximately 1 in 6 respondents (15.5%) felt that none of the above should be considered when determining overnight visits.

Discussion

Clinicians and researchers agree that very young children, including those in the second half of the first year of life, have responses to experiencing or witnessing traumatic events (Zero to Three, 2005; Scheeringa, 2006). Both the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised Edition* (DC 0-3 R) and the *Diagnostic and Statistical Manual – IV-TR*-derived Research Diagnostic Criteria-Preschool Age (APA, 2000; Luby, 2006) indicate that trauma symptoms in early childhood may include categories of behavior that are similar to those by older children and adults. Specifically, young children re-experience symptoms, present with a numbing of responses, and / or demonstrate increased arousal. Similarly, the National Institute of Mental Health (2001) has indicated that symptoms of trauma exposure in early childhood include fears of separation from primary caregivers, signs of fear, such as crying, screaming, and trembling; disorganized behavior (freezing, aimless movement) and regressive behaviors, including loss of previously acquired skills or return of fears.

Participants in this study – primarily DCS workers – demonstrated knowledge about some of the potential observable effects of trauma on young children and about appropriate steps that can be taken to assist children and families in these situations. However, there were some differences between the responses to this survey's vignette questions and what current research may suggest as best practices for infants and young children.

Responses to Physical Abuse

When asked to select likely responses following physical abuse, respondents in this sample primarily identified behaviors related to increased arousal, including whiney mood, problems falling asleep, and aggression. They also selected self-stimulation behaviors, which are not specifically listed in the available criteria, but could be viewed as related to dissociative behavior (a re-experiencing symptom). This is important, as some experts view dissociative and other re-experiencing and numbing symptoms as more likely than hyperarousal symptoms for young infants (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). This difference is explained as occurring because hyperarousal responses are associated with "fight or flight" behaviors which are less likely to be an effective strategy for a very young child compared to mobile older children and adults. An important symptom for young children that was chosen less frequently was regression of developmental skills, which can occur as part of numbing of responsiveness. Self-soothing

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behavior, which could also be interpreted as a regressive behavior (e.g., a return to thumb-sucking following trauma), was frequently chosen by these respondents.

Responses to Witnessing Violence

Very young children can also be profoundly affected by witnessing violence toward others, especially a caregiver or attachment figure. Seeing a caregiver injured is especially difficult and can lead to many trauma symptoms. Violence occurring between two people a child loves and whom the child has come to rely on for a sense of safety and security can be particularly damaging (Lieberman & Van Horn, 2005). Practitioners must have knowledge of both attachment behavior and trauma responses to understand the child's response to these experiences. In one study of children under the age of 4 years with PTSD, threats to the caregiver resulted in more hyperarousal symptoms, along with more aggression and onset of new fears (Scheeringa & Zeanah, 1995). In this same study, numbness symptoms were less likely to occur in this situation. Participants in the present study frequently identified symptoms of hyperarousal (easily startled, sleep problems, irritability, aggression), but also endorsed numbing (quiet or withdrawn and self-soothing behavior) as occurring after exposure to domestic violence.

Loss of Caregiver

Loss of a caregiver is a difficult experience for any child, particularly for an infant or very young child who is almost entirely dependent upon that person. This loss can be so significant that the *DC 0-3 R* (Zero to Three, 2005) lists Prolonged Bereavement/Grief Reaction as a separate diagnosis within the Disorders of Affect. This disorder is characterized by a sequence of responses initially proposed by Bowlby (1980): protest, despair, and detachment. Two vignettes requested that respondents interpret behavior of a child who is separated from the primary caregiver. The responses of the child in the abuse/foster care vignette are discussed below in the section on attachment. In the neglect/foster placement vignette, the child experienced four total moves and eventually showed withdrawn behavior in the fourth and final placement. Over 80% of the participants suggested this child receive an assessment for reactive attachment disorder, and over 30% indicated that reactive attachment disorder would be the best explanation of his withdrawn and quiet behaviors. This interpretation suggests that participants are aware of the centrality of attachment in the lives of young children; however, given that reactive attachment disorder is highly unusual (occurring in about 1% of the population; Boris & Zeanah, 2005), the chances of a given child meeting criteria for a reactive attachment disorder seem minimal and other interpretations should be considered. Furthermore, although reactive attachment disorder can occur as a result of many changes in caregivers, the child described in the vignette did have an available parent and had sufficient time with a family substitute caregiver to develop a relationship. It is likely that the respondents to this survey are unfamiliar with the *DC 0-3R,* which indicates that Deprivation / Maltreatment Disorder (its version of reactive attachment disorder) is reserved for abuse and severe neglect, and that other challenged relationships should instead be coded on the *DC 0-3 R* Axis II (2005).

Neglect

Two vignettes included information that suggested possible neglect. Recognizing behaviors associated with neglect is important because they can be similar to those observed in

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other forms of abuse (Harden, 2007). Just over 80% of the respondents in the present study indicated they would seek a developmental evaluation for a child removed for neglect. According to the Child Abuse Prevention & Treatment Reauthorization Act (Public Law 111-320, 2010) and the Individuals with Disabilities Education Improvement Act (Public Law 108-446, 2004), all children under three years of age with substantiated abuse and neglect should be referred to the Part C agency (for Indiana, First Steps). This finding that nearly 1 in 5 respondents would not have made a referral to evaluate for developmental delays is concerning. Nearly one-third of the participants in the survey indicated they would likely obtain an evaluation for signs of possible abuse when a child was removed for neglect. This referral is appropriate, given that it is not unusual for children who are neglected to also be victims of physical or other abuse.

Frequent moves/change of placement

Change of placement can disrupt attachment and frequent changes of placement can result in lack of opportunity to form a secure attachment relationship (Dicker, 2009). In the vignette portraying neglect with foster care placement, the child is described to show sadness and withdrawal following a series of placement changes. As discussed earlier in the section on attachment, participants in this study were likely to identify the child's behavior as representing reactive attachment disorder rather than a grief response to loss of access to a primary caregiver. When asked about a helpful treatment for the child, participants most often suggested a stable placement that includes supports for the foster parent to help him feel safe. This recommendation for stability is supported by research; reducing relationship disruption and avoiding or minimizing placement changes are some of the most important ways that young children can be supported when in care (Dicker, 2009).

Visitation and Attachment Behavior

Two vignettes discussed visitation within the context of foster care and a third vignette discussed visitation within the context of parent divorce. In the abuse/foster care vignette, the child was in out-of-home care for two months before visitation began. The child was described to cling to the foster mother at the beginning of the session with her mother and to show protest behavior when the foster mother left the room. In addition, the child approached the case worker for support rather than the mother. The majority of the respondents suggested that the child showed attachment behavior toward the foster mother; however, over 15% identified the case worker as an attachment figure. Research has shown that infants in foster care can show a secure relationship with the foster parent within about 2 months of placement (Stovall-McClough & Dozier, 2004). In the vignette, the child showed the ability to use the foster mother to navigate uncertainty upon seeing her biological mother again, and became sober when the foster mother left, turning to the caseworker for help. In the domestic violence/foster care vignette, participants agreed that frequent, short visits in which parents provide caregiving for the child were indicated. This type of activity within the visitation schedule has the potential to provide the young child with repeated opportunities to be with parents over time, and is in line with the idea that attachment develops and is maintained when a child experiences having his or her needs for safety and security consistently and sensitively met by caregivers.

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In the parental divorce vignette, the father requested week long visitation with the 14 month old child since he planned to move out of state. This would include a lengthy separation from the primary caregiver (mother), overnight stays and care provided by an unfamiliar person. The overwhelming majority of respondents indicated that the father should be granted the visitation, and over half agreed that the age of a child was not important when determining visitation, as long as the child is familiar with the parents. Decisions about visitation are difficult and often a clear-cut "right" answer is not possible. However, decision-makers must balance many issues as they look for ways to avoid disrupting the primary attachment relationship while supporting both parents. Factors to be considered include the child's developmental level and experience of moving between parents, degree of conflict between the parents, and the parents' ability to support the child to tolerate the visitation schedule. For many babies and toddlers under two years overnight visitation with separation form the primary caregiver may be stressful; more successful visitation is likely once the child is older (George, Solomon, & McIntosh, 2011; Lieberman, Zeanah & McIntosh, 2011). It will be important for decision-makers and families to work together to consider ways to support the young child to have positive relationships with both parents even when overnight visitation is not recommended or possible.

Recommendations for Evaluation and Treatment

About one-third of infants and young children who become involved with child welfare agencies have developmental delays. All forms of trauma, including witnessing violence, abuse and severe neglect can impact child development and behavior (Cohen, Cole, & Szrom, 2012; Harden, 2007). In this study, participants recognized that a developmental evaluation was needed a child removed for neglect, but seemed less likely to identify regression in development as a concern for children who experienced physical abuse or witnessed domestic violence, perhaps because other concerns took priority. Referrals for developmental, behavioral, and medical evaluation are recommended for all children in care (Cohen, Cole, & Szrom, 2012).

With regard to treatment for concerns of social and emotional development and relationships with caregivers, about 10% of the participants indicated they would refer the child for play therapy for reactive attachment disorder when asked what would help a parent-child relationship. According to the American Academy of Child and Adolescent Psychiatry Practice Parameter, the most important interventions for a child with attachment problems are provision of a stable and responsive caregiver and dyadic treatment approaches that involve the parent and child together, such as Parent-Child Psychotherapy (Boris and Zeanah, 2005).

Summary

The results of this survey indicate that workers in Indiana have knowledge of many of the kinds of responses that very young children may have when they experience trauma. Most providers expected symptoms of hyperarousal and dissociation and they were less likely to suggest concerns about or evaluations for developmental delays. Providers may have over-identified the chances that a given child's behavior would represent reactive attachment disorder and may not recognize behaviors and factors related to other types of relationship

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concerns. Finally, participants in this study appear to be more knowledgeable about visitation related to foster care rather than for families needing help with visitation related to divorce.

This project has a number of limitations. The sample is a convenience sample and may not be representative of all providers in Indiana working with young children in court systems. As with any vignettes, the amount of information must be simplified and cannot be comprehensive, potentially leading participants to have difficulty making appropriate decisions about their responses. Ideally, evaluations of young children in these situations would occur across time and include observations in multiple settings; reflecting this level of detail in a vignette is difficult. In addition, the questions were designed for ease of analysis; this could result in truncating of participants' responses. However, within these limitations, the project provides a beginning point to gather information about ideas that workers have about young children's responses to traumatic events and may help to stimulate further conversations about how best to support young children and families involved in child welfare and the court system.

For Future Consideration

The experiences of very young children involved in court systems are varied and complicated. There are no easy or "one size fits all" answers. However, research and focused clinical experiences provide some guidance to our practices. The following points for discussion are offered:

- ✓ Under federal guidelines, children under the age of three years in out of home placement as a result of substantiated abuse or neglect should receive developmental screening and referrals to Indiana First Steps. Providers who participate in these evaluations should have experience with trauma responses of young children.

- ✓ Visitation schedules for young children should be individualized with attention to many issues including the child's developmental and chronological age, the overall caregiving context, and the degree of conflict between the parents. Often, shorter and more frequent visits are better than once a week visits that are suitable for older children. Because attachment grows over time through repeated experiences of safety and security, parents should be encouraged to demonstrate they can provide the child safety and security through caregiving activities (e.g., activities that typically occur throughout the day such as feeding, play, and limit-setting) during the visits.

- ✓ Volunteers and professionals working with the child welfare system should be encouraged to recognize and address through evaluation and intervention all possible ways that infants and toddlers can show distress and symptoms of trauma, including age-congruent symptoms of re-experiencing a traumatic event, hyper-arousal, and evidence of numbing or responsiveness, including developmental delay and loss of previously demonstrated capacities.

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- ✓ Providers are in need of more detailed information about caregiving and attachment relationships across ages, including how attachment behaviors are affected by trauma, loss of access to caregivers and foster care.
- ✓ With regard to training for professionals who conduct evaluations about young children's emotional status and assess relationships, ongoing mentorship is a preferred method for individuals to gain knowledge in this area short-term didactic instruction is insufficient.
- ✓ Foster parents have an important role in a young child's adjustment to being apart from their parents. Recognition and support for foster parents, including their own experiences of relationship should be part of the equation.
- ✓ Use of the *DC 0-3R* which allows for better delineation of attachment concerns within specific relationships, has been allowed for diagnosis and for billing in some states, and there is a national call for early childhood advocates for other states to begin similar discussion (Cohen, Oser, & Quigley, 2012).
- ✓ Consider ways to provide dyadic supports and interventions that assist foster, biological and adoptive parents to reconnect and establish positive relationships with young children needed to repair the effects of prior trauma and to enhance development and behavior.

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