The Department of Children and Families

Early Childhood Practice Guide for Children Aged Zero to Five

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Note: The Early Childhood Appendices are in a separate document that contains additional information. The Table of Contents for the Appendices can be found on the next page.

Introduction

The Department of Children and Families supports healthy relationships, promotes safe and healthy environments and assures that the social and emotional needs of all children are met. The 0-5 population comprises a third of our overall caseload and we know by virtue of age, they are among the most vulnerable in our society. The work we do with young children and their families early on sets the stage for their future success. The intent of the Early Childhood Practice Guide is to provide a framework and important information to support child welfare staff in their work with young children and their families. In the past few decades, there has been overwhelming research that highlights the significance of the first years of development and the impact of early adversity on long-term health outcomes. The Early Childhood Practice Guide is designed to inform child welfare staff of this research and articulate the practical application of that research and knowledge in direct service with young children and families.

This Practice Guide is designed to build upon the many strengths of our practice and provide further guidance and information that support comprehensive assessments and engagement with families and our community partners. The Early Childhood Practice Guide and Appendices provide tools, resources, and information that address essential areas of our work, including developmental milestones (incorporating social and emotional development), understanding the importance of attachment, the impact of trauma, assessing safety and risk, and the role and importance of supervision in our work with families with young children.

Very Young Children in Child Welfare

Children's early experiences can have a profound impact on their development and well being now and later in life. Research on the developing brain clearly demonstrates that these early experiences are incredibly powerful. During the earliest years of life—the first five years—the brain is more easily impacted by outside experiences than at any other stage of life. The developing brain is shaped in very important ways by these experiences. Positive experiences, such as loving attention, calm routines, sights, sounds and other sensory experiences that are varied but not overstimulating, can directly impact the brain's architecture.

Because the brain is so sensitive during this early stage, however, extremely stressful or traumatic experiences can also have powerful repercussions. Almost 200,000 children in the US under the age of 3 come into contact with the child welfare system every year. This population also has the highest rate of child fatalities. For young children, this threat arises at a crucial time in life, when early experiences are shaping the brain's architecture into a foundation for learning, health, and future success.

The traumatic experiences that bring children into our care (e.g., physical and sexual abuse or severe neglect) affect the basic foundation of the developing brain. Such experiences make it more difficult for a child to develop the cognitive, emotional and sensorimotor skills they will need to meet life's challenges. Research suggests that the more harmful experiences a child is exposed

to, the more likely the child is to have difficulty with social and emotional functioning, exhibit cognitive problems and fall behind in school.[1]

One of the most important influences on a young child's growth and development is his/her relationship with a caring and nurturing adult beginning at birth. This relationship is the basis for an infant's ability to form a secure attachment, which sets the stage for their cognitive, social, and emotional development.

This early stage in life is also unique because the well being of a young child is particularly shaped by the relationship the child has with his or her primary caregiver. The quality of interactions between the caregiver and child shapes the child's developing brain and creates the context through which learning occurs.

Trauma in early childhood—particularly trauma that impacts the relationship between caregiver and child—can have a cascading effect on a child's well being. Not only can the brain be shaped by experiences of neglect and/or abuse at the hands of the caregiver, but these experiences also leave the child with the message that adults cannot be trusted.

Research has found that children who have insecure relationships with their primary caregiver are more likely to struggle both academically and in developing healthy relationships with others. Children who develop insecure attachments to their caregiver are also at increased risk for mental health problems like depression and anxiety.[2] A growing body of research has shown that adverse environments and experiences place young children at risk for limited language and cognitive skills, difficulties interacting effectively with their peers, insecure attachments, developmental delays, behavioral and mental health problems, and an array of health problems and conditions (e.g. lung disease, cancer, depression, or alcoholism) later in life.

Working with very young children can be especially challenging since they often have not yet developed the skills to tell you what has happened to them, what they are feeling, or what they need.

An important part of your role as a CPS worker is to learn to interpret children's expressions, body language, behavior, and emotions so that you can make sure they get the help and support they need to thrive.

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[1] Center on the Developing Child, Harvard University. *In Brief- The Impact Of Early Adversity On Children's Development.*

[2] Jakobsen, I.S., Horwood, L.J., & Fergusson, D.M. (2012). Childhood Anxiety/Withdrawal, Adolescent Parent-Child Attachment and Later Risk of Depression and Anxiety Disorder. *Journal of Child and Family Studies*, *21*(2).

Understanding the Importance of Attachment in the Early Years

A young child's connection and bonding experience are formative in the early years. Relationships matter…and in order to understand a child, we must be willing to explore and understand the relationship between a parent/caregiver and child.

The first years of life are almost entirely about building trust and security. The quality of the parent/child relationship creates a foundation for a child's future development. Young children, through physical and emotional contact and interaction, create and sustain attachments.

The quality of the attachment is one of the strongest predictors of later development.

Understanding the attachment patterns and the outcomes for young children has great implications for child welfare practice in regards to planning transitions, placement of children in care, the reunification process, observation of parent/caregiver child interactions, and ultimately our case planning decisions. These decisions must support and promote nurturing and stable relationships in the lives of infants, toddlers, and preschoolers if we hope to achieve improved outcomes for the children and families we serve.

Attachment research tells us the quality of the parent/child relationship can be captured in two major categories:

Secure Attachment = healthy relationships
Insecure Attachment = disrupted relationships

A **secure attachment** is characterized by the child's ability to use his or her parent as a source of comfort and a "secure base" from which to explore. A key principle of attachment theory is that dependence leads to independence. In other words, it is only when a child feels confident in his parent's availability that he can fully explore and play on his own.

Many research studies have shown that sensitive, responsive parenting promotes secure attachment.

When a parent/caregiver responds sensitively and consistently to a child's needs, the child is able to:

- **Gain confidence that his/her needs will be recognized and responded to**
- **Develop healthy relationships**
- **Regulate or manage his/her emotions**
- **More easily comfort himself/herself**
- **Feel safe exploring the world around him/her**
- **Cooperate and help others**
- **View himself/herself and others positively**

What do healthy toddler/young children behaviors look like with secure attachments?

- Interest and confident to explore in the presence of an attachment figure
- When hurt, going to an attachment figure for comfort (i.e., not a stranger)
- Seeking help when needed
- Willingness to comply with requests with minimal conflict
- No pattern of controlling or directing the behavior of caregivers (no role reversal)

What do healthy parental behaviors look like with secure attachments?

- Sensitive and responsive care
- Clear, consistent, developmentally appropriate expectations and supervision
- Warm, positive, and responsive verbal interaction
- Seeing the child as a unique individual, having insight into the child (i.e., why he does what he does)
- "Holding the child in mind" (i.e., awareness of and ability to reflect on the parent's own feelings and responses to the child)

A child who had a secure attachment with her parent as an infant is more likely in childhood to be independent and self-confident; to have appropriate interactions with peers and teachers; to manage her emotions, to be focused, curious and motivated in school; and to have strong problem solving skills.

- **Insecure Attachment** – disrupted relationships.

An **insecure attachment** is characterized by the child's inability to use his or her parent for comfort or as a secure base. Insensitive, rejecting, or inconsistent parenting has been linked to insecure attachment.

There are three types of insecure attachment:

1. When a parent is unavailable or rejecting, a child may become **"avoidantly"** attached, meaning that the child adapts by avoiding closeness and emotional connection. It is a strategy often developed by an infant whose parents have discouraged overt signs of either affection or distress, and who do not readily offer sympathy or comfort (Karen, 1994). The insecure avoidant infant rarely cries when separated from the primary caregivers and avoids contact upon his or her return (Papalia *et al*., 1999).

2. An **"ambivalently"** attached child experiences the parents' communication as inconsistent and at times intrusive. Because the child can't depend on the parent to connect or respond, he develops a sense of anxiety and feelings of insecurity. The lack of consistent nurturing and protection from the parent makes it hard for the infant to feel that exploring the world is a safe option. Thus the child has a low threshold for distress, but no confidence that comfort will be forthcoming.

3. **"Disorganized"** attachment occurs when the child's' need for emotional closeness remains unseen or ignored, and the parents behavior is a source of disorientation or terror. When children have experiences with parents that leave them overwhelmed, traumatized, and frightened, children become disorganized and chaotic. Disorganized attachment leads to difficulties in the regulation of emotions, social communication, and academic reasoning, as well as to more severe emotional problems.[3]

Insecure Attachments can result in the child:

- Having difficulty developing healthy relationships
- Lacking confidence in the predictability of the world around him/her
- Struggling to manage his/her emotions
- Lacking the skills to comfort him/herself
- Feeling unsafe and unwilling to explore the world around him/her
- Being aggressive or withdrawn

What do the toddler/young children behaviors look like when an insecure attachment is developed?

- Excessive dependence
- Marked shyness, withdrawal, or unfriendliness
- Failure to seek contact, comfort when needed
- Indiscriminate friendliness or contact seeking
- Punitive, bossy behaviors
- Over-concern with the parent's well-being (i.e., role reversal)
- Disoriented or frightened in presence of the parent, such as approaching while looking away, stilling, freezing, or rocking
- Promiscuous, sexualized behavior
- Viewing him/herself and others negatively

What do the parental behaviors look like when an insecure attachment has developed?

- Interfering with the child's attempts at exploration (i.e., intrusive, overly controlling)
- Unclear, inconsistent, developmentally inappropriate expectations and supervision
- Ignoring the child's needs and cues
- Inconsistent, unreliable responsiveness
- Hostile, threatening, and frightening behaviors
- Prioritizing the parent's needs over the child's (i.e., self-absorbed)
- Behaving like a child or treating the child as though he/she is in charge (i.e., role-reversal)
- Marked withdrawal, fright, hesitance or timidity around the child
- Sexualized or overly intimate behaviors

[3] Parenting: Attachment, Bonding and Reactive Attachment Disorder. Children's Problems and Behaviors Related to Stress: Help with Stressed Kids for Parents and Educators

A core question for all young children is grounded in attachment: *Do I have an adult who cares about me and will keep me safe? What does it mean and what do I do when that adult who is supposed to care about me and keep me safe is also the same adult who is scary and hurtful?*

To encourage attachment, staff can suggest the following activities:

- Explain the importance of skin to skin contact between baby and their parents
- Parents to hold the baby while feeding
- Parents making eye contact with the baby
- Parents talking to the baby in a soothing voice
- Parents talking to the baby while doing natural daily activities (feeding, diaper changes, playing, going shopping etc.)

SERVE AND RETURN: HOW INTERACTIONS BUILD BRAINS

Brain structures are built through the interactive influences of genes and early experiences. The active ingredient is the "serve and return" relationships that children have with caregivers in their family or community. Like the process of serve and return in games such as tennis and volleyball, young children naturally reach out for interaction with others. A caregiver who is sensitive and responsive to a young child's signals provides an environment rich in "serve and return" experiences. When a child's caregiver is unable to provide these experiences or provides inappropriate responses, some brain structures may not form as they should. Inadequate interaction has huge negative implications for later learning, the development of skills and abilities, behavior, and health. When children have adverse early experiences that include chronic physical and emotional neglect, recurrent abuse, and parental addiction, it can lead to the development of **toxic stress** in a child's environment and can have a tremendous impact on their overall health and development.

Toxic Stress:
When strong, frequent, or prolonged adverse experiences such as extreme poverty or repeated abuse are experienced without the buffering of adequate adult support.

SERVE AND RETURN IN EARLY CHILDHOOD

The interactive serve and return between a child and a caregiver – cooing, making facial expressions, and babbling back and forth – literally builds the architecture of the developing brain. Having a positive, nurturing relationship with a caregiver early in childhood is one of the most important ways to promote healthy social, emotional, and cognitive development. A disturbance in any one of these domains, including adverse events, can lead to problems in other areas. For example, children who are unable to regulate their emotions are not likely to make many friends, which can limit their social development. An absence of friends is associated with poor academic achievement even at early ages, which can hamper some aspects of cognitive development. In this way, these capacities are connected over the course of the developmental period and help lay a foundation for lifelong health and well-being. (http://developingchild.harvard.edu/resources/three-core-concepts-in-early-development/)

Risk Factors and Attachment

Maternal depression, anxiety disorders and other forms of chronic depression often disrupt the parent-child bond because parents with untreated mental health disorders are often less able to provide developmentally appropriate stimulation and parent-child interactions.[4] Parenting and child development are most affected when depression simultaneously occurs with other factors such as extreme poverty, substance abuse, adolescence and maltreatment.[5] Infants of clinically depressed mothers often withdraw from their caregivers, which ultimately affects their language skills, as well as their physical and cognitive development. Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulties in school. [6]

The attachment that a child develops in the early years of their lives dictates the outcome for children into adulthood. Helping parents develop a secure relationship with their children is equally as important as providing consistency in care of their child, responding quickly to a baby's cry, exuding warmth and being sensitively attuned promotes a sense of security and trust in children. When children develop a secure attachment, they can thrive in every facet of their lives-educationally, relationally, and occupationally, etc.

For more information, please review Appendices section on Attachment, beginning on page 19.

The Impact of Trauma on Early Childhood Development

Research has shown us that traumatic experiences hold the potential of strong and lasting impact on the normal development of a child's brain. During early childhood, the brain is developing the framework for learning, planning, making connections, and abstract thinking. When the architecture of that framework is impacted by trauma, there can be adverse effects to the cognitive capacity, emotional experiences, and ability to manage and control their behaviors, ultimately impacting their interpersonal relationships[7]. The significance of this is even stronger when you consider that 47% of children experiencing trauma do so by the age of 5[8].

While trauma can impact any child, children involved in child welfare are at a much higher risk of experiencing trauma and its consequences. This is in part due to the complex nature of the trauma, stemming from their primary attachment figures (traumatic loss, separation, intimate partner violence, impaired caregiver, emotional abuse, neglect, physical abuse, and sexual abuse), and also because of the chronicity of traumatic experiences for many in the child welfare system. Adults may see young children adapt to these repeated traumatic events and experiences with behaviors

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[4] Administration for Children and Families. (2000). Summary of Current Literature – Maternal depression.

[5] Gurian, A. (2003). Mother Blues – Child Blues: How Maternal Depression Affects Children. New York University Child Study Center Letter, 7(3).

[6] Knitzer, J. (1996). Meeting the Mental Health Needs of Young Children and Families: Service Needs, Challenges, and Opportunities. Children's Mental Health: Systems of Care in a Changing Society. Baltimore, MD: Brookes, P.H.:Ed. Stroul, B., 553-572.

[7] The National Child Traumatic Stress Network, pp. 28-29.

[8] http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf Child Maltreatment 2013 p. 31

that are sometimes confusing and displaced. Young children can learn at a very early age how to cope with trauma and may present with behaviors or actions that are often misinterpreted by adults. For example, a child may present very clingy with a caregiver but is unable to calm down when the caregiver tries to comfort him. The child becomes more upset and may hit or push away the caregiver, refusing to accept comfort. The caregiver responds by putting the child down; the child then tries to climb back up onto the caregiver's lap.

Children who have experienced trauma in their early developmental years are more prone to perceive threats in their environment, exhibit impulsive or inhibited behaviors, and have difficulty trusting others. Most traumas experienced by children under the age of 5 are not explicit and instead are held in the body and can result in physical sensations, distress, and dysregulation.

The impact on children exposed to early trauma is often reflected in developmental delays. A national survey conducted of children in the child welfare system found that 35% of children who experienced trauma had developmental delays in the following areas:

- motor skills;
- speech and language development;
- emotional/behavioral regulation;
- and cognitive functioning

Types of Stress

Learning how to cope with adversity is an important part of healthy child development. When we are threatened, our bodies activate a variety of physiological responses, including increases in heart rate, blood pressure, and stress hormones such as cortisol.

Positive Stress	*When a young child is protected by supportive relationships with adults, he learns to cope with everyday challenges and his stress response system returns to baseline.*
Tolerable stress	*Occurs when more serious difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury, are buffered by caring adults who help the child adapt, which mitigates the potentially damaging effects of abnormal levels of stress hormones.*
Toxic Stress	*When strong, frequent, or prolonged adverse experiences such as extreme poverty, violence, or repeated abuse and neglect are experienced without the buffering of adequate adult support.*

Response to Toxic Stress

Infants respond to toxic stress by producing a stress hormone called cortisol. Prolonged activation of the infant's stress response system can result in disruptions in brain development and can have lasting impact on psychological and overall health into the adult years.

Without appropriate intervention early on or if untreated, these symptoms may intensify and lead to mental health problems for infants and toddlers that may manifest in physical symptoms, delayed development, inconsolable crying, sleep problems, aggressive or impulsive behavior and paralyzing fears.

Infants and toddlers who have experienced abuse and neglect, or who have been exposed to substance abuse prenatally, have higher rates of physical and emotional problems. If not addressed, these delays can have serious consequences for children as they age.

Trauma's Impact on Brain Development

Exposure to chronic, prolonged traumatic experiences has the potential to alter children's brains, which may cause longer-term effects in areas such as:

- **Attachment**: Trouble with relationships, boundaries, empathy, and social isolation
- **Physical Health**: Impaired sensorimotor development, coordination problems, increased medical problems, and somatic symptoms
- **Emotional Regulation**: Difficulty identifying or labeling feelings and communicating needs
- **Dissociation**: Altered states of consciousness, amnesia, impaired memory
- **Cognitive Ability**: Problems with focus, learning, processing new information, language development, planning and orientation to time and space
- **Self-Concept**: Lack of consistent sense of self, body image issues, low self-esteem, shame and guilt
- **Behavioral Control**: Difficulty controlling impulses, oppositional behavior, aggression, disrupted sleep and eating patterns, trauma re-enactment

Source: Cook, et al. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390-398.

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) Study is one of the largest scientific research studies conducted designed to analyze the relationship between **childhood trauma/maltreatment** and the

risk for **physical and mental illness in adulthood**. The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States.

Over the course of a decade, the results demonstrated a strong, graded relationship between the level of traumatic stress in childhood and poor physical, mental and behavioral outcomes later in life. The ACEs Study found as the number of traumatic experiences in childhood increase, the risk for 17 serious problems later in life increases as well including but not limited to; health related quality of life, risk for intimate partner violence and illicit drug use. The study identified a set of traumatic experiences and family dysfunctions that significantly impacts the trajectory of an individual's life as it relates to their physical, emotional, and social health.[9] These traumatic experiences were grouped into two major categories: Abuse (includes verbal, physical and sexual); and Household Dysfunction (which is witnessed by a child and includes mental health impairments, substance use, parental separation/divorce, and domestic violence. [10] This trajectory leads to the adoption of risk related behaviors that can result in disease and disability and social problems that are often the backdrop of dysfunction experienced in the households with which we work: depression, drug and alcohol use, homelessness, criminal behaviors, parenting problems, and family violence.

A trauma trigger is an experience that causes an individual to recall a previous traumatic memory. Trauma triggers in young children can include:

- sights
- sounds
- smells
- touches
- a combination of some or all, causing sensory overload for the child.

Trigger responses function to help a child achieve safety when exposed to perceived danger. There are four primary responses to danger: **FIGHT, FLIGHT, FREEZE, and FAINT[11].**

- A young child whose trigger response is **FIGHT**, may present with hyperactivity, verbal or physical aggression or oppositional behavior.
- A young child whose trigger response is **FLIGHT,** may present as withdrawn, isolated or avoidant.

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[9] ACESTUDY.gov

[10] CT DCF Special Review Summary Report: Deepening Competency From Adversity (2016)

[11] Perry, B.D. The neurodevelopmental impact of violence in childhood. Chapter 18: In **Textbook of Child and Adolescent Forensic Psychiatry**, (Eds., D. Schetky and E.P. Benedek) American Psychiatric Press, Inc., Washington, D.C. pp. 221-238. 2001.)

- A young child whose trigger response is to **FREEZE**, may shut down emotionally or may appear watchful or dazed. Their bodies may show signs of trembling, shaking or they may curl into a ball.
- A young child whose trigger response is **FAINT**, may act stunned or numb, appear to be gazing off into nowhere, dissociated, 'off in another place'.[12]

It is important to know that most children have a combination of responses to trauma triggers that are often inconsistent and confusing to adults. Children may respond to a perceived threat by fighting with one adult and by freezing with another. Most trauma-exposed children are so overwhelmed by emotions when they feel threatened that they have very little ability to regulate their emotional state. This is why strategies such as "time out" are often not useful and can actually be harmful to children in some cases. When children are struggling to manage their responses to fear, they need a trusted caregiver to anticipate these responses and provide them more support and emotional availability, not take it away by putting them in "time out."

Understanding Trauma Triggers – A Case Example

Sally was removed from her parents care at the age of three and placed with paternal relatives. Prior to removal, Sally's parents had been transient/homeless often staying at shelters or with various friends for short periods of time. Sally witnessed physical violence between her parents throughout her childhood, the last incident resulting in father's arrest and incarceration. Subsequently, Sally's mother began struggling with depression and alcohol abuse, had minimal supports available to help her, and often left Sally with strangers at the shelter.

Sally now lives with her paternal uncle, his wife and their four children ranging in age from 10 to 18. Sally's uncle bears a strong physical resemblance to Sally's father and they have similar voice tones. One day, Sally's male cousins (ages 15 and 17), engaged in playful rough housing in the living room and knocked over a lamp that crashed to the floor. Sally witnessed this from the kitchen where she was having lunch with her aunt. When Sally's uncle heard the crash he came into the living room, separated the boys and yelled at them for rough housing in the house.

This is a very busy family. Both parents' work and enrolled Sally in a community based Head Start program. The family is involved with their church community and they are busy with their children's sports activities. As a result of their busy life style, Sally has been exposed to many new people and caregivers both at home and Head Start.

[12] Perry 2001 above. Infants and young children tend predominantly toward a dissociative adaptive reaction perhaps because they are not capable of fighting or fleeing but must rely on the caregiver to fight or flee or warm or protect, for them. (Page 7)

Paternal relatives provide Sally with a safe, secure, stable, and nurturing family environment. Due to her past trauma experiences with her parents, Sally occasionally experiences trauma triggers, (false alarms or reminders of her past traumatic experiences).

Can you identify what some of these triggers might be in her new home? Keep in mind the most common trauma triggers are sight and sound, followed by smell, touch and taste.

Sight:

- Sally's uncle may be a trigger as he resembles her father who was an abuser.
- Sally observes rough housing between her cousins.
- Sally seeing the lamp being knocked over as a result of her cousins' rough housing.
- Sally seeing her uncle physically separate and yell at her cousins.

Sound:

- Sally hearing her uncle's tone of voice when he yelled at her cousins.
- Sally hearing her cousins yelling at one another during their rough housing.
- Sally hearing the loud bang when the lamp crashed to the floor.

Other triggers for Sally may include the numerous transitions she is experiencing in this home, inclusive of the changes in her daily routines and habits, recent enrollment at Head Start, introduction to new people and new caregivers, daily separation from her new caregivers, and possible overstimulation with all of these new experiences. In addition, Sally may also experience physiological symptoms as a result of her trauma.

The Role of the Social Worker to Support Sally and Caregiver:

- It is important the Social Worker share information about the child's background and history with the child's caregivers so that those caring for him/her have a better understanding of her childhood experiences.

The Role of the Caregivers to Support Sally:

- Parents/caregivers of children who have a history of trauma need to be educated around trauma triggers so they can be mindful that children's reactions/behaviors to events/circumstances that typically would not cause a reaction in other children, may for these children based on their past experiences and that young children will react to trauma in ways that are different from older children and adults.
- Caregivers should be informed of the nature of the children's trauma. Although the caregiver/parent may never learn/know the full story of these traumatic experiences, it is important for them to review what may have precipitated these reactions in the children they are caring for. Without this understanding, these behaviors may be misinterpreted and/or result in a disruption in placement. Support and connection to trauma informed services for these children are critical in their ability to heal.

- Educating caregivers about the possible effects of maltreatment on brain development, and the resulting symptom, may help them better understand and support the children in their care.
- Children need nurturance, stability, predictability, understanding and support.

For more information on Trauma, please review Appendices section beginning on page 4.

Child Development

Early childhood is a time of remarkable physical, cognitive, social and emotional development. Growth and development includes not only the physical changes that will occur from infancy to adolescence, as well as changes in emotions, personality, behavior, thinking, and speech that children develop as they begin to understand and interact with the world around them.

Types of Developmental Milestones:

1. **Physical Milestones**: involve both large-motor skills and fine-motor skills. The large-motor skills are usually the first to develop and include sitting up, standing, crawling and walking. Fine-motor skills involve precise movements such as grasping a spoon, holding a crayon, drawing shapes and picking up small objects.

2. **Cognitive milestones** are centered on a child's ability to think, learn and solve problems. An infant learning how to respond to facial expressions and a preschooler learning the alphabet are both examples of cognitive milestones.

3. **Social and emotional milestones** are centered on children gaining a better understanding of their own emotions and the emotions of others. These milestones also involve learning how to interact and play with other people.

4. **Communication milestones** involve both language and nonverbal communication. A one-year old learning how to say his first words and a five year old learning some of the basic rules of grammar are examples of important communication milestones.

While most of these milestones typically take place during a certain developmental stage, parents and caregivers must remember that each child is unique.

Typical Behaviors You Might Observe During Visits		
Young Infants (0-8 months)	Mobile Infants (6/8 – 18 Months)	Older Infants (18-36 months)
Focus: Safety/Security	Focus: Exploration	Focus: Independence/Identity

✓ Sleep ✓ Smile ✓ Look around/visual tracking ✓ Cry ✓ Turnover ✓ Sit ✓ Reach ✓ Pick things up ✓ Imitate ✓ Mouth objects ✓ Cooing ✓ Laughing ✓ "Ba-ba" (beginning of language)	✓ Stands ✓ Walking ✓ Crawling ✓ Grabbing ✓ Playing ✓ Throwing ✓ Hitting ✓ Dump/fill ✓ 1st words ✓ Feeds self ✓ Motor skill development ✓ Exploring	✓ Talk ✓ Run ✓ Kick ✓ Climb ✓ Bite ✓ Tantrums ✓ "No" ✓ "Mine" ✓ Demanding ✓ Ego-centric ✓ Concrete thinkers ✓ Exhibits autonomy

Note:
If children are not exhibiting the behaviors described above within their respective age range, these are red flags and should be assessed further. Consultation with Supervisor, RRG, Child's Pediatrician, and/or Birth to 3 is recommended.

The achievement of the initial stage of development influences all others.
Based on their own history and experiences as well as their understanding of child development, parents may misinterpret their child's behavior as they begin to explore and become more independent.

For more information on Child Development, please review Appendices section beginning on page 10.

What is Social and Emotional Health?

Within the context of one's family, community and cultural background, social and emotional health is the child's developing capacity to:

- Form secure relationships
- Experience and regulate emotions and,
- Explore and learn

Social health reflects a child's developing ability to form close, secure relationships with other familiar people in their lives such as parents, relatives and other nurturing caregivers. This trusting bond helps children to feel safe in exploring their world. The term social competence is defined as a group of behaviors that permits each individual child to develop and engage in positive interactions with other people.

The following groups of behavior related to social competence are included below:

- responding to and initiating interactions between caregivers, siblings, other adults, and peers;
- participating in cooperative and social activities;
- managing behavior and resolving conflict;
- knowing about self and others;
- showing empathy; and
- developing a positive self-image and self-worth.

Primarily for older children, age 4 or older

Emotional development is closely tied to social development. It references how children view themselves and others; whether they are open to new challenges and exploring new environments, as well as learning to focus and be patient in the context of nurturing support by familiar caregivers. It is critical to note that infants and toddlers begin to understand and regulate their own emotions through their relationships with trusting adults.

Emotional competence has been defined as the ability to effectively regulate emotions to accomplish one's goals. Emotions are reactions, which are experienced differently by each individual. This is why different people can have different emotions when experiencing the same event.

Young children need to develop and safely express a variety of emotional responses so they can learn to adjust to new situations and achieve their desired outcomes. This results in a richer social environment and more satisfying relationships for the child and those around him/her.

Research findings show that infants are born with the ability to connect with other people in their environment. Infants recognize familiar voices and even match tone of voice to facial expression. The brain of the infant is designed to connect the newborn with other people who care for them. The infant's brain matures through the interactions between the infant and their environment.

The infant's communication of emotions and needs and the adult's response to these needs, establishes the learning pathways in the brain that lead to all other physical, cognitive, and emotional learning. The family's culture has an important influence in all areas of the infant's development, including their social and emotional development.

When children's social and emotional health is compromised, it can create significant challenges for children leading to failure in school, inability to make and sustain friendships, and negative feelings about themselves.

Supporting the social and emotional health of infants, toddlers and young children makes sense because:

- Early relationships set the stage for healthy or unhealthy brain development

- Poor early social, emotional and behavioral development predicts early school failure which in turn predicts later school failure
- Early intervention can address concerns and reduce later higher cost interventions

The following factors may affect the way children express their social skills or emotional competencies or the rate in which children acquire these skills/competencies:

- environmental risk factors such as living in an unsafe community, receiving care within a low-quality child care setting, lack of resources available in the community etc.,
- experiencing an adverse event – physical, psychological, sexual abuse or neglect
- family risk factors such as maternal depression or mental illness in the family, parental substance abuse, family violence, poverty, etc. and
- child risk factors such as a fussy temperament, developmental delay, and serious health issues.

All of these factors need to be taken into careful consideration when gathering information to fully understand and support children's social and emotional health.

Intensity and frequency of the following signs may indicate that a child or family needs assistance. They do not necessarily indicate definite mental health concerns and are to be used only as "red flags" or warning signs. In these situations, consult with your Supervisor, RRG, the child's Pediatrician or Early Intervention Specialist.

Infant (birth -12 months)	Toddler	Pre-school child	Parent
▪ Unusually difficult to soothe ▪ Limited interest in things or people ▪ Consistent strong reactions to touch, sounds, or movement ▪ Always fearful or on guard ▪ Reacts strongly for no apparent reason ▪ Evidence of abuse or neglect	▪ Displays very little emotion ▪ Unable to comfort or calm self ▪ Limited interest in things or people ▪ Does not turn to familiar adults for comfort and help ▪ Has inconsistent sleep patterns	▪ Consistently prefers to not play with others or with toys ▪ Goes with strangers easily ▪ Destructive to self or others ▪ Hurts animals ▪ Limited use of words to express feelings	▪ Known mental illness ▪ Substance use ▪ Limited coping skills ▪ History of trauma ▪ Frequent moves or lack of friends and supports

Social and Emotional Milestones

The following charts represent social and emotional development from birth to age 5. It includes examples of typical social/emotional development and potential concerns. [13]

[13] Center for Early Childhood Mental Health Consultation. Georgetown University for Child and Human Development.

Infants – Birth to 3 months

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development- Attachment:		
• Recognizes human language and prefers own mother's voice • Prefers human faces • Engages in mutual eye gaze • Begins to imitate smiles and other facial expressions	While changing Matthew's (6 weeks old) diaper, his caregiver talks softly to him. Matthew and caregiver make eye contact and the child coos as he moves his arms and legs. At the end of the day, Jamal's (3 months) mother arrives to pick him up. As soon as Jamal hears his mother's voice, he directs his gaze on his mother. When she picks him up, she smiles and looks at him while saying, "Oh, there's my big boy! Who is my big boy?" In response, he looks at her and smiles.	When Toby (1 ½ months) first arrives at the childcare center, his caregiver notes that his skin is pale, splotchy, and clammy. When his mother comes in to pick him up, he does not respond to her voice, nor does he attempt to make eye contact or maintain a mutual gaze with his mother or his caregiver.
Emotional Development- Self-Regulation:		
• Brings thumb or fingers to mouth to suck • Sleeps often • Enjoys being cuddled • Can typically be comforted by familiar adult when distressed • Cries to signal pain, hunger or distress	Lia (2 months) awakens and begins to cry. As the caregiver makes her way to the crib, Lia sucks on her fingers and begins to calm down. The caregiver picks Lia up and carries her to the rocking chair. As she rocks her, she gently touches Lia's face until she calms. Jason (3 months) lies on his back looking up at the mobile above him in the crib. In the crib next to him, Lilly awakens and begins to cry. Within a minute, Jason is also crying. The caregiver goes to them and says in a quiet voice, "Oh my goodness, what is wrong?" Lilly quiets when the caregiver comes near and then goes back to sleep. Jason continues to cry, so the caregiver picks him up and gently pats his back. He calms quickly.	Three-month-old Chandra has been attending childcare for over a month, but has no regular sleep patterns. When she does sleep, her body often jerks and she wakes up screaming and cannot be calmed or comforted by her primary caregiver. When her caregiver attempts to rock her, swaddle her, or give her something to suck on, she resists and continues to cry in a loud, unregulated manner.

Signs of sensory overload are as follows:

- **Movement**: The infant tends to show jerky movements of his/her arms and legs or thrusts his/her tongue. The infant also is likely to turn his/her head away, arch the back, squirm, and push himself/herself away when being held.
- **Facial expression**: Observe the facial expressions of the infant. Frowning, grunting, yawning, and grimacing are all signs of sensory overload.
- **Arousal/alertness level**: An infant who falls asleep suddenly when the environment around him/her is noisy may be shutting down due to sensory overload. If the infant is quiet and calm but suddenly begins crying a lot, it could also be a sign of sensory overload.
- **Vital signs**: A fast heartbeat, breathing irregularly, sweating, and a color change, especially in the face (from pale, flush, or blue), are signs of sensory overload.
- **Infant's response**: Observe the infant when you try to calm him/her. Dim the lights, turn off any loud noises, talk in a calm voice, remove any noisy and brightly colored toys, and rock and swaddle the infant.

Infants – Age 3-6 months

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development-Attachment:		
• Smiles socially in response to facial expressions and familiar voices • Gazes at familiar person • Tracks objects • Tracks familiar voice • Prefers familiar adults • Begins to mimic adult sounds/vocalizations • Laughs	Samuel (4 months) is lying on the floor on his stomach as his caregiver sits on the floor beside him. The caregiver rolls a ball in front of him and talks to him in a soft voice. Samuel looks at the ball, and when the caregiver speaks he raises his head to look at the caregiver and smiles. As the caregiver changes Olivia's (6 months) diaper, she says quietly, *"I'm going to tickle you! I'm going to get you!"* In response, Olivia smiles, looks up at her caregiver and laughs. The caregiver moves in close to Olivia and says, *"Oh, you are so ticklish! Oh my goodness, listen to those laughs!"*	Owen (5 months) is lying on the floor while his mother prepares a bottle. Although his mother knows he is hungry, he does not smile or respond when his mother comes near him with a bottle and says, *"Are you hungry, Owen?"* While taking the bottle, he does not look at his mother's eyes or face.
Emotional Development:		
Self-Regulation: Discovers and watches own hands Responds to own name **Expression:** Expresses emotions such as, fear, sadness, joy	Jackson (3 ½ months) and his mother arrive for group time at a local childcare center. As the mother carries Jackson into the center in a carrier, he examines his hands and puts his thumb in his mouth. The home visitor walks over and as she says, "Hello Jackson!" He looks up smiles at the home visitor. Ella (5 months) is napping when the tornado siren sounds. She awakens immediately and begins to cry loudly in response to the loud sound. As her caregiver approaches and picks her up, Ella clings to her and continues to cry until the alarm stops.	In the three months Brandy (6 months) has been in the classroom, the caregivers have never seen her smile or laugh. In fact, Brandy rarely shows any expression of emotion, including crying. Her caregivers have noticed recently that Brandy does not respond to her name like other children her age. When her grandmother comes to pick her up, she always walks directly to Brandy, picks her up and leaves without saying a word. Brandy rarely has any emotional reactions during arrival or departures.

Infants: 6-9 months

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development:		
• Reaches out to familiar adults to be picked up and held • Babbling • Seeks out adults for play • Can sit up by herself and can reach for toys	Carlos (6 months) is sitting in his high chair eating his lunch. After about 10 minutes he begins to cry when his caregiver tries to give him more bananas. His face turns red as he moves his hands in front of his face rapidly. When his caregiver asks him if he is all done, he reaches up to her until she picks him up out of the high chair. Rachel (9 months) crawls to her caregiver and then props herself up next to the caregiver. She laughs as her caregiver covers her face and then quickly uncovers it, saying, "Peek-a-boo!"	Tara (7 months old) is not yet able to sit up on her own. She has very poor muscle tone and prefers to lie on her back in her crib or on the floor. Occasionally, her caregivers will prop her up with pillows, but generally she usually slides down and ends up lying on her back again. She is not yet babbling, nor is she making attempts to seek out adults for play or attention.
Emotional Development- Self-Regulation:		
• Uses a blanket or other toy for security • Tries to make things happen • Seeks comfort from familiar caregivers • Expresses feelings of discomfort, anxiety, pleasure, hunger, and being tired • Acts anxious around unfamiliar adults	Henry (7 months) sits and hits at a toy. When he hits the button, the toy lights up and plays music. When this happens, his eyes light up, he laughs and then looks at his caregiver as if to say, "Did you see that!" Maria's (8 months) caregiver was sick, so a substitute was caring for her. When the new caregiver approached to pick Maria up after her nap, she cried and searched the crib anxiously for her favorite stuffed toy. The caregiver said, "Oh, you don't know me so well do you? Does your bear make you feel better?"	Mario (9 months) is startled very easily by loud noises, bright lights, or if someone touches him unexpectedly. When this happens, his body will begin to tremble as he cries uncontrollably. The crying typically continues from 20 minutes to one hour. When he cries, he sometimes gets the hiccups and spits up. His caregivers have tried holding him, rocking him, walking with him, and giving him a pacifier, but nothing will console him. On several occasions the caregiver has called his parents to seek advice and assistance when he cries for such a prolonged period of time. Once his father came to pick him up when he cried for over an hour. When his father arrived, Mario did not respond positively; rather, he cried with even more intensity.

Infants – 9-12 months

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development- Attachment:		
• Shakes head to signify "no" to an adult • Begins to use a few words and babbling to seek attention/express self • Babbles to self when alone • Enjoys exploring toys with an adult	Sarah (9 months) crawls across the floor until she reaches the plastic rings. She balances on one arm and picks one up, looks at it, babbles a few syllables, and then puts it in her mouth. Her caregiver comes over to her and says, "Sarah did you find something to chew on?" Sarah responds by taking the ring out of her mouth, laughing, and handing the ring to her caregiver. Keyla (10 months) sits on her caregiver's lap exploring a book. As the caregiver turns the page and describes the pictures, Keyla imitates the caregiver's tone of voice with an excited, "bah" and "whoa." After finishing the book, the caregiver says, "Well Keyla, it is time for your nap. Are you ready for your nap?" To this Keyla responds by shaking her head "no." The caregiver picks her up and talks to her softly and rocks her gently as she walks toward the crib.	When the home visitor arrives, Liam (10 months) is asleep. While he sleeps, the home visitor asks the parents if they would be willing to complete a developmental questionnaire. As she goes over some of the items, she notices the mother and father are looking at each other with puzzled looks. Sensing their confusion, she asks if they have any questions. Liam's mother reluctantly says, "Um, he doesn't do any of this," as the father nods his head. The home visitor talks with the parents about their concerns. When Liam wakes, the home visitor sees that indeed, Liam is highly unresponsive, is not babbling, does not make eye contact, and does not explore the environment.
Emotional Development- Self-Regulation:		
• Explores environment by crawling or walking away, but checks back frequently to ensure adult contact • Shows strong feelings of affection, anger, and anxiety • Exhibits intensely strong feelings toward parents or other primary caregivers	Sophia (10 months) has just begun pulling up and cruising around the couch in her classroom. As she moves around to the side of the couch, she keeps looking back at her caregiver to make sure she is still there. After Jada's (twelve months) mother drops her off, she begins to cry. Jada stands, looking out the door, crying. A few moments later, she walks to her cubby, picks up her blanket, and then walks to her caregiver with her arms up. Jada's caregiver picks her up and cuddles with her, saying, "I know you miss your mama. I'm sorry you are so sad."	McKenna's (9 months) caregivers think that she is fearless! She just started crawling and will crawl all around the room, without looking back to make sure a caregiver is there to support her. She is often labeled the "easy baby" because she is so agreeable and will willingly go to anyone, even if the person is not familiar. In fact, even when McKenna's mother or father are holding her or are in the room, she will readily go to a stranger

Toddlers: 12-18 months

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development-Attachment:		
• Imitates adult behaviors • Seeks out others to do things for them • Is curious about people. • Smiles/plays in front of mirror	Jaydin's (13 months) teacher hands each child a banana for snack. Jaydin goes to the teacher and takes her hand and pulls her to the play kitchen area. Jaydin says to the teacher "baba" to look for the toy banana. His teacher says, "Wow! You are looking for a banana!" They look for the toy banana in the kitchen cabinet. The teacher finds a toy orange and a banana and holds both fruits up. The teacher shows Jaydin both fruits and asks him "Is this the banana?" Jaydin says "no" and points to the correct fruit. The teacher says, "That is the banana, Jaydin. Let's eat our bananas at the table." Molly (18 months) climbs up the steps on the play structure in her classroom and stops and waves at Jillian before she goes down the slide. At the top of the platform, Molly notices herself in the mirror. She stops to look at herself and laughs. Jillian climbs up the steps and joins Molly at the mirror; both laugh as they look in the mirror.	When Toby's(13 months) mother arrives at the childcare center to pick him up, he does not respond to her voice, nor does he attempt to make eye contact or maintain a mutual gaze with his mother.
Emotional Development-Self-Regulation:		
• Uses familiar adults as a secure base when exploring environments • Shows strong sense of self by telling others what to do (*e.g.*, "You eat!") • Shows affection for familiar persons by giving hugs, smiles, kisses, etc. • Reacts to changes in daily routine	During group time, Martha (14 months) plays with a small group of children. When a new child or unfamiliar adult enters the area, she looks back at her father to make sure he is still there. When Cody (13 months) picks up the toy Martha was playing with, she shouts, "No," then moves toward the child and is about to bite him when a caregiver intervenes and says, "Martha, I know you are upset because you were playing with that toy. Let's find another toy so you and Cody can both play." At the end of the day, Joel's (16 months) grandmother comes to pick him up. When she walks into the room, he smiles and runs to her and hugs her legs.	Chandra (12 months) has been attending childcare for over a month, but has no regular sleep patterns. When she does sleep, her body often jerks and she wakes up screaming and cannot be calmed or comforted by her primary caregiver. When her caregiver attempts to hold her or verbally comfort her, she resists and continues to cry in a loud, unregulated manner.

Toddlers: 18-24 months

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development-Attachment:		
• Brings items of interest to caregivers to show, play with, read, etc. • Expresses difficulties sharing preferred items with others • Often says, "No!" to adults and other children • Enjoys receiving attention from others for accomplishments	Mya (19 months) runs to the bookshelf, picks up *Goodnight Moon*, and says "moon" as she turns and runs toward her teacher. Mya puts the book in her teacher's lap and says, "Read. Moon." Her teacher picks her up and says, "So you want to read *Goodnight Moon*?" Mya nods yes. After reading the first page, her teacher says, "Can you turn to the next page, Mya?" Mya turns the page and smiles broadly and claps when her teacher says, "Yay! You did it, Mya!" Josie (24 months), Neil (23 months), and Chen (21 months) are playing in the dramatic play area. Chen sits off to the side holding a doll. Josie is busy putting all of the plastic food in the sink. She says to Neil, "In here!" as she picks up more fruit and places it in the sink. In reply he shouts, "No! Me nana!" He grabs the banana out of the sink and runs across the room. Josie begins to cry and stomps on the floor while shouting, "No, in here! In here!	José (20 months) is extremely attached and dependent on one primary caregiver. This caregiver is the only person at the center who speaks Spanish, José's native language. When she leaves the classroom, even to use the restroom, José cries uncontrollably. Recently the center hired a Spanish-speaking floater who can come in the classroom and be with José while his primary caregiver is out of the room. Unfortunately, José does not respond to the new person and cries until his primary caregiver returns or his mother comes to pick him up.
Emotional Development-Self-Regulation:		
• Often experiences intense feelings when separating or reuniting with parents • Has mood swings in which expression of feelings can seem erratic • Expresses anger focused on others or objects • Shows pride in accomplishments • Wants to do things "my way"	At the end of the day, David's (18 months) father comes to pick him up from childcare. As soon as he sees his father he squeals, "Daddy!" and runs toward him. His father picks him up and says, "Hey buddy! I'm so happy to see you." David buries his face in his father's shoulder and hugs him tightly. As they are walking toward the door, Katie (22 months) stops them and says, "Katie draw" as she holds up a picture she drew. David's dad puts him down and looks at Katie saying, "Wow! You used a lot of blue in your picture." David then pushes his way between Katie and his father saying, "No!" Gentry's (23 months) mother practically runs into the room, sits him down and tells the teacher, "Sorry, I'm running late!" As soon as she leaves, Gentry gets up and runs to the door, sobbing "Mama. No mama go! No mama go!" His teacher walks to him and says, "I know you are so sad that your mama had to leave. Do you want to go and have some breakfast?" Gentry shakes his head no and sadly says, "Mama go." His teacher stands back as he goes to look at the picture of his mother in his cubby. After a few moments he stops crying. His caregiver then goes to him and says, "Oh, you know that we are having your favorite breakfast today, waffles!" Gentry turns his head, looks at her, and says, "Wapples!" She says, "Yes, let's go get some waffles." He runs to the table smiling and saying, "Wapples, please."	Rachel (19 months) frequently "gets lost" in the classroom. In the mornings when her mother drops her off, she usually cries for at least 30 minutes. The caregivers used to try to console her, but now they just give her a stuffed toy and let her cry. After she stops crying, she never participates in activities. No matter what is happening, Rachel always seems to have a blank stare on her face. When her teachers ask her questions, she does not respond. The only word she uses consistently is mama.

Children: 24-36 months

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development-Attachment:		
• Sees others as a barrier to immediate gratification • Participates primarily in parallel play • Identifies self with children of the same gender	Cooper (32 months), Jade (34 months), and Jocelyn (30 months) are playing at the water table outside. Jocelyn plays by herself, pouring water out of a pitcher onto a water wheel. She giggles as the water splashes in her face. Cooper is standing by Jade washing his doll in the water. Jade says, “My doll! My girl doll.” Cooper frowns and says, “My dolly.” Cooper keeps playing with the doll. Bella (28 months) loves to play outside. When her teacher announces that it is time to go outside, Bella runs fast toward the door, knocking into two of her peers.	Adrienne (30 months) has been in the same classroom for four months and she is only interested in going to the writing table during choice time. This would not concern her teachers so much, but she will not allow any other children to be near her during this time. She loves for teachers to come and work with her, but if another child comes near her she uses a loud voice to say, “No! Get out!”
Emotional Development-Self-Regulation:		
• Enjoys directing others • Frequently displays aggressive feelings and behaviors • Shows increasing awareness of being judged by others • Shows pleasure in mastering new skills • Asserts independence (*e.g.,* “Me do!”) • Attempts to regulate behaviors	When Madeline’s (30 months) caregiver announces, “It is time to clean up!” Madeline rushes around picking up toys and other materials in the dramatic play center. A teacher comes over to help and Madeline says, “Me do!” Her teacher says to her, “You are working hard at cleaning up Madeline, so we can have lunch.” Madeline says, “I'm done." Her teacher responds by saying, “Would you like to help me set the table for your friends?" Madeline says, "I help you" Madeline has a smile on her face and takes her teachers hand. During a playgroup time, the home visitor tells the children (and parents) that they will be playing with shaving cream at the discovery table. When Erin (35 months) approaches the table she looks at the shaving cream, then at her mother. Her mother says, “It’s okay to touch, see?” Her mother touches the shaving cream and puts a little on Erin’s hand. Erin quickly wipes it off on her shirt and stands by her mother as two other children enter the area. Jonas (32 months) and Desmond (34 months) stick their hands in and laugh while looking at each other. Erin looks at her mother and then slowly puts one hand into the shaving cream. She smiles and puts the other hand in.	Triton (34 months) has a great deal of difficulty interacting with others in the classroom environment. Last week, he began crawling on the table where other children were painting. He picked up a container of paint and poured it on the table. The other children asked the teacher for help. When the teacher tries to help or redirect Triton he becomes upset and uses inappropriate words or gestures

Children: Age 3-4 years

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development- Attachment:		
• Begins to include others in joint exploration and play. • Engages in pretend play with peers • Learns to take turns in conversations with peers • Begins to see the benefits of cooperation • Recognizes when a child is absent from the group. • Has secure relationships with adults	Jordan (3 ½ years), Sasha (3 ½ years), and Georgia (3 years) are playing in the restaurant created as a part of the dramatic play area. Sasha says to Jordan and Georgia, "Do you want a menu?" Jordan replies, "Yes, please." Sash hands him a menu, saying, "Here." He says, "Thanks." He then looks at Georgia and says, "Do you want to see, too?" Georgia nods yes and looks at the menu with Jordan. Sasha then says, "You guys should get the pizza, it's my favorite thing." Jordan says, "I'll have the pizza please." Georgia says, "Yes, pizza." Sasha goes and puts a plastic piece of pizza on two plates and carries them back to the table. She says, "Here's your pizza!" Jordan responds by saying, "Thanks, this is good!" Georgia picks up her piece and says, "Oh good, pepperoni!" At the lunch table, Jennifer (3 ½ years), Luca (3 ½ years), and Noah (3 ½ years) take turns passing dishes of food to each other, taking what they want and passing it along. They also pour milk into their cups. During circle time the teacher asks the children who is missing today. The children look around at each other and Danielle (3 years) says, "Jonathon?" The teacher responds by saying, "Nope, Jonathon's right here. Wave to everyone, Jonathon." Jonathon waves. Chloe (3 ½ years) says, "Kara?" The teacher says, "Yes, Kara is missing today. Her mommy called this morning to tell us that Kara is sick today." Chloe says, "I wanted to play with Kara today." The teacher replied, saying, "I know that you feel sad when Kara isn't here, Chloe. Maybe you could draw Kara a special picture to let her know how much you missed her today."	Hope (3 ½ years) likes things to be neat and orderly. During choice time she follows other children around, picking up after them and telling them to, "Stop messing." She refuses to take part in activities in which she might get dirty by verbally protesting or walking away. Hope will spend extended periods of time setting up displays of her favorite toys and if another child touches them, she cries and is very difficult to console.

Emotional Development- Self-Regulation:		
• Shows concern/empathy for others • Begins to show greater self-regulation and cooperation with peers • Shows increasing fears (e.g., dark, monsters, etc.) • Can wait for a short time. • Enjoys daily routines and doing more for themselves	Max (4 years) is playing with two friends with blocks and trucks. The boys are making the cars go down a block ramp very fast. Wes (three years) is watching the boys play with a smile on his face. Max looks up and says, "Wes you can use this yellow truck." Wes looks down. Max gets up and brings the truck over to Wes, they sit down and Wes puts his car down the ramp, Max says, "That was fast!" "Watch me next." In the block area, Lizzy (3 ½ years) and Ryan (3 ½ years) are working together to build a block tower. After a few minutes of building, they decide that after the building gets as tall as they are they will knock it down at the same time. Once the building reaches the specified height, Ryan and Lizzy count to three and push it over, shouting, “Whoo! Hoo! We did it!” When it is time to lay down for nap time, Jasmine (3 years) begins to cry softly. When the teacher comes to check on her, Jasmine says, “Can you turn the light on brighter?” The teacher asks her if she is scared and Jasmine says, “A monster is in the closet.” The teacher opens the closet door to show Jasmine that there is no monster in the closet. The teacher asks Jasmine if she would like to move her cot closer to the teacher's desk where there is a brighter light. Jasmine nods her head, "Yes." The teacher says, “See, it is okay, no monsters here.” Jasmine smiles and lays down when her teacher softly rubs her back.	Carmen (3 years) is experiencing a lot of fear. At school, his teachers struggle, because his fears seem to be affecting his daily routine. He is afraid of the toilet, crying and standing back from the bathroom when others line up. The teachers had to have his parents sign a consent that someone could go into the restroom stall with him. He is hesitant to climb the steps on the bus, so someone has been carrying him to his seat. When the air filter in the fish tank makes noise it startles Carmen, so he doesn't go near the discovery area. When the teachers attempt to provide him support to overcome his fears (stay close by, use words of encouragement, etc.) he begins to cry and cannot be calmed for extended periods of time. His parents have also expressed concern to his teachers because he exhibits similar behaviors at home and often has nightmares as well.

Children: 4-5 years

Social and Emotional Milestones	Examples of Typical Social and Emotional Development	Examples of Risk Factors for Potential Social and Emotional Concerns
Social Development- Attachment:		
• Acts out roles with other children • Enjoys cooperative activities • Easily participates in individual, small, and large groups • Makes up imaginary games and may invite others to play	The first two weeks of preschool, the teacher regularly has the children act out how to follow the classroom rules using role-plays with each other. During circle time, all children sit together and participate in songs and activities. After circle time, Kim, Sanjay, and Sara choose to play at the discovery table. They put on smocks and begin playing. Juan and Tommy decide to go to the block area. They quickly get out the blocks and begin building together. Carla and Melissa go to the computer center and work independently on two separate computers. Macy, Harold, and Marcie go to the writing center to work with the teaching assistant on writing their names.	Four-year-old Leo rarely joins in with activities occurring in the classroom. He often talks quietly to himself, but his teachers and peers cannot understand his speech patterns. If given the choice, Leo would spend all of his time sitting in a quiet part of the room running a toy train across the windowsill. His behavior is often reported by the teachers as being unpredictable. Sometimes he will get up and move if asked by a peer or teacher and other times he might lash out by, scratching those closest to him.
Emotional Development- Self-Regulation:		
• Recognizes differences in others (e.g., race, disability, height, weight) • Expresses and array of emotions with increasing control • Is aware of own feelings as well as the feelings of others • Verbalizes feelings • Shows empathy for others	Each morning during circle time, the teachers allow each child to ask a question or share something they have been thinking about. Today, Finn shares that he saw someone in a wheelchair today on the way to school. He asks the teacher, "Why were they rolling instead of walking?" The teacher explains that sometimes people have something happen to their legs so they can't walk very well. She asks if any of the children have ever seen anyone in a wheelchair before. Will shares that his grandpa rides in a wheel chair, and Lydia says that her uncle has one too. The next day the teacher brings in a wheelchair for the children to look at and explore. When the children are playing a game, an argument begins between several children over who should go first. When the teacher sees this, she asks the three children to go to the problem-solving table until they can come up with a solution to their problem. After a few moments they decide that Evie should go first because it was her idea to play the game, Kareem should go next because he asked to play with Evie first, and So-Yung should go last because he was the last to ask to play. The teacher asked if everyone was happy with that solution. All nodded yes and ran off to play.	Mary (4 1/2 years) often engages in outbursts inside and out of the classroom. When other children get too close in proximity to her play she will push the other child away. If a child comes too close or gets a toy from her, she will often tantrums for up to 10 minutes, and she often has to be removed to a safe area of the playground or classroom for the safety of her and others. Afterwards, she shows little to no remorse for what she has done. When her teacher asks her why she is doing this, she generally replies, "He (or she) was taking my things."

To access additional information and resources, please review Appendices section, beginning on page 24.

Assessing Safety and Risk for Children 0-5 – Intake and Ongoing Services

Background: Young children are at especially high risk for maltreatment and death. In July 2014, The Office of the Child Advocate issued a report reviewing 82 fatalities of children between 0-3; 24 families had prior, recent, or current involvement with DCF at the time of the child's death. Many of these families had multiple risk factors including:

- History of DCF involvement as a child
- History of substance use
- Intimate partner violence
- Mental health issues (parents)
- Criminal history
- Trauma history

CT data reveals that infants are more likely to die from unsafe sleeping conditions than from child abuse, car accidents, choking, drowning, falls, or any other source of accidental injury.

In January 2015, the Office of Research and Evaluation conducted a study of child fatalities involving children ages birth to three that occurred in CT from January 2005 through May 2014 as a means to identify potential risk factors common among families who experienced a child fatality and to help identify practice improvements and strategies to reduce the likelihood of a child fatality. This analysis identified the following factors to be statistically significant:

- Child age (65% of the children who died were less than 6 months of age)
- High risk newborn (children between the ages of 0-3 with medical issues)
- Unsafe sleep environment
- Parental risk factors present (substance use, mental health, CPS history)
- Parental needs and connection to services (issues not thoroughly assessed to gauge level of impact on the family; needs were not appropriately matched to services)
- Frequency of caseworker visits (more frequent parent/caseworker visitations were less likely to have a child fatality)
- Young parents (between the ages of 20-24)
- Perpetrators were typically household members
- Lack of connection to services in the community including home visiting and routine health care/primary care providers, and
- Lack of fatherhood engagement, particularly with the unrelated male caregiver.

This population is also vulnerable to developmental delays; more than half of young children in foster care experience developmental delays which is 4 to 5 times greater than the rate found among children in the general population. Young children are also vulnerable because they are

less visible in the community. Infants and toddlers do not attend school and, if not enrolled in childcare or other programs, may not be visible outside the family.

Young children are also totally or primarily dependent on others to meet their needs.

Given their special vulnerability, it is important that we make careful and purposeful assessments when conducting visits in the homes of young children and that our intervention and supervision targets those areas of concern and vulnerability. We cannot or should not do this alone.

When working with young children and their families, it is important we collaborate internally and with the community to help inform our assessment, including identifying safety and risk concerns, assessing strengths, needs, and protective factors of the family, and connecting them to appropriate resources and services in the community promptly throughout our intervention. Intervening early has been shown to have significant improvement in long-term outcomes for children.

This consultation and support includes but is not limited to: primary care providers (health care providers), early intervention specialists including home visiting, DCF supervisors, managers, and RRG staff. This attention to young children should occur any time there is a child between the ages of 0-5 in the home regardless of whether the child is the "index" case (child of concern).

The following information provides a basic framework for assessing the needs and safety of infants and toddlers that come to the attention of the DCF. The goal of this section is to provide areas of focus for our social work and supervisory staff that need to be considered and explored when assessing the safety and risk of young children. These areas are divided as follows:

- Environment
- Caregiver Factors
- Child-Specific Factors.

For each component there is a list of possible risk factors with suggestions for ways to explore these factors. It is important to keep in mind the child's vulnerability. This information is intended to augment, not replace, the Social Worker's standard and ongoing assessment process.

Key Practice Principles for Children 0-5:

- The safety of the infant or child is the essential consideration.
- The infant's or child's vulnerabilities, including trauma history, necessitate extra vigilance when assessing his or her protective and care needs.
- All decisions should be based upon high quality, holistic risk assessment that takes into consideration the child, the family (birth, foster) and the social context.
- Early establishment of a healthy attachment to a consistent caregiver is essential to positive long-term outcomes. Establishment and maintenance of attachment must be critical elements in case planning.
- It is essential that work occurs in collaboration with other key providers and professionals including primary care providers, early intervention specialists and others.

Environment

It is essential to assess the home and home environment with specific attention to safe sleep environments, household composition and atmosphere.

Safe sleep (it is essential that attention **be paid to sleep environment for infants ≤ 12 months of age).**

Assessing safe sleep involves accessing the family's rituals and routines both historically and in the present when it comes to infant care. **All caregivers must participate in the safe sleep conversation** (preferably at the same time), including **older siblings** when they are an integral part of the caregiving network. Obtaining information and feedback about the family's rituals and routines is by and large an act of asking curious and relevant questions. These questions can include, and are not limited to:

- What are your child's sleeping routines? (Who, when, where, how)?
- What times of the day and night does your child routinely enter a sleep period?
- What elements tend to help soothe and comfort your child when he or she is preparing for sleep?
- Who is responsible for your child's sleep time and who taught these responsible persons about safe and effective ways to transition infants to sleep?
- What time did your child go to sleep last night and when did he awake?
- When the baby wakes up during the night, who tends to the baby and how is the baby put back to sleep?
- When you can't get your baby to stop crying at night, what do you do? (Provide other options if the parents say they bring the baby in bed with them, lay on the couch together, etc.).
- Do you ever fall asleep while feeding your baby in the middle of the night?
- What do you understand about the dangers of co-sleeping with infants?
- Who assists with caring for your child? Are they aware of safe sleep practices and environment?
- In what ways do you and your family monitor nighttime sleeping and naps?
- What do you and family members do when your child awakens?
- How is your sleep and overall schedule impacted by your child's sleeping rituals?
- What do you expect from your family and caregivers when they assume responsibility for the child's sleep?
- Who has been most helpful and supportive when you have questions or concerns about your child's sleep?
- What do you carry over from your own family of origin that you believe is helpful in the sleep routine?
- What have you decided to change from what you previously learned in your family about safe sleep? Remember that there is increased risk of unsafe sleep deaths with caregiver substance use. Consider other safety and risk factors and the needs of the caregivers and child and assess how these might impact the safe sleep practice and environment.
- It is important to assess and reinforce safe sleep at each visit and with each caregiver.
- Observe the infant's sleeping environment – crib/basinet free of hazards, sleep routine

Safe Sleep Policy:
http://www.ct.gov/dcf/lib/dcf/policy/pdf/44120800.pdf

Safe Sleep Practice Guide: http://www.ct.gov/dcf/lib/dcf/policy/pdf/Safe_Sleep_-_practice_guide_FINAL.pdf

A similar line of "appreciative inquiry" can be useful in discussing meal times, curfews, family chores, family roles, coordination of schedules, supervision of young children and so forth. Along with observations of the physical environment, entering into conversations with families in this way is a method of identifying the family's routines, structure, existing strengths, and areas that would benefit from change.

Note: Research suggests that are child whose parents express difficulties feeding the child or report the baby cries for prolonged periods are at greater risk of abuse.

Household composition

Find out who lives in the home or visits regularly and what role they have in the care of the child, including any potential trauma history that the child may have experienced with specific visitors.

Note: The presence of unrelated adults, especially males, is associated with an increased risk of child abuse and death.

- ☐ It is important to assess whether the home has age-appropriate child-proofing. Safety Tips: http://www.safekids.org/safetytips)
- ☐ Does the caregiver have access to an appropriate child car seat and have knowledge about use and installation? (http://www.safercar.gov/parents/CarSeats/Car-Seat-Safety.htm)
- ☐

Note: Observe whether the child is contained in a car seat during visits with the family.

Living Conditions and Cleanliness of Home

Pay attention to:

- ☐ Overcrowded conditions. This should raise concerns about safe sleep environment – does the infant sleep alone or with adults? Is there adequate bedding and furniture? Is the crib being used for storage? Is there a separate sleeping area for the child?
- ☐ Infestations (bugs, rodents).
- ☐ Unsanitary living conditions or hazards, open or broken or missing windows or screens.
- ☐ Is the furniture too close to the windows? (Screens will not keep a child from falling out of a window.)
- ☐ Window shades with long cords may pose a choking hazard for young children.
- ☐ Look for drug paraphernalia, weapons and indications of gang involvement, as all raise concerns about safety (the association between safe sleep and substance abuse is significant).
- ☐ Are there toys or other objects in the home to help stimulate growth, development, and play?

Household Safety Checklist: (http://kidshealth.org/parent/firstaid_safe/home/household_checklist.html)

Financial Conditions and Poverty

Infants and toddlers in low-income families are twice as likely to be exposed to abuse and neglect.

- Be aware of financial challenges and poverty which research has shown increases exposure to abuse and neglect and results in poorer developmental outcomes.
- Does the family receive WIC?
- Does the family have an adequate supply of food, diapers, formula, wipes, and clothing? Are they aware of resources in their own community if they need these items (*e.g.,* diaper banks, food pantries)?

Note: **Poverty alone does not constitute abuse or neglect**. Poverty, in addition to other risk factors, increases the likelihood of young children experiencing abuse or neglect. A thorough assessment of risk factors and their impact on the child and the family is essential.

Access to Social Supports and Isolation

Lack of family and community support has been determined to increase the risk of abuse for infants and toddlers. Parents who are experiencing significant stress may have limited peer, family or service supports and may be less inclined to seek out social contact. Many families may be reticent to initiate contact with family members due to "a falling out" and concern that they would be denied help.

Promoting and enhancing social supports for families with infants and toddlers is a critical step in reducing the likelihood of abuse and neglect. In fact, it may be the most critical factor in the family's success.

- Do the caregivers have connections and support and are they willing to utilize these resources for support? The lack of family and community support has been identified as a contributing factor to increased risk of abuse during infancy.

Families with young children are often socially isolated especially if they have a child who is exhibiting behavioral issues or developmental delays. Exploring the family's natural supports can prompt the family to begin thinking differently about their support system.

Caregiver Factors – It is important to assess risk factors for primary caregivers, all adult household members, and those having direct access to the child.

If there are concerns related to substance use, mental health or IPV, please consult your Supervisor and RRG.

Substance Use

Children are at a much higher risk of harm during infancy when one or more of their parents or caregivers or others living in the home are using substances. It is important to assess the impact of their substance use on their capacity to provide constant and consistent care and supervision for infants and toddlers. It is also important to assess to what extent others using substances in the home present risks for infants and young children in the home environment.

Remember: there is a relationship between substance use and sleep-related deaths so it is important that this be addressed fully with caregivers and documented in case narratives and protocol. Consultation with RRG staff is recommended to assess risk and identify appropriate treatment interventions.

- ☐ Assess immediate caregivers as well as others in household.
- ☐ Ask open-ended questions and observe individuals and the environment.

The following questions can be used to gather information to determine the level of substance use in the home and whether further assessment is needed. **Two or more positive responses indicate possible abuse or dependence and the need for further assessment. Answering "no" to all questions on the UNCOPE* does not rule out the possibility of an alcohol- or drug-related problem.**

- ☐ **U** = have you continued to **use** alcohol or drugs longer than you intended? Or, have you spent more time drinking or **using** than you intended?
- ☐ **N** = have you ever **neglected** some of your usual responsibilities because of alcohol or drug use?
- ☐ **C** = have you ever wanted to stop using or **cut down** alcohol or drugs but couldn't?
- ☐ **O** = has your family, a friend, or anyone else ever told you they **objected** to your alcohol or drug use?
- ☐ **P** = have you ever found yourself **preoccupied** with wanting to use alcohol or drugs? Or, have you frequently found yourself thinking about a drink or getting high?
- ☐ **E** = have you ever used alcohol or drugs to relieve **emotional** discomfort such as sadness, anger or boredom?

**A workgroup was established to review our Structured Decision Making Tools (SDM) and develop specific recommendations to enhance the quality of our assessments. After conducting considerable research, the workgroup is recommending utilization of UNCOPE. This tool has been implemented in multiple jurisdictions and has demonstrated success in screening adults for substance use.*

- ☐ Observation
    - o of individuals – do they appear to be under the influence?
    - o of environment – is there drug paraphernalia?
- ☐ Screen for Infant Exposure to Substances

- Did you continue to smoke, drink, or use drugs while pregnant? Can you recall how often? Are you aware of the impact?
- Positive toxicology
- Signs of withdrawal
- Medical complications
- Special health care needs including developmental delays

- Information gathering – if a primary caregiver is on Medication Assisted Treatment, obtain a Release of Information to discuss with the provider. Consultation with the RRG Substance Abuse Specialist is recommended either prior to or following the call with the provider.

Determine:

a. Does substance use affect the caregiver's ability to make sound judgments regarding the welfare of the child?
b. What behaviors are resulting or have resulted from the caregiver's substance use that may put the child at risk?
c. What behaviors or actions have been taken by the caregiver to manage issues related to substance use?

Parental substance abuse is often exacerbated by other risk factors, including but not limited to:

a. Poverty
b. History of Trauma
c. Young age
d. Poor pre-natal care and nutrition
e. Intimate Partner Violence (IPV)
f. Homelessness
g. Unemployment
h. Poor physical health
i. History of DCF or DDS involvement as a child
j. Mental illness
k. Stress
l. Low self-esteem
m. Poor parenting skills
n. Criminal activity and incarceration

CAPTA Requirement

CAPTA requires that health care providers provide notification to DCF of *all* infants born substance-exposed. In cases in which a practitioner suspects abuse or neglect, a referral consistent with mandated reporting must be made. It is then the responsibility of CPS staff to assess the level of risk to the child and other children in the family and determine whether the circumstances constitute child abuse or neglect under state law. In cases involving a substance-exposed infant, DCF is required to develop a "plan for safe care." This plan is developed in collaboration with the family, the discharging birthing hospital, and potential service providers.
DCF High Risk Newborn Policy: http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=394016

For more information regarding substance use, please access the link below for the Clinical and Community Consultation Support Division (CCCSD) SharePoint site:

http://bhm.dcf.ct.gov/sites/BHM/SU/SitePages/Home.aspx

Note: This link is not accessible to those outside of DCF.

Mental Health

Research indicates that caregivers who have a history of depression, postpartum depression, anxiety, delusional thoughts or past history of suicide attempts are at heightened risk, particularly in the following conditions:

- If a parent or caregiver symptoms significantly impair daily functioning or specific parenting capacities such as responsiveness, judgment, and stress management;
- If a parent or caregiver experiences mood swings, appears emotionally unavailable to an infant or young child, or does not feel attached to the child;
- If a parent or caregiver displays delusional beliefs or hallucinations involving the child;
- The are co-occurring risk factors such as intimate partner violence, substance use; or
- If a parent or caregiver is homicidal or suicidal.

If one of these conditions exist and there is no alternative caregiver to meet the needs of the child, consultation with the Supervisor and RRG is required to assist in safety planning efforts (including the need for a CR-CFTM), identifying treatment needs, and resources for both the child and parent.

For babies and infants, maternal depression may hamper the mother's capacity to empathize with and respond appropriately to her baby's needs, as well as limit the level of interaction and engagement between mother and child, often resulting in an insecure attachment. The symptoms of depression - low energy, sadness, sleep problems, poor memory – can impact a mother's ability to fully engage and benefit from services that are ultimately going to be beneficial to the child. Social isolation and lack of concrete resources (*e.g.,* childcare and stable housing) often contribute to and sustain maternal depression. Promoting the family's protective factors can further support the family and enhance child well being.

CPS history

Parents with CPS history as a child may have limited exposure to positive parenting.

- Assess how the family's past history is impacting their current level of functioning. Look for trends or patterns in behavior, relationships, etc.
- Families with prior CPS history and involvement with DCF as a child are more likely to maltreat their children.
- Caregivers with prior history of abusing or neglecting a child are more likely to be identified as a perpetrator.

Utilizing genograms to create a family blueprint provides opportunities to better understand the family's past, present and future.

Recognizing our co-workers as collateral contacts, as well as providers who may have worked with the family at different periods of time, will help us learn more about family dynamics, relationships and connections. Reach out to Adolescent Social Workers who may have had the parent on their caseload as an adolescent. Learn from past relationships and dynamics to better inform present and future planning.

Intimate Partner Violence (IPV) and Domestic Violence

Research has clearly demonstrated that infants and toddlers are at higher risk in households in which IPV is present.

The following open-ended questions can be used to determine if IPV is an area of concern. When IPV is identified, consult with your Supervisor and IPV Consultant.

For Caregivers:

- Tell me about your relationship.
- How do you and your partner get along?
- Every couple has disagreements. How do you and your partner resolve conflict?
- What happens when you disagree?
- How are your arguments resolved?
- Do either of you yell at each other? Push or shove each other?
- Do arguments escalate to the point of hitting each other? Throwing something? Threatening to hurt each other?
- Has anyone ever called the police when you were fighting?
- Was there violence or fighting during the pregnancy?
- Does your partner restrict visitors or not allow anyone to visit the home?
- Is your child present during arguments? If so, how does your child react when there are arguments in the home? Do you notice any changes in the child's behavior after an argument?

Observation:

- Weapons
- Holes in walls
- Broken items and furniture

For more information regarding IPV, please access the link below for the Clinical and Community Consultation Support Division (CCCSD) SharePoint site:
http://bhm.dcf.ct.gov/sites/BHM/IPV/SitePages/Home.aspx
Note: This link is not accessible to those outside of DCF.

Parental Age

Younger age is associated with increased risk of abuse and neglect. This should be considered in your assessment of the family.

Trauma History

See Practice Guide (page 10) and Appendices (page 4) for more information.

Poor Parenting Skills and Unrealistic Expectations

Unrealistic expectations, lack of sensitivity or responsiveness to the child's needs, rigidity towards the infant's behavior, poor parent-child attachment and lack of knowledge of typical child development or behaviors have all been associated with increased risk of abuse.

Parent

Ask about:

- ☐ Physical health
- ☐ Cognitive limitations (see section in Practice Guide on Cognitive Limitations)
- ☐ Support systems and utilization of supports
- ☐ Parent perception of the child and his or her description of the child (*e.g.,* identify three words to describe your child)
- ☐ Knowledge of child development – feeding, nutrition, expectations, supervision appropriate to child's development
- ☐ Does the parent have any concerns about their children?
- ☐ Assess the parents' feelings about being a parent
- ☐ Assess the individual needs of the parents and evaluate their capacity to parent and respond to the needs of their children

Parent/Child Attachment and Interaction & Caregiver Attachment

The following should be observed during all home visits and documented.

- ☐ Is there frequent or infrequent contact (note verbal and physical interactions)?
- ☐ How does the caregiver respond to the child's cues? Is there a muted response? Intrusive response? Positive emotion? Failure to recognize cues?
- ☐ Is the caregiver able to comfort the child when distressed?
- ☐ Does the caregiver initiate interaction? Does the caregiver ignore, demean, criticize or yell at the baby? Does the caregiver often hug, praise, or kiss the child?
- ☐ Is the caregiver gentle or rough with the child?
- ☐ Does the caregiver seem to delight in the play or accomplishments of the child?
- ☐ What is the pair's capacity to play together?
- ☐ Does the caregiver present as controlling and unwilling to allow the child to explore?
- ☐ Does the caregiver ignore the child when the child "returns" from exploring or not pay attention to what the child is doing?
- ☐ Is the caregiver physically and psychologically accessible? Does he or she hold the child close to comfort?
- ☐ Evidence of "serve and return" interactions? (Is it evident that the parent responds to the child and the child responds to the parent in an ongoing manner?)

See page 9 in this Practice Guide for information on serve and return.

Child's Attachment to Caregivers

- What is the child's affect when interacting with the caregiver (joyful, angry, relaxed, engaged, somber, sad, withdrawn, or anxious?)?
- Does the child make an effort to physically connect with the caregiver? Does the child initiate negative contact (kicking, hitting, *etc.*)?
- Does the child seek out the caregiver for help? Do they hold mutual eye gaze? Does the child ignore the caregiver or attempt to solve problems on his or her own?
- Does the child become whiny and demanding without calming? Is the child difficult to soothe? Does the child actively seek comfort from the caregiver?

Red Flags: Child averts eye contact, arches, appears stiff or rigid, displays irregular breathing, rocks back and forth, is hypervigilant, or is willing to go to anyone (strangers).

Note: Culture has a major influence on parenting beliefs, how good parenting is defined, values, expectations, and behaviors, as well as on children's relationships with their parents. Asking questions and understanding cultural differences in these areas is important in our overall assessment of the family.

Child Factors

A number of child specific risk factors have been identified in the research as follows:

1. **Premature and low birth rate**: Babies born prematurely or those who have a low or very low birth weight are at greater risk of harm from abuse and neglect. This increased risk may be due to infant health problems and the parent's inability to handle this additional responsibility while dealing with many other issues. The factors that increase the likelihood of premature birth or low birth weight and impact postpartum care include:

    a. Poverty
    b. Social isolation
    c. Intimate Partner Violence (IPV)
    d. Stress and depression
    e. Maternal smoking or substance use
    f. Poor nutrition
    g. Poor pre-natal care

2. **Pre-natal exposure to alcohol and drugs**: Research supports that infants born with exposure to maternal substance abuse are at higher risk of abuse and neglect. This increased risk may be due to the combination of the infant's complex health and care needs (including the impact upon the developing brain) and impaired parenting capacity where substance use continues following birth.

    Note: Fetal Alcohol Syndrome Disorder (FASD) may be noted at birth or at well child visits because of facial dysmorphia (though this is only present in the most severe cases of prenatal alcohol exposure). It is important that there be ongoing attention to developmental milestones and social and emotional behaviors throughout a child's early years by

pediatricians and other health care professionals. A high percentage of children entering foster care are on the FASD continuum and it is often not until very late, *e.g.,* when a child enters school, that the developmental delays are recognized and often misdiagnosed.

3. **Disability:** Research has identified that young children with speech, language, or learning difficulties are more likely to be involved in the child welfare system.

Child Vulnerability

Children from birth to age 5 are always vulnerable. Infants and toddlers are particularly vulnerable to the emotional effects of abuse and neglect. Some children are more vulnerable to the effects of child maltreatment than others. In general, very young children (infants, toddlers, and preschoolers), pre-verbal children, and children with developmental delays, or physical or medical conditions are more likely to experience physical abuse and neglect by their caregivers. Child vulnerability is not based on age alone. Child vulnerability is the degree to which a child can avoid or modify the impact of threats of harm. The following must be considered when assessing for child vulnerability:

- **Child's ability to protect self**: some children can and do find ways to avoid harm. A child who is able to escape from an assault or call for help has increased his or her own ability to self-protect. Children who cannot get away from harm or cannot defend themselves (physically or emotionally) have increased vulnerability.
- **Child's ability to communicate**: Pre-verbal children cannot express themselves or their frustrations verbally. Physical, emotional, and developmental conditions impact the child's ability to tell others.
- **Child's developmental delays or disabilities**: Children with developmental delays or disabilities may have reduced coping skills, and may be less able to defend themselves or disclose their distress. There is increased vulnerability of children with developmental disabilities. They may be more isolated, may lack knowledge of boundaries, and may have increased dependency on caregivers. A child who is cognitively limited may be vulnerable due to a limited ability to recognize danger, to know who can be trusted, to meet his or her basic needs, to communicate concerns and to seek protection.
- **Child's behavior or temperament**: Children with emotional, mental health, or behavioral problems may cause feelings of stress, frustration, and failure on the part of caregivers and may provoke an inappropriate action.
- **Child's behavioral and emotional needs**: Children with behavioral health or emotional issues may have needs beyond what the parent can provide.
- **Child's physical special needs**: Children with physical challenges are more dependent on others to provide care and meet their special and basic needs. Parents may be ill equipped emotionally or financially to handle the child's needs or lack the protective capacities that are required.
- **Child's visibility**: Children who are isolated, do not have extended family or community support, or who are not routinely seen by others outside the family may be more vulnerable.

Primary Care Visits

Primary care visits provide an opportunity for someone familiar to the child and with the expertise to assess the child's overall health and development to see the child. It is important for the Social Worker to determine whether the family has followed through with all scheduled pediatric appointments. If there have been missed appointments, it is important that the infant be seen promptly. The Primary Care Physician can determine whether the child is doing well and identify areas of concern, including developmental concerns and evidence of trauma.

Once a family has signed a release, it is important that the medical form be sent to the pediatric office quickly to ensure medical information is obtained prior to case closing. There may be cases in which having direct communication with the pediatrician or pediatric office is preferable. This can be discussed in supervision. This communication may identify concerns or risk factors within the family that may not be communicated in the documentation they provide to DCF.

- ☐ Ask about concerns with the family
- ☐ Ask about concerns with the child, including development
- ☐ Ask about evidence of trauma or adverse events

If staff have not been able to observe the child awake or interacting with the caregivers during visits, Social Worker must ensure speak to someone who has (either the child's primary care provider or early intervention specialist).

Timely and ongoing pediatric physical and dental care is essential to maintaining and ensuring good health throughout the first eight years of life. Tooth decay is the most common chronic childhood disease, affecting 11% of young children between one and five years old. [14]

Infants:

Ask about:

- ☐ Pre-natal care and exposure to drugs or alcohol and birth history
- ☐ Potential health problems - child born HIV, HBV positive
- ☐ Trauma history and adverse events
- ☐ Infant care: routines (bathing, feeding, sleeping)
  - o Is the parent having difficulty breastfeeding?
  - o Is the parent struggling to feed the baby?
  - o Is the baby gaining weight?
  - o Is the baby crying excessively?

[14] National Survey of Children's Health, NSCH 2011/12. Data Resource Center for Child and Adolescent Health website.

Older Infants

Ask about:

- Behaviors (social, exhibiting aggression, exploring, becoming more independent
- Sleeping, eating issues
- Trauma history and adverse events

High Risk Newborns (HRN) – (CAPTA requires that DCF be notified of infants born to mothers with positive toxicology).

Please access the following HRN policy below:
http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=394016

Development (link to age specific development guide – see Missouri example) https://uwmadison.app.box.com/s/tzm58e4ss1hc1db02y5dwmazf7ab5pz5)

DCF Response

When assessing a report for response, the CPS history of the alleged perpetrator as an adult or child as well as those individuals having access to the child is important to collect, categorize and define in order to have a clear understanding of child safety and risk and a clear understanding of the family's protective factors.

The assessment for children 0-5 must be viewed through the lenses of child development and trauma and from an attachment perspective.

Initial supervisory consultation: Intake staff should be utilizing the direction provided by the assigning supervisor of the case as a spring board to understand the complexities facing the family and how that information is used to make an accurate assessment. More important is the need to look at current history, including trauma history, and critically review past reports for areas of concern due to re-occurring themes and patterns. All pertinent case history should be documented in this initial supervisory conference narrative.

0-5 follow-up supervision: Once it has been identified that a household has children within this age range, it is incumbent upon the Social Worker to have a follow-up discussion with his or her supervisor that takes into account the following information:

- ages of the child(ren) in the home;
- age of caregiver;
- developmental milestone(s);
- non-custodial parent-child interaction and relationship;
- care and supervision of the child;
- sleeping arrangements;
- medical, psychological (*e.g.,* attachment styles), cognitive and behavioral indicators or concerns;
- CPS history and impact on current situation;
- trauma history;
- parental risk factors: IPV, substance use, mental health and impact on parenting;
- the family's protective factors and how they can mitigate concerns;

- the parent's exposure to ACE and the parent's own trauma history;
- individuals frequenting the home and risk they may present; and
- the child's overall physical appearance.

Frequency of visitation with the family will be determined in supervision based on presenting issues and risk factors. Consultation and support from the Supervisor and Manager and RRG staff is critical given the vulnerability of this population and risk factors that may exist within the family.

Special Assessments: A thorough discussion of FASD (Fetal Alcohol Syndrome), Safe Sleep, Shaken Baby Syndrome, High Risk Newborns, fatalities, CAPTA Part C and other identified special concerns should occur and be documented by the Social Worker. Social Workers must obtain pre-natal information from the mother's health care provider in all high-risk newborn cases.

Documentation: Throughout the intake, all information, assessments, observations, consultations and supervisory guidance should be clearly documented in a manner that illustrates DCF's involvement and the rationale for case decisions.

"Unknown information is different than unasked questions." There needs to be a clear assessment of risk factors and safety concerns and how DCF is addressing them.

See Documentation Guide for more information: http://cw.dcf.ct.gov/sites/cw/default.aspx

Note: This link is not accessible to those outside of DCF.

Birth to Three

The Child Abuse Prevention and Treatment Act (CAPTA) provision at section 106(b)(2)(B)(xxi) requires that states have provisions and procedures for the referral of children under the age of three who are involved in substantiated cases of child abuse or neglect to early intervention services funded by Part C of the Individual with Disabilities Act (IDEA).

DCF is required to refer children under age 3 who are involved in a substantiated case of abuse or neglect and there is a developmental concern or qualifying diagnosis (Down Syndrome, autism, blindness, deafness, etc.) to Birth to Three, Connecticut's Early Intervention Program. This is accessed through Child Development Infoline (CDI) (1-800-505-7000).

Upon receipt of the referral, interventionists will go to the home to complete a holistic developmental evaluation of the child. They assess the following domains:

- adaptive;
- communication;
- cognitive;
- physical (including motor, hearing and vision); and
- social/emotional.

Eligibility for services is based on the level of delay and is typically provided in the home or other natural environment:

- < 2 standard deviations in one area of development, OR
- < 1.5 standard deviation in two or more areas of development or established condition.

Infants and Toddlers diagnosed with FASD are automatically eligible for Birth to Three. Children with a diagnosis of Fetal Alcohol Effects are eligible when they show developmental delays.

Policy 34-14-1, "Referrals to Early Intervention Services"

Legislation requires the Department to ensure that children age 3 or younger who have been substantiated as victims of abuse or neglect and those children age 3 or younger who are being served through the Department's Differential Response System are screened for both developmental and social- emotional delays. **When a concern exists, the Department will work with the family to ensure the referral is made to Birth- to- Three for an evaluation.** Such screenings are administered twice annually, unless the child has been found to be eligible to receive services from the Birth-to-Three program.

The department shall refer any child exhibiting developmental or social-emotional delays to the Birth-to- Three program. Any child who is not found eligible for services under the Birth-to-Three program will be referred to the Help Me Grow prevention program through the Family Support Services Division of the Office of Early Childhood.

Help Me Grow is accessed through Child Development Infoline (CDI) and serves families of young children "at risk" for developmental or behavioral problems. It connects families to existing programs in the community to provide support, including Family Resource Centers, home visiting programs, and other parent supports. In addition, Help Me Grow offers developmental tracking and monitoring through mail out questionnaires (Ages and Stages) sent to parents at various intervals. This program encourages parents to partner with child health care providers to actively monitor their child's developmental progress. This is accomplished through the questionnaires and age-appropriate activities designed to develop the infant's motor, communication and social skills, and promote the parent/child bond. The program can remain involved with the family and track a child's development from 2 months of age up to 5 ½ years. Parents are required to complete and submit the questionnaires and feedback is provided. If concerns exist, staff will assist the family in securing appropriate services, including an evaluation.

Quality Early Education and Care

For young children experiencing trauma or living under less than optimal conditions, it is important that they regularly participate in developmental and learning opportunities that provides stimulation and individualized supports from early childhood programs that are trauma informed and provide appropriate interventions. While child care subsidies are often seen as the way to access care

for young children during the day so parents/foster parents can work, all children, particularly children who've experienced trauma, are best served by early care and education programs designed to promote and foster development and learning.

***Quality* early care and education** offers both nurturing caregiving and learning opportunities to infants, toddlers and preschoolers.

***Quality* early childhood centers and licensed family child care homes** assess and monitor each child's development and base their daily activities on developmentally appropriate curriculum.

***Quality* ECE programs** meet quality standards and maintain compliance either with federal Head Start Performance Standards or Accreditation by the National Association for the Education of Young Children (NAEYC) or the National Association for Family Child Care (NAFCC).
Programs and providers are embedded within networks of social and community services so that children and families have ready access to the full range of additional supports they may need, such as ECCP, Birth to Three, TANF or medical/dental homes. Additionally, their staff have received training in serving vulnerable families, e.g., infant mental health, endorsement and reflective supervision, trauma, intimate partner violence, etc.

For some families of infants and toddlers, ***quality* early care and education** can be provided ***through home visiting*** programs, such as Early Head Start, which also meet quality standards.

Many of these programs are free or subsidized similar to childcare subsidies. Access to any ***quality* early care and education programs and providers** is easily obtained by contacting 211/Child Care Infoline or Child Development Infoline or through active participation on local DCF-Head Start Partnership community teams.

Special Act -14-22
Purpose: Early childhood interventions optimize children's curiosity and readiness for school. Involvement for children in preschool programs has been found to offer important foundational learning experiences. Children who attend high-quality early learning programs are shown to perform better not only academically, but throughout their lifetime as well.

Studies have shown both the short and long-term effects of quality early learning programs.

Positive impacts from high-quality preschool programs can last a lifetime and help children become:

- more likely to succeed academically;
- less likely to require special education or remediation;
- more proficient at reading and math;
- more likely to graduate from high school;
- more likely to attend and complete college; and
- less likely to commit crimes.

DCF Policy 45-1 intends to assist Social Workers with maximizing the enrollment of children in eligible programs.

Eligible preschool is defined in state statute as:

- a school readiness program, as defined in Conn. Gen. Stat. § 10-16p;
- a preschool program offered by a local or regional board of education or regional educational service center;
- a preschool program accredited by the National Association for the Education of Young Children (NAEYC);
- a Head Start program;
- any preschool program that the Commissioner deems suitable to meet the needs of the child.

Note: For children in DCF care, there is value in visiting the child in their daycare/early care setting.

Parents with Disabilities

The American's with Disabilities Act (ADA) defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activities.

When a parent has a disability it is important not to generalize or make assumptions about their parental capacity.

Disabled parents may need support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly needed where they experience additional stressors such as having a learning disabled child, physical violence, poor physical and mental health, substance misuse, social isolation, inadequate housing, poverty and a history of growing up in DCF care. It is these additional stressors when combined with disabilities that are most likely to lead to concerns about the care a child or children may receive.

Quality assessments are important as research highlights that people with disabilities are more vulnerable to victimization, often establishing relationships with partners who may abuse their children or have their own substance use or mental health problems. Consideration must also be given to the discrepancy between the parent's knowledge, skills, experiences, and supports and the parent's ability to learn and understand the needs of their children over time. Children with developmental delays or medical issues are particularly vulnerable. *Assessing the family's protective factors is critically important throughout our intervention to help assess the strengths and needs of the family.*

Documentation should include:

- Description of characteristics and patterns of a parent's functioning in adult and caregiving roles
- Strengths and natural supports that help the caregiver meet their parenting role
- Explain possible challenges/barriers the parent/parents may have as a result of their disability
- Identify person-based and environmental conditions likely to impact behavior and/or parenting (positive and negative)
- Describe children's functioning and needs in relation to the parent's ability
- Provide concrete directions for intervention

Ongoing Assessment questions:

- Tell me about your personal support system?
- Have you been able to obtain basic needs? If not, what are your supports to help you obtain basic needs?
- Who are your professional supports?
- Tell me about what it takes to help you make it through the day?
- Parenting skills? How do you parent? Do you understand the needs of your child and are you able to manage them presently? How do you discipline your child? What do you think you need now and in the future?
- Is your child in an early care and education setting, family daycare, or early intervention program? If not, help them access an appropriate program.
- What services does your family currently receive? Can they be referred to a home visiting program? What is their history with services especially in-home supports?
- Do you receive public benefits? If not, help them get it. DDS services?
- Have you ever attended a parent support group?
- Are there other resources for your child or supports that you may not have thought about?
- How much schooling did you complete?

Parents with Cognitive Limitations (PWCL) – Special Considerations

Although the number of families headed by a parent with cognitive limitations is uncertain, and identification of these families is a challenge, it is estimated that at least one third of families in the current child welfare system are headed by a parent with cognitive limitations. These limitations are not limited to particular diagnoses (ADHD) or IQ scores; rather these limitations in executive functioning run along a continuum that may result from brain injury, fetal alcohol syndrome, lead poisoning, trauma or unknown causes.

People with cognitive limitations may have difficulty including but not limited to the executive functioning abilities listed below:

- Exercising judgment
- Planning
- Organizing
- Remembering
- Regulating emotion
- Scheduling and keeping appointments
- Setting limits and following through

These parents may be unidentified or may be misidentified as mentally ill or as substance users. When they cannot meet the expectations of the available programs and services, these parents are often labeled as "noncompliant", or "uncooperative" and the consequences of these labels may have tragic consequences, including loss of home or removal of children. Isolation and lack of

transportation exacerbate these problems. Maneuvering public transportation alone, requires the ability to plan ahead in order to reach the desired location by the desired time, read bus schedules, organize the baby's/children's clothing and supplies (diapers, bottles, toys/games); locate exact change, overcome the fear of getting lost and tell time. Parents with cognitive limitations tend to think more concretely than others and time is a very abstract concept.

For example, providers working with Candace had difficulty communicating with her. They would deem her as non-compliant because she was not showing up or often late for appointments and because she failed to complete tasks requested of her.

Working with Families with Young Children Headed by a Parent with Cognitive Limitations

1) **Assess how the parent learns and then use concrete aids,** (e.g. calendars, posters, pictures) "A person may not understand what it means to "put four ounces in the bottle" but might understand "fill it to here" when "here" has a textural difference that can be **felt** on the bottle or a piece of tape that can be **seen. (Mark Sweet) "**

   The first thing I did was obtain a planner for Candace. I went to a home visit and we sat down together and called all her providers and wrote her appointments down. A few weeks later, I arrived at her home and she had a large wall calendar on her closet door that serves as a big reminder of her daily appointments because she only travels with the small planner I gave her. She copies everything from her small planner to the big calendar and every morning and evening she walks by the wall calendar and can check what she has planned. I also put everything in writing for Candace, usually bullet points and in step-by-step direction.

   Other tools include:
   a. Tape recorded messages
   b. Checklists (adapted with pictures)
   c. Schedules
   d. Digital Clocks
   e. Alarms
   f. Timers
   g. Labels
   h. Notebooks
   i. Maps
   j. Magnet Boards

2) **Tell, demonstrate, and then give the parent an opportunity to practice the skill or invite them to do it with you.** Be careful not to take over when you model parenting behavior, the parent may think they'll never do it as good as you.

3) **Help them to have reasonable expectations of their children's' abilities by sharing child development information and helping parents understand that children learn through play by using the following strategies:**

- Provide a developmental chart and emphasize that not all children develop at the same rate.
- Tell a story from child's point of view and act it out with the parent. The "child" would tell the parent what he/she needs, like, doesn't like, etc. Make it personal. Tape the story so they can listen to it over and over again. If the child is very young and/or nonverbal, speaking the child's needs can help.
- Demonstrate an activity or use specific toys with parents and children and talk about what skills they help children develop. Toys can be made from common household objects (e.g. wooden spoons and pans; cardboard boxes; etc.) Some parents will need support in tolerating the "mess" that sometimes comes with play.

EXAMPLE: A parent tells you that she doesn't understand why her 28-month-old child does not know her colors yet. She tells you that they have been going over it ever since she was one and some days she gets it right and other days, she gets every color wrong.

WHAT YOU CAN DO TO HELP

- Review a developmental chart and determine the age in which a child can reasonably be expected to perform the task the parent is concerned about.
- Help the parent understand that not knowing her colors at 28 months is normal and she should not be concerned.
- Show the parent ways she can play with her daughter and name colors without pressuring the child to identify them accurately.
- Identify the areas the child is on target to help the parent understand the child is progressing normally and to validate the parenting. (She isn't learning her colors, but she just learned to hop on one foot, did you teach her that?)

4) **Stress the importance of parents' communication with babies and toddlers in creating a strong bond between the parent and the baby as well as helping the growing child have the verbal tools they need to succeed in getting their needs met at home and in school.** Encourage the parent to talk and respond to the baby/child's sounds as well as facial expressions and body movements.

   You might ask: **What do you like to do with your children?** (If reading is not mentioned, ask *do you look at books with your children? Do you read to them? Do they read to you?*) And let parents know that they can "read" to their children by describing what's on the page. For example, pointing out the colors on a page, talk about what is happening in the picture, name and point to what you see. These activities can help with language development and foster attachment.

   - **Stress how important it is for parents to attend to or interact with their children to and for parents to help toddlers explore in a safe environment.** Help parents understand that they create safety by their vigilance. Car seats and swings are appropriate for short periods of time.

- **Routines help to establish a sense of predictability for children and help parents organize their family's activities for the day and create more order in their lives.** The Sunny Side of the Street Curriculum www.irised.com/products/sunny-side-of-the-street is a wonderful tool that incorporates music to help parents and children learn about routines for bedtimes, meals, and school readiness. A discussion of routines is particularly important when working with children who have experienced trauma.
- **Stress impacts executive functioning in all of us.** The stress of living in poverty and unsafe environments exacerbates the impact on executive functioning.

Working with Candace was like riding a roller coaster. She would call me frequently for everything! If I were not at my desk to answer her phone call, she would leave numerous voice messages; each message was left with increased intensity and agitation in her voice. Once she got me on the phone, which was usually only a few hours later, she would curse me out and state that I never help her with anything. Once she would calm down, I would ask her what exactly she needed that caused her so much distress and she would say, "I want to know when my next visit with my kids is", or she would ask me for her therapist's phone number, again. Non-emergent issues stressed her out immensely.

- **Shower parents with praise.** Many parents with cognitive limitations have experienced a lifetime of people telling them or assuming that they were "stupid" or "incapable". Observe what the parent can do, look for strengths and praise generously.

  I encouraged her by telling her that she was a strong woman and that I knew she was capable of doing great things. I praised Candace for everything! Whether it was getting to her visit on time with her kids or cleaning her house. Her providers started doing the same. They praised her for attending therapy sessions on time and taking her medication as prescribed. Her APRN provided her with prescription boxes and would fill them for the month with her.
  Very quickly, we all noticed an almost "different" Candace. She smiled more and yelled less. She expressed excitement about her pregnancy and voiced looking forward to having the chance to do things right this time. She even said thank you a time or two!
- **Parents need to know that separation anxiety is normal for young children. The children will learn that their parents will return when left with someone else and that it is normal for young children to develop fears.**

- **Remind parents to always say good-bye when they are leaving and to give the child a special toy or "security blanket" to help make the transition easier.**

- **Identify and help the family to identify significant adults to help build a supportive network,** e.g., Family Resource Centers, Birth to Three, DDS, Faith Based Communities, Head Start and other early care and education providers and relatives. Pull everyone together who is working with the family. These parents often have multiple providers in the home and it is not unusual for the family to get conflicting requests. ***Remember: Increasing the number of services doesn't ensure better outcomes.*** If the providers are not skilled at

working with parents with limitations the services can feel very fragmented and overwhelming and the provider and the family can become very frustrated.

5) Be direct in your communication

Note: Documentation should include the same areas identified in the previous section (Parents with Disabilities) on page 57.
Acknowledgments and Resources

Building Foundations: A Curriculum Guide for Supported Parenting, Bridget McCusker & Bernadette Irwin, Kennedy Krieger Institute (no date)

Sunny Side of the Street Curriculum: http://www.irised.com/products/sunny-side-of-the-street Owned by The Connecticut Center for Prevention, Wellness and Recovery 1-800-232-4424

The Health & Wellness Program: A Parenting Curriculum for Families at Risk, Alexander J. Tymchuk, Brookes Publishing Company, October 2005

Discovering the Parent's Language of Learning: An Educational Approach to Supporting Parents with Cognitive Limitations, Mark Sweet, Wisconsin Council on Developmental Disabilities
HELP: When the Parent is Handicapped, Stephanie Parks, (ed.), VORT Corporation, 1984

Case example provided by Dorothy Zyla, Social Worker, New Britain

Parents who were in DCF care as children

As indicated by the ACE study, many of the parents with which we work have their own history of childhood trauma. Those experiences, and their impact on risk related behaviors, can result in a parent's inability to form consistently nurturing bonds with their children, make healthy decisions regarding those to whom they expose their children, and appropriately interpret and respond to their child's needs. Often this intensifies the trauma experience for younger children, given what we know about the importance of secure attachment.

Young children depend exclusively on parents/caregivers for survival and protection. When trauma also impacts the parent/caregiver, the relationship between that person and the child may be strongly affected. Without the support of a trusted parent/caregiver to help them regulate their strong emotions, children may experience overwhelming stress, with little ability to effectively communicate what they feel or need. They often develop symptoms that parents/caregivers don't understand and may display uncharacteristic behaviors that adults may not know how to appropriately respond to when confronted with such behaviors. Additionally, some child behaviors (hitting, kicking, screaming, and name-calling) may also be trauma triggers for adult caregivers who have experienced their own personal trauma. When this occurs, it is important to connect the family with appropriate trauma-informed interventions that help from a multi-generational approach. Adult caregivers who have experienced their own trauma can learn to manage their own trauma symptoms so that they can provide emotional availability and stability for young children.

Multigenerational Trauma: A Case Example

Mother was asked about her childhood. Mother stated her own mother committed suicide when she was 12 years old reciting July 1991 when her mother passed away. Mother explained that after her mother committed suicide all of her siblings were separated and DCF would not allow her to see her siblings. Mother stated that she had 58 total placements. She explained that she had anger issues growing up and was on Lithium and Prozac. She stated that she had a very traumatic childhood. Mother is currently in a 7-year relationship that is described as violent and abusive. However, mother has just realized that she is struggling with ending their relationship, as this is the only attachment that she has made to another adult since her childhood.

Mother and the Department have learned from the above example her childhood trauma has impacted her ability to form healthy adult attachments. The practice of permanency teaming for children will enable children to develop secure attachments, which may reduce the impact of trauma in the child's relationships in the future.

Many of these parents, often very young and perceive their experiences with the child welfare system negatively. They are likely to have very few positive role models or others to depend on and their prior connections/supports may no longer be available to them. Given the negative experience as a child/youth in care, they may be highly untrusting of the system in their role as a parent.

The role of the social worker is to rebuild and repair this relationship between DCF and the parent. This is done through consistency (showing up for visits and meetings on time, following through on whatever agreements are made), as well as being fully transparent (communicating the department's concerns, the options that might be available, and potential consequences). Building on strengths that promote protective factors is also important. Viewing parents through a "trauma lens" can help staff approach parents in a non-threatening way and instill hope and healing for the parents.

Helping parents identify their team of support and be actively engaged and involved in planning through the permanency teaming process is instrumental in developing this partnership.

Source: National Child Traumatic Stress Network NCTSN.org: http://nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_history_fact_sheet_final.pdf

To complete a thorough assessment, it is important to review the case record. If family had prior CPS history in another state, request that information.

Assessment Questions to Explore:

Note: If the parent is not ready to talk about childhood trauma please stop and refer the parent to trauma focused individual therapy and consult with an ARG.

Information about Past History:

- Tell me about your childhood? Who raised you? Do you have a favorite childhood memory – tradition, holiday, etc.?
- Do you know if your parents used drugs or alcohol when you were born? Do you know if your mom used drugs or alcohol when she was pregnant with you?
- Do you know what happened that caused you to come in to DCF care? Would you mind sharing this with me?
- Do you know how long you were in DCF care? Do you remember anything about the families you lived with – good and bad or how you felt when you were there?
- Are you in contact with any of the families (or staff if they've lived in group settings) you lived with? Would you consider them as a support to you?
- Do you remember what your relationship was like with your parents before you came into care?
- Can you tell me about your relatives? Have they helped/supported you? Did you ever live with them and/or keep in contact with them while in care? What about now, are you in contact with your family?
- How were you disciplined growing up? Do you discipline your child the way you were disciplined? Tell me about the way you discipline your child.
- How have your experiences influenced the way you parent your child? Can you provide examples?
- When you were growing up, do you remember if you or your family received any community services? Were they helpful? Did you receive any extra help at school?
- Is or was there someone in your life who you try to parent like? What was it that they did that you try or want to try to do with your child(ren)? Is there anyone you don't want to parent like? What was it that they did that you don't want to do with your child(ren)? Who are your role models?

Current Situation

- How does it feel to have DCF back in your life? Does it bring up any old feelings that you'd like to share?
- Who do you feel closest to? Who do you lean on for support? Who would you call in times of need or when good things happen?
- If you could wish for three things for your child(ren) what would they be?
- Who do you like to spend time with and what do you do when you are together?

Early Childhood – Adolescent Services

The adolescent worker plays a significant role in the life of a young parent as they prepare to become a parent themselves. Whether it is a young male, or female who is the parenting teen, their history of trauma, abuse and neglect will have an impact on this process. It is important that staff working with these youth properly assess their needs, help them make healthy connections for themselves and their child to support systems, and give them the tools they will need to break the cycle of early childhood trauma. This is a challenging time in the life of an adolescent, and staff

need to be aware of the risk factors associated with teen pregnancy and parenthood, as well as their role in assisting the adolescent in developing the skills necessary to be a parent.

Supervision – The role of the supervisor is an important one in providing oversight and guidance to adolescent cases of pregnant and parenting teens. Supervision with this population should focus on the following areas depending on the needs of the parenting adolescent:

a. How will pregnancy impact the parenting adolescent's placement or living situation?
b. What are the youth's needs? What is the youth's plan regarding the pregnancy? What services are they receiving or need?
c. Who is available to support the youth during pregnancy and following birth? Will these individuals continue to support the adolescent parent and father of the child?
d. How do we prepare the youth?
e. What is the nature of the relationship between the parenting adolescent and the father of the child? How actively will he be involved in caring for the child/co-parenting?
f. What safety checks are needed? (including other birth parent, extended families, etc.)
g. Is substance use/mental health or trauma history a concern for the youth or the other parent?
h. Are there financial factors to consider? What is the Department's contribution and in what time frames?
i. Who is/will be providing care to the youth's child? Is there a plan for early care and education for the youth's child? Home visiting? Has a referral or contact been made?
j. How will the current placement provide support to the adolescent parent and their child? What will be the role of the foster parent in supporting the adolescent parent and caring for the child? What are the expectations for the parenting adolescent as they transition to parenthood?
k. What are the risk factors? Has a safety assessment been completed? What are the family's Protective Factors?
l. What does our visitation plan look like through pregnancy and the first six months of the baby's life?
m. What does the parenting adolescent think they need?
n. What tools does our adolescent worker need in order to make these important assessments? How do they assess parenting abilities/risk?
o. Who will help model for the youth what being a parent is going to look like?
p. Ensuring the Adolescent SW knows their role in relation to youth and care of their infant.
q. How can the youth's life goals be supported while pregnant and parenting?

Worker Role – The relationship between a worker and the adolescent on their caseload is vital to engaging and assessing the youth's readiness to parent. Some of the factors to consider are as follows:

a. Connect with Supervisor and refer to RRG Nurse when youth becomes pregnant to ensure they have appropriate pre and post-natal care.
b. Confirm pre-natal appointments. Attend with the youth whenever possible.

c. Assess what the youth understands about pregnancy. What services the youth needs during and after pregnancy; ensure referrals are made.
d. Assist in applying for WIC, Child Support, and other state assistance as necessary.
e. Refer to RRG clinical social worker if there are mental health or executive functioning issues that require assessment and monitoring.
f. Include the other birth parent; what is their involvement in the pregnancy? How will they be involved in the future? Is their family involved and supportive? What will they contribute financially? How will they co-parent?
g. What does discharge planning look like? This youth and their child will not always receive adolescent services from the Department.
h. What are our expectations of this pregnant/parenting adolescent? What are their expectations of us and the support system? What do they expect of themselves?
i. SAFE SLEEP and Safe Haven discussions.
j. What are the long-term goals of the pregnant/parenting adolescent? What is their continuing education plan?

- Developmentally appropriate parent-child contact:
- Is individualized for each family, according to their needs;
- Aims for daily contact;
- Occurs in locations and times that work for birth parents, foster parents, and the infants and toddlers;
- Addresses parenting practice and relationship building;
- Focuses on parent involvement in normal family activities, such as doctor's appointments and birthday celebrations; and
- Limits those involved in supervising visits to one or two people who develop ongoing relationships with the child and caregivers.

From: A Call to Action on Behalf of Maltreated Infants and Toddlers. American Humane Association; Center for the Study of Social Policy; Children's Defense Fund; and ZERO TO THREE, 2011. P. 14

Visitation

Parenting Time: The primary path of child development, emotional stability, and healthy attachment is through the parent/child relationship. Even in relationships where the parent's behavior or actions put the child at risk, there is a dance of attachment that is formed, and through which the child learns to understand the world. That relationship is built on consistent and ongoing connection and ready access between the child and the parent.

When children are separated from their known caregivers, even for safety reasons, they can experience a traumatic reaction to the loss of that caregiver and the routines and patterns that they have come to know. This can lead to challenging behaviors, emotional distress, and difficulty for the child in attaching to new caregivers. Given the impact of this loss, parent/child visitation is crucial to the emotional health and development of children who enter foster care; particularly for younger children who require more frequent contact in order to maintain relationships.

For young children, frequency of visits is much more important than the length of time spent in the visit.

The permanency goal for children who enter care is most often to be reunified with their parent. Through ongoing contact, the parent is able to be present in the child's life, reducing the experience

of disruption that a child can experience when they leave their foster home to return to their family. In addition, parents are able to demonstrate increased parenting skills and the child is able to adjust to these new skills as a natural part of the parent child relationship.

By broadening the concept of visitation beyond the valuable time spent in traditional visitation to include general care provision, doctor visits, pre-school and school events, and extracurricular activities, the relationship between the parent and the child can be more normative in its nature. In addition, the parents can feel more connected to their parenting role and more engaged in their child's life.

It's hard to remember at times that 'visiting' your child is not a normal aspect of parenting. In addition, parents are often struggling with issues of guilt and shame regarding the events that prompted their child coming into care and can feel displaced in their role as parent. Through engagement techniques aimed at supporting the parenting role, emphasizing the needs of the child, and including the substitute care giver, parents can be encouraged to take an active role in their child's life, even while their child is not in their direct care.

Role of Social Worker

Assessing child safety, identifying risk factors, and identifying the needs of children and families, and connecting them to resources and services in the community is a critical function and important role of the social worker. The following provides guidance around possible topics for discussion during visits and supervision relative to this population:

Respond to Signs of Trauma:

Observe the child's behavior. Even though very young children may not be able to explicitly tell you when they are frightened or sad, they often exhibit many behavioral cues that can help you to gauge their sense of well being. Pay careful attention to these signs and non-verbal cues.

- Educate the caregiver about the infant/toddler/preschooler's experience.

  It is important that the caregiver knows what the child has experienced and should be made aware of signs or behaviors to look out for as they care for the child. If the child has been placed with a substitute caregiver, including early care and education providers, every effort should be made to avoid disruption of this relationship and this information should be shared in a way that helps them be prepared to respond appropriately to the child, while not making them biased toward the child's birth family. Caregivers should also be fully aware of and engaged with the clinical services to which the child is referred. During every visit, caregivers can be helped to more fully understand the child's behaviors, as well as their own role in the child's healing and healthy development. It is also important to discuss with caregivers their own self-care, so as to ensure that they are emotionally ready to cope with possible challenges the child may presents. Taking care of a child who has been traumatized can be challenging. Caregivers may need additional support to understand that many challenging behaviors are likely a reflection of the trauma the child has experienced, not a rejection of the caregiver. You may also consider offering them a referral to an Early Childhood Consultation Project (ECCP) consultant, as appropriate.

- Observe how the infant/toddler/preschooler is interacting with his/her caregiver.

  Do the caregiver and child respond appropriately to one another's behavior – laughing/cooing and playing in response to the other's smile and joy? Does the caregiver show praise for accomplishments? Does the caregiver provide comfort when the child seems anxious or distressed? These interactions are key to the child's healing. Explore how the child and caregiver spend time together. What do they do for fun? What do they do during quiet times? If there are others adults or children in the home, observe how the child interacts with them and how the caregiver supports or directs those interactions.

- If the child begins to exhibit behaviors related to trauma, link the child and caregiver to therapeutic assessments.

  A child who has been removed from his/her birth family and placed with substitute caregivers may not immediately demonstrate any concerning behaviors. There may be a "honeymoon" period for both the child and the caregiver. The frequency of worker/child visits should be discussed in supervision. Meaningful visits and regular communication should provide you with sufficient observations to identify "out of the ordinary" behaviors and to discuss them with the caregivers. Such behaviors should be monitored and may require further therapeutic assessment and response. Be prepared to connect the child and caregiver to the appropriate resources. Review the MDE conducted when the child enters care. A series of screenings can further inform linkages to key supports.

- Support the Child's Development

  Prepare for the visit by reviewing the appropriate developmental guidance contained in this guide and Appendices and reflect on what you have observed in previous visits. This will help you make notes about what to look for, how to interact with the child and questions to ask the caregiver about the child's daily routine. It will also prepare you to check up on anticipated and/or achieved developmental milestones. Use the information obtained about the child from service providers – clinicians and early care and education providers – to further prioritize what needs to be accomplished during a visit. It is also important to contact providers and SWCA staff that supervise parent/child visits.

- Support and Strengthen Parental and Caregiver Protective Factors

  Get to know the caregiver. Develop an understanding of what is going on in the caregivers' lives, any potential sources of stress and how they are managing to cope with challenges. Respond with empathy to the life stresses they may be experiencing – job frustrations, financial issues, family dynamics, etc. Explore what they are doing to take care of themselves. Acknowledge that your visit itself may be a stressor and alleviate this stress by fully explaining the purpose and goals of your visit. For instance, talk with them about the developmental checklist and how you are using it to guide your interactions with the child. Discuss with them the changes you see from visit to visit so that you can include them in your assessment and understand their perspective. Always respect them as an expert about this child. Additionally, connect with FASU Support staff as they may have information about the child's caregiver that may be beneficial in working with the family.

The Role of Supervision in Early Childhood (Ages zero to five)

Supervision and management are one of the seven core strategies of the Strengthening Families Practice Guide. Improvements in leadership, management, supervision and accountability; and establishment of a Department culture as a learning organization are two of our cross cutting themes. Performance Expectation #5 is to prepare and support the workforce to meet the needs of children and families, which is measured in part by consistent and effective supervision.

There are four functions of supervision (as outlined in **DCF Policy 7-22 - http://www.ct.gov/dcf/lib/dcf/policy/pdf/07220000.pdf**). (See also the ***Supervision Practice Guide – http://www.ct.gov/dcf/lib/dcf/policy/pdf/Supervision_Practice_Guide.pdf***.)

1. Ensuring the quality of services provided
2. Ensuring that administrative tasks are completed accurately and in a timely way
3. Providing support to employees in their jobs as they face work related challenges
4. Helping employees to grow and develop their skills

The DCF Supervision Agenda (DCF – 4101) is to be used to help organize the discussion in supervision. All case related discussions are to be documented in LINK in real time.

Supervision starts at the Careline and remains integral throughout the life of a case. For families with children aged zero to five, supervision becomes even more important given the vulnerability of children in this age group. Critical thinking is necessary in order for workers to assess the individual needs of the children and their caregivers. The signs of abuse or neglect are not as readily identifiable and understanding child development and parental capacity are critical. Through supervision, this can be achieved.

The supervision practice for Investigations and Family Assessment Response is that supervision take place a minimum of three times; upon assignment, in the middle of the assessment, and at the end to determine the results of the assessment and case disposition.

- http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=393946
- http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=393948
- http://www.ct.gov/dcf/cwp/view.asp?a=2639&q=332408

Timeframes for supervision are important, as is the content of what is discussed. The following is guidance of what should be discussed in supervision for families with children aged zero to five. The goal is to assess the worker's ability and knowledge to work with this population; strengthen their critical thinking and assessments skills; and provide coaching and support as needed in order to adequately identify the strengths and needs of the children and their caregivers; determine the case outcome; and begin to lay the groundwork for the development of a case plan that includes the child(ren)'s caregivers, including non-custodial parent(s) and considers the permanency needs of the child(ren).

Recommended Issues for discussion in supervision:

1. Identify families on their caseload with children aged zero to five in the household, not limited to children identified as victims of abuse/neglect

2. Worker's knowledge of and comfort in working with children aged zero to five

3. Recognizing their work with young children is a parallel process. The relationship between the supervisor and social worker, the social worker and the family, and the relationship between parents and their children are important and often affect each other. Focusing on the social worker's experiences, thoughts, and feelings in relation to their work with young children and their families through a reflective supervision approach will help staff work through complex feelings and identify what may trigger those feelings/responses in order to better attend to the needs of families. Supervisors can help the social worker think about how their own emotional experiences may shape or influence their work and/or decision-making

4. Case History – to include all household members and non-custodial father, including mother's partner or other caretakers that reside in the home or have regular access to the child and/or caretaking responsibility

5. Risk Factors Present (Per ORE Child Fatality Study, the following were found to be highly prevalent in CT's child fatalities)
    a. Child's age/special needs (medical issues)
    b. High Risk Newborn
    c. Mental health concerns
    d. Substance use
    e. Prior DCF History
    f. Young Parent

6. Documentation of Observation
    a. Assessment of physical environment (based on the child's age)
    b. How do things look different from one visit to the next?

7. Develop a visitation schedule that meets the needs of the family, taking into consideration the history and risk factors present
    a. Visits should be announced and unannounced and frequency determined by the needs of the family and/or risk factors
    b. If the child(ren) are removed, develop a family visitation schedule with the parents

8. Discuss Family Strengths and Needs
    a. How do these impact the safety and well being of the children in the home?
    b. Protective Factors/Structured Decision Making Family Strength and Needs Assessment (SDM FSNA)

9. Review families' understanding of childhood development/parenting capacity
    a. How do families cope? How does this impact their parenting?
    b. What experiences do parents bring from their upbringing to their own parenting styles?

10. Include Father/non-custodial parent – what role does he play in parenting the child (ren)?
11. Include Provider input/assessment
    a. How are we including the provider input/assessment into our overall assessment of the family?

12. Use of Structured Decision Making (SDM)
    a. Are the tools being completed accurately?
    b. Are overrides needed and discussed in supervision?

Consult with supervisor regarding use of discretionary override for children 0-3 <u>and</u> a known risk factor that is not included in the SDM Risk Assessment (e.g. parental age, trauma history etc.).

13. Level of Risk
    a. How and why risk was determined (supporting information documented)?
    b. Were overrides used?
    c. Patterns/trends noted and how history is impacting current functioning?

14. How are the needs of the family tied to services being offered?
    a. Are the objectives identified consistent with the goals of the service?
    b. How will progress be measured?
    c. What does success for the family look like?

15. Case outcome
    a. Summary of information used to determine
        i. Substantiation (for investigation cases)
            1. For children who are confirmed to be abused or neglected (between the ages of zero to three), confirm a referral to Birth to Three was made
            2. See MOA 341 – Memorandum of Understanding Between DCF, DDS and Office of Early Childhood - http://www.ct.gov/dcf/lib/dcf/mou/moa_341_ct_birth_to_three_system_-_dds.pdf
            3. Special Act 14-22 enrollment in preschool programs for children 2.9 – 5

        ii. Placement on Central Registry
        iii. Case Disposition

Consults

Regional Resource Group and Legal Consults:

The Regional Resource Group (RRG) should be consulted with to assess the needs of children in families and in deciding how and what types of services are required. They could also be consulted with to help with understanding the medical and mental health needs of adults and children, and make referrals for exams, or evaluations. See DCF Policy 38-3 – Area Resource Group Consultation Functions -http://www.ct.gov/dcf/cwp/version_preview.asp?l=692744&c=21847&q=394498&a=2639. The decision to make a referral to the RRG for consultation should be discussed in supervision.

Examples of when to make a referral to the RRG:

- High risk newborn
- Critical Incident
- CPS report identifies medical concerns for the child
- When a child is hospitalized or seen in an emergency room
- When a child with complex medical needs (CCMN) comes into care or has a change in his/her circumstances, including but not limited to - routine follow up or ongoing care or a routine/non-emergent home visit
- Any observation of developmental delays
- Hospitalization - Medical or Psychiatric (for parent or caretaker) that results in child needing placement
- Current allegations of intimate partner violence with possible child exposure (including serious physical violence, suspicion of firearms, and child/children in close proximity and/or intervening)
    - Assistance needed in coaching and assessing current relationship
- Identification of substance abuse history of caretaker of newborns or children five and under
- Reports from mandated reporters alleging harm or potential harm to a child due to parental/adult substance use
- Any substance use that poses imminent risk to child/youth/parent that may cause overdose or a need for detox
- Suicidal/homicidal risk assessment of parent or caretaker

Recommendations made following an RRG consult should be reviewed and discussed in supervision and are to be made part of the family's case plan.

Legal Consultation

The need for legal consultation should be discussed in supervision for both intake and ongoing services cases. The discussion is to include legal involvement at different stages of case and not just during crisis or at the end prior to closing.

In ongoing services, a legal consult is to place when a case has been open for more than six months with no legal intervention. A legal consult should also take place, when the court is already involved with a family and there is a new birth.

Foster Care: Focusing on Children Entering and In Care - Birth to Age 5

Recruitment & Training

Targeted recruitment is needed for resources willing and able to meet the needs of young children. Below are some of the criteria that should be sought when recruiting foster families to care for our young children:

- A stay-at-home parent for infants and ideally up through 2 years of age or prior to the start of pre-school
- A foster parent willing to work closely with birth families, kin and fictive kin for the purpose of increased parenting time as well as role modeling and coaching
  - **Ideally: daily for infants and every 2 to 3 days for toddlers**
- A foster parent willing to work closely with all identified providers to ensure the child is medically up-to-date and developmentally on target
- A foster parent who is willing to preserve relationships the child may have with an early care and education provider and peers
- A foster parent who understands the signs and symptoms of trauma in children from birth to 5 years old and is committed to helping the child and birth family through the stages of healing
- A foster parent caring for a child with complex medical needs must complete the Medically Complex training, age appropriate CPR and Child-specific training.
- A foster parent who speaks the child's native language
- A foster parent who understands and can respond to the needs of the child or children placed in their home, including race, culture, religion, and disability.

In addition to the **T**rauma **I**nformed **P**artnering for **S**afety and Permanence **M**odel **A**pproach to **P**artnerships in **P**arenting (TIPS-MAPP) pre-licensing curriculum, foster/adoptive parents are also to receive additional trainings related to meeting the health and multi-cultural needs of our children (i.e. Fostering Health, CPR, etc.).

Licensing

When assessing a family for licensure for a child between the ages of zero and 5, the following discussions should take place in supervision:

- What prior parenting experience or training do they have, especially in the area of parenting a young child with a trauma history?
- What are the proposed sleeping arrangements within the home? What is the child sleeping in? Is the sleep environment safe?
  - ✓ children can sleep in the caregiver's bedroom up to 1 year old
  - ✓ children under 5 years old should sleep on the same level as the caregiver

- ✓ children 3 years old+ cannot share a bedroom with the opposite sex

- In consideration of the age of the child that the parent is seeking to foster/adopt, is the home childproofed and/or are they willing to childproof the home?
  - ✓ child access to pool/water sources
  - ✓ child access to peeling paint, toxic materials/substances, medications, etc.
  - ✓ child access to stairs or balconies
  - ✓ children with complex medical needs – does the medical care needs require adjustments to the home environment to ensure safety? This may include where the child sleeps and sleep position in accordance with child's treatment provider.
- What is their proposed childcare plan? Specifically for children over the age of three.
- Are they willing to work closely with the birth family and providers to meet the needs of the child including in-home services and frequent contact with the parent?

Matching

If a match is identified that is in the best interest of the child but the placement of the child would create regulatory concerns, an assessment should be completed including a plan to address the concern and ensure the child(ren)'s safety. This information is then documented utilizing the DCF-009: "Foster Care Licensing Placement Waivers Request Form" and submitted to the approving authority identified.

Please note the three different vignettes below which involve placement decisions that impact children from birth to age 5. Each vignette results in a placement waiver being authorized with a plan for the FASU Support and Treatment Social Workers to follow-up within 90 days or less to ensure the regulatory concern is resolved and/or the placement continues to be in the best interest of all parties.

Best Interest Consideration	Regulatory Concern	Waiver Justification
Relatives have been identified as a potential placement resource for a newborn child.	The current household income does not meet the identified monthly bills.	One parent is working and the second parent was recently laid off but is actively seeking employment.
A 1yo male child enters DCF care, no kin have been identified but there is a 5yo female sibling who is currently in foster care.	The foster family caring for the 5yo is willing to care for the 1yo but the siblings would need to share a bedroom.	Although the children are of the opposite sex and of disparate age, the room is large enough for a privacy screen and no concerns have been identified regarding sexualized behaviors. The foster parents have stated that they would seek a larger apartment if they were needed as permanent resource for both children.

Best Interest Consideration	Regulatory Concern	Waiver Justification
A foster home has been identified for a 3yo, which will allow him to be placed within close proximity to his pre-school program, his play therapist, church family and birth family.	There are currently 3 children in this home under the age of 6yo = 2 mos old (placement) 5yo twins (adopted)	The permanency plan for the 2mos old is reunification with a date scheduled in 30 days & the 5yo twins will be turning 6yo in 90 days. The foster parents have experience working with young children exposed to trauma, have mentored birth parents in the past & their adult daughter is home from college for the next 2 months and agreed to assist with childcare as needed.

Support

When supporting a licensed family who is caring for a child between the ages of 0-5 years old, the following discussion should take place in supervision and be part of the family's Quarterly Support Plan:

- How has this placement(s) changed the dynamics in the home for all household members? Are all household members, including the children in placement adjusting well? **consider family pets**
- What are the child(ren)'s identified needs? Are they being adequately addressed in a timely manner?
- Are there any new developmental or behavioral concerns identified by the foster parent or the MDE? What is being done to address these? Has the Ages and Stages Questionnaire been administered?
- Are there additional services, training or supports needed to meet the child and/or foster parent's needs?
- How is the relationship going between the birth family and the foster/adoptive family?
- In consideration of the child's current level of mobility and mobility in the near future, are there any changes needed regarding the physical home environment?
- Who in the home is identified as having caretaking responsibility? Are all caretaking parties aware of safe sleep practices? Are they CPR certified?
- Have there been any changes regarding household membership that need additional assessment?

Communication between the FASU Social Worker and Intake/Ongoing Social Worker are key in ensuring a child's needs are being met. FASU Social Workers should engage foster/adoptive parents to review the goals, objectives, and action steps outlined in the child's case plan during quarterly visits. The FASU Social Worker should also attend the ACR with the foster/adoptive parent.

DCF's Teaming Continuum

Considered Removal Child and Family Team Meeting (CR-CFTM)

The purpose of a CR-CFTM is to mitigate safety factors in order to prevent removal from the home by identifying and utilizing the family's natural or formal supports in safety planning. The meeting results in a live decision about safety/removal and recommendations regarding placement. When removal is required to ensure child safety, staff will need to be mindful of the trauma connected with the child's separation from their primary caregiver(s). Placement with relatives/kin who can provide a safe, stable and nurturing environment is the preferred option. Maintaining the child's relationship with an existing early care and education provider can provide some continuity for the child. It is important for the substitute caregiver to understand the child's experiences in the home including trauma, routines/rituals, medical issues/concerns, and developmental delays in order to make a smooth transition. Additionally, the child's cultural, spiritual, and linguistic background is considered.

Child and Family Permanency Teaming

Permanency Child and Family Teaming is a case management process designed to focus practice on activities leading to permanency. Permanency teaming informs and enhances assessment, service planning, service delivery and case closing. It is also an excellent opportunity to help strengthen and build caregiver protective factors and track children's developmental progress. Permanency teaming can help workers to:

Respond to Signs of Trauma

- Explore how the lack of permanency can be unsettling for the infant/toddler/preschooler/ child. A child who has been removed from home and only allowed to see family members within certain structured settings – times, location and duration – may experience some attachment issues. Since early childhood is a particularly sensitive period for the development of the child's mental model of attachment, it is important to address attachment problems as soon as possible. Keep in mind that attachment issues may eventually affect successful reunification or other permanency options. Be sure to consider the possibility of such issues and discuss what needs to be in place to achieve successful permanency for a child. For example, if the plan is to reunify the child with his/her parents, identify what therapeutic services may need to be put into place both before and after reunification.

Support the Child's Development

- Ask parents if early childhood partners can be invited. Children placed in out of home care and who have been linked to early childhood care resources should be represented at permanency child and family team meetings by those who see them on a daily basis – particularly teachers and caregivers from early childhood settings. These individuals bring valuable knowledge about what the child needs from a permanent family and can share this knowledge with family members in a useful way.
- Identify how the child's connections to family and community can be preserved. Many permanency options can be constructed in ways that allow children to stay connected to both the family and to any substitute caregivers they may have become attached to. These opportunities should be discussed in light of their importance to the child's healthy development. This may include the continual integration of the child's culture, language, and spiritual practices.

Support and Strengthen Parental and Caregiver Protective Factors

- Explore barriers to developing healthy social connections. Use the meeting as an opportunity to discuss how the parents could be assisted in developing healthy connections for themselves and their children. For example, unresolved family dynamics may be impeding the parents from having a healthy, supportive relationship with their own immediate and extended family. Discussing the importance of resolving those familial issues may lead to the identification of additional actions to help the child achieve permanency. Help parents determine who within their support network really can contribute positively to helping them and their child. Inclusion of the parents in this decision- making can also help foster an environment that supports cultural, language, and spirituality.

- Model good relational behavior. As the facilitator, help parents develop stronger relational skills by demonstrating effective interactions with others. Encourage the parents to interact with others by giving them the freedom to ask as many questions as they want and to respond to the information that is shared.

- Provide parents with information about their child. Use this opportunity to review the child's physical and emotional progress and discuss how the parent perceives the child's progress. Help the parent understand how to use information about their child's development to identify the child's needs.

- Make protective factors part of the conversation. This teaming provides an important platform to think about what will happen after the case closes, and the protective factors can serve as a strength-based framework for that process. Helping caregivers to think about their on-going plan to support and build their own protective factors should be a major part of the conversation.

DCF Early Childhood Practice Guide

Appendices

Introduction

During home visits or placement visits, front-line staff are required to cover many areas with parents/caregivers of young children, including but not limited to assessing the physical/social *environment* in which the child resides, child development, and the parent-child relationship. The Appendix consists of tools and additional information that staff can use to inform their overall assessment of the safety and well-being of the child. When these tools are used to help guide our engagement with families, they enhance our critical thinking and provoke conversations with caretakers to gather important information to inform a more comprehensive and thorough assessment.

The tools provided in the appendix are not designed to replace or supplant the SDM tools, but rather supplement SDM. The tools can be utilized throughout the life of the case with multiple caretakers, enhanced by case observations, and can be used at various stages of the child's development. Information obtained can be added to information received from service providers, including but not limited to, pediatricians, educators, behaviorists and clinicians.

No tool is to be used to singularly drive our case decisions. The proverbial tag lines of "there were no visible marks or bruises" and "child appeared bonded", have proven over time, as evidenced in the 2011 ORE report, that our assessments of the 0-5 population goes beyond our "checklist/check boxes" and requires a broad and exhaustive multi-disciplinary approach. We must move away from asking the same question on every case, when the risk factors and complexity of cases vary.

As a learning organization in a changing world, it is necessary for us to develop our workforce. This can only be achieved when we are able to learn from our past practices by way of research, in addition to our collaborations with specialists in related fields and systems, acknowledge where we could have done something different and consequently, DO something different.

The Impact of Trauma on Early Childhood Development

Almost 200,000 children under the age of 3 come into contact with the child welfare system every year and have the highest rate of child fatalities. For young children, this threat arises at a crucial time in life, when early experiences are shaping the brain's architecture into a foundation for learning, health, and future success. Maltreatment chemically alters the brain's development and can lead to permanent damage of the brain's architecture. The developmental risks associated with maltreatment (such as cognitive delays, attachment disorders, difficulty showing empathy, poor self-esteem, and social challenges) are exacerbated by removal from home and placement in multiple foster homes.

The human brain is an amazing and complex organ. It allows us to think, act, feel, laugh, speak, create, and love.

The core "mission" of the brain is to sense, perceive, process, store, and act on information from the external and internal environment to promote survival.

The brain is composed of many different parts or systems that control different functions.

While the most basic part of our brain is completely functional when we are born, the other parts continue to develop after birth.

The brain is organized so that the basic functions develop first and the most complex functions develop last. The brain develops in order: from least (brainstem) to most complex (limbic, cortex) areas.

Different parts of the brain control different functions.

The brainstem controls the basic functions such as breathing, heart rate, swallowing, digestion, and temperature.

The limbic area is part of the central nervous system that controls more complex functions such as regulating emotions and memory.

One of the most important influences on a young child's growth and development is his/her relationship with a caring and nurturing adult beginning at birth. This relationship is the basis for an infant's ability to form a secure attachment which sets the stage for their cognitive, social, and emotional future.

The factors that play a key role in determining an infant's mental health in the context of these early relationships are as follows:

- the developing brain;
- the importance of attachment;
- the effects of trauma;
- the influence of toxic stress; and
- the family's protective factors which can be buffers to adverse life situations.

Brain Development

In the past, some scientists thought the brain's development was determined genetically and brain growth followed a biologically predetermined path. Now we know that early experiences impact the development of the brain and influence the specific way in which the circuits (or pathways) of the brain become "wired." A baby's brain is a work in progress. The outside world shapes its development through experiences.

During early childhood, the brain is developing the framework for learning, planning, making connections, and abstract thinking; whether the foundation is strong or weak greatly depends on the nature and quality of their experiences and environment.

Traumatic experiences hold the potential for a strong and lasting impact on the normal development of a child's brain. When the architecture of that framework is impacted by trauma, there can be adverse effects to the cognitive capacity,

emotional experiences, and behavioral control of the child, ultimately impacting their interpersonal relationships and long term well-being. This is important when you consider that 47% of children experiencing trauma do so by the age of 5.

Traumatic events have a profound sensory impact on young children. Their sense of safety may be shattered by frightening visual stimuli, loud noises, violent movements, and other sensations associated with an unpredictable frightening event. The frightening images tend to recur in the form of nightmares, new fears, and actions or play that reenact the event. Lacking an accurate understanding of the relationship between cause and effect, young children believe that their thoughts, wishes, and fears have the power to become real and can make things happen.

Young children are less able to anticipate danger or to know how to keep themselves safe, and so are particularly vulnerable to the effects of exposure to trauma. A 2-year-old who witnesses a traumatic event may interpret the event quite differently from the way a 5-year-old or an 11-year-old would. Children may blame themselves or their parents for not preventing a frightening event or for not being able to change its outcome. These misconceptions of reality compound the negative impact of traumatic effects on children's development. Unlike older children, young children cannot verbally express whether they feel afraid, overwhelmed, or helpless. However, their behaviors provide us with important clues about how they are affected.

A growing body of research has shown that adverse environments and experiences place young children at risk for limited language and cognitive skills, difficulties interacting effectively with their peers, insecure attachments, developmental delays, behavioral and mental health problems, and an array of health problems and conditions (e.g. lung disease, cancer, depression alcoholism) later in life.

Unlike adults, infants and toddlers have a fairly limited repertoire of coping responses to stress and trauma and are more likely than older children and adults to have a dissociative adaptive response and may act stunned or numb. Mental health disorders in young infants might be reflected through physical symptoms such as poor weight gain, slow growth, constipation, delayed development and inconsolable crying. In older infants, excessive tantrums, eating and sleeping problems, aggressive or impulsive behavior and developmental delays can be present. Toddlers may also present with paralyzing fears and withdraw from social interaction.

The following chart demonstrates some ways in which maltreatment affects the brain[1]:

Type of Maltreatment	Effects
Shaken Baby	• Tear blood vessels • Destroys brain tissue • Sensory impairments • Cognitive, learning, and behavioral disabilities.
Traumatic Maltreatment (physical abuse, exposure to violence)	• Alters brain's ability to use serotonin to feel well and stable • Persistent fear, which interferes with brain development • Hyperarousal • Dissociation
Neglect	• Malnutrition stunts brain growth • Lack of stimulation leads to underdevelopment of neural pathways • Babies not talked to have difficulties with language development • Severe neglect leads to smaller brain size • Impaired attachments leading to excessive dependency, social isolation and difficulty regulating emotion

[1] Children and Family Research Center, University of Illinois at Urbana-Champaign SSW,
Child Maltreatment Victims Age Zero to Five: Developmental Challenges & Program Opportunities,
Ted Cross, Jesse Helton, Sandra Lyons & Judy Havlicek

Signs and Symptoms of Trauma—Ages 0 to 2

A child may have experienced trauma if he or she exhibits any of the following signs and symptoms:

- Acts withdrawn or dissociates
- Demands attention through both positive and negative behaviors
- Demonstrates poor verbal skills
- Displays excessive temper tantrums
- Exhibits aggressive behaviors
- Exhibits memory problems
- Exhibits regressive behaviors
- Experiences nightmares or sleep difficulties
- Fears adults who remind them of the traumatic event
- Has a poor appetite, low weight and/or digestive problems
- Has poor sleep habits
- Screams or cries excessively
- Shows irritability, sadness, anxiety and fear in facial expressions, tone or body language
- Startles easily

Signs and Symptoms of Trauma—Ages 2 to 6

A child may have experienced trauma if he or she exhibits any of the following signs and symptoms:

- Acts out in social situations
- Acts withdrawn or dissociates
- Demands attention through both positive and negative behaviors
- Displays excessive temper
- Is anxious and fearful and avoidant
- Is unable to trust others or make friends
- Is verbally abusive
- Believes he or she is to blame for the traumatic experience
- Develops learning disabilities
- Exhibits aggressive behaviors
- Experiences nightmares or sleep difficulties
- Experiences stomachaches and headaches
- Fears adults who remind him or her of the traumatic event
- Fears being separated from parent/caregiver
- Has difficulties focusing or learning in school
- Has poor sleep habits
- Imitates the abusive/traumatic event
- Lacks self-confidence
- Shows irritability, sadness and anxiety
- Shows poor skill development
- Startles easily
- Wets the bed or self after being toilet trained or exhibit other regressive behaviors[2]

[2] Source: National Child Traumatic Stress Network: http://www.nctsn.org/trauma-types/early-childhood-trauma/Symptoms-and-Behaviors-Associated-with-Exposure-to-Trauma

Other National Resources

In addition, the following links are helpful resources for caregivers who want to support children who have experienced trauma:

- ☐ A general guide to trauma for all parents: http://actagainstviolence.apa.org/materials/publications/act/trauma.pdf
- ☐ Guide written for adoptive parents on providing care to a child that has experience trauma: http://www.fosteringperspectives.org/fp_v10n1/Kennedy&Bennett.pdf
- ☐ The National Child Traumatic Stress Network. Includes a wealth of resources including a trauma training for child welfare workers.
- ☐ Best Practice Tutorial Series on the Center for Early Childhood Mental Health Consultations' website
- ☐ Excerpts from *Your Child* on Childhood Trauma and Its Effects from the American Academy of Child and Adolescent Psychiatry
- ☐ Identifying Seriously Traumatized Children: Tips for Parents and Educators from the National Association of School Psychologists (pdf available here)
- ☐ American Psychological Association: Resilience Guide for Parents and Teachers
- ☐ The NYU Child Study Center's Children's Resilience in the Face of Trauma
- ☐ US Department of Health and Human Services Administration for Children and Families, Child Welfare Information Gateway: Resiliency in Children and Youth
- ☐ Effects of Traumatic Events on Children, The Child Trauma Academy www.ChildTrauma.org
- ☐ The Neurodevelopmental Impact of Violence in Childhood https://childtrauma.org/wp-content/.../11/Neurodevel_Impact_Perry.pdf

Parents with Trauma History

Many of the parents with whom we work have their own history of childhood trauma. Those experiences, and their impact on risk related behaviors, can result in a parent's inability to form consistently nurturing bonds with their children, make healthy decisions regarding those to whom they expose their children, and appropriately interpret and respond to their child's needs. This can compound the experience of trauma by younger children, as the presence of a primary attachment figure is a crucial element in a child's resilience in the face of traumatic experiences.

Young children depend exclusively on parents/caregivers for survival and protection. When trauma also impacts the parent/caregiver, the relationship between that person and the child may be strongly affected. Without the support of a trusted parent/caregiver to help them regulate their strong emotions, children may experience overwhelming stress, with little ability to effectively communicate what they feel or need. They often develop symptoms that parents/caregivers don't understand and may display uncharacteristic behaviors that adults may not know how to appropriately respond to.

Early childhood is considered by many scientists to be the most critical and the most vulnerable developmental period in the lifespan.

But the early years of life also offer the greatest opportunity for preventing or mitigating harm and setting the course for healthy development.

Early and appropriate interventions can help minimize lasting damage caused by abuse, neglect, and placement in foster care. By understanding the developmental risks, identifying delays early, and linking infants, toddlers and their families and caretakers to appropriate interventions, outcomes for maltreated infants and toddlers can be improved.

Child Development

Examples of Typical Child Development by Age

Age	Behaviors
1-3 months	• Able to suck and swallow • Startled by loud noise • Pays attention to faces nearby • Makes soft, throaty, gurgling sounds
3-4 months	• Holds a rattle and shakes it • Holds head up well • Shows gains in height and weight • Smiles at familiar people
4-6 months	• Reaches for and grasps objects • Moves toys from hand to hand • Rolls from tummy to back and back to tummy
6-9 months	• Babbles and laughs out load • Sits up without help • Plays peek-a-boo and pat-a-cake • Creeps or crawls forward on tummy by moving arms and legs
9-12 months	• Pulls to a stand • Picks up small objects • Waves “bye-bye” • Points at something to draw your attention
12-15 months	• Comes when called by name • Drinks from a cup • Takes turns rolling a ball with you • Shakes head to mean “no”
15-18 months	• Looks at picture books • Likes to push, pull, and dump things • Tries to talk and repeat words • Walks without help • Nods head to mean “yes”
18-24 months	• Carries objects while walking • Uses 5-10 words • Gives hugs and kisses • Follows simple directions
24-30 months	• Runs well, with few falls • Holds a crayon, likes to scribble • Can eat without help • Asks simple questions
30+ months	• Helps with getting dressed • Walks up and down stairs • Sings simple songs • Understands right from wrong

Child Development

Early childhood is a time of remarkable physical, cognitive, social and emotional development. Growth and development includes not only the physical changes that will occur from infancy to adolescence, but also some of the changes in emotions, personality, behavior, thinking, and speech that children develop as they begin to understand and interact with the world around them.

Types of Developmental Milestones:

1) **Physical Milestones**: involve both large-motor skills and fine-motor skills. The large-motor skills are usually the first to develop and include sitting up, standing, crawling and walking. Fine-motor skills involve precise movements such as grasping a spoon, holding a crayon, drawing shapes and picking up small objects.

   From the moment of birth, babies are inundated with sensory experiences that they are eager to explore. Babies watch their parents with the eyes, attempt to move toward the touch of caregivers, and move their mouths to touch and taste just about anything they can get in their mouths. As children grow, their abilities to control balance, movement, and fine-motor skills become increasingly advanced.

   Developmental milestones are abilities that most children are able to perform by a certain age. During the first year of a child's life, physical milestones are centered on the infant learning to master self-movement, hold objects and hand-to-mouth coordination.

2) **Cognitive milestones** are centered on a child's ability to think, learn, and solve problems. An infant learning how to respond to facial expressions and a preschooler learning the alphabet are both examples of cognitive milestones.

3) **Social and emotional milestones** are centered on children gaining a better understanding of their own emotions and the emotions of others. These milestones also involve learning how to interact and play with other people.

4) **Communication milestones** involve both language and nonverbal communication. A one-year old learning how to say his first words and a five year old learning some of the basic rules of grammar are examples of important communication milestones.

While most of these milestones typically take place during a certain window of time, parents and caregivers must remember that each child is unique.

These developmental abilities also tend to build on one another. More advanced skills such as walking usually occur after simpler abilities such as crawling and sitting up have already been achieved.

Five Stages of Development:

Gross Motor Development

Gross motor skills include balance, muscle tone, strength, and coordination of upper and lower extremity movements for activities such as sitting, crawling, and walking.

Fine Motor Development

Fine Motor Activities addresses the child's ability to reach, grasp, and release objects in a purposeful manner. This includes using the arms and hands in an integrated way to plan movements and manipulate items. Adequate fine motor skill development is imperative for children as they will use these skills throughout life. Fine motor skills are necessary for simple daily living skills like eating, dressing, and performing household chores.

Cognitive Development

The development of cognitive skills is related to the experiences a child has with the world around him. Initially, these experiences include movement of the body in space and movement to explore objects. These experiences also include sensation and sensory feedback that the child gains from the world around him, interactions with other people, toys and objects, and the availability of environments that stimulate interest and exploration during the birth to 5-month period of development.

Physical changes in early childhood are accompanied by rapid changes in the child's cognitive and language development. From the moment they are born, children use all their senses to attend to their environment, and they begin to develop a sense of cause and effect from their actions, and the responses of their caregivers.

Language Development

Communication includes expressive, receptive, and social use of language. Articulation and speech production are also part of the development of effective communication skills. Communication includes the use of pictures, behavior, gestures, signs, and body language. Expressive language is verbal expression. Receptive language is the ability to understand language.

Over the first three years of life, children develop a spoken vocabulary of between 300 and 1,000 words, and they are able to use language to learn about and describe the world around them. By age five, a child's vocabulary will grow to approximately 1,500 words. Five-year-olds are also able to produce five-to seven-word sentences, learn to use the past tense, and tell familiar stories using pictures as cues. Language is a powerful tool to enhance cognitive development. Using language allows the child to communicate with others and solve problems.

Social/Emotional Development

This area describes the child's social responsiveness, appropriate attachments to familiar adults, and the level of independence when interacting with others. Awareness of rules such as imitation or interactions and turn taking are also considered part of social skill development.

A key moment in early childhood socioemotional development occurs around one year of age. This is the time when attachment formation becomes critical. Attachment theory suggests that individual differences in later life functioning and personality are shaped by a child's early experiences with their

caregivers. The quality of emotional attachment, or lack of attachment, formed early in life may serve as a model for later relationships.

From age three to five, growth in socioemotional skills includes the formation of peer relationships, gender identification, and the development of a sense of right and wrong. Taking the perspective of another individual is difficult for young children, and events are often interpreted in all-or-nothing terms, with the impact on the child being the primary concern. For example, at age five a child may expect others to share their possessions freely but still be extremely possessive of a favorite toy.

The Connecticut Part C Memorandum of Understanding

In recognizing the importance of providing Part C services to young children who have experienced abuse and neglect, the Connecticut Department of Children and Families and the Connecticut Department of Developmental Services have developed a Memorandum of Understanding, which outlines the priorities, roles, responsibilities and processes needed to ensure that young children served by DCF are assessed for and receive Part C services as needed.

Connecting Families to Part C Services

Studies show that half of all children birth to three who have experienced abuse and/or neglect have significant delays in communication or cognitive development, and a quarter have delays in motor development.[3] Part C services are designed to support children who have developmental delays or conditions that might cause a developmental delay. Nationally, there is a special interest in ensuring that children connected to child welfare systems are also connected to Part C services.

Based on the Part C Memorandum of Understanding, social workers should make a referral for assessment for Part C eligibility for **any child in their caseload who is age three or below and, (a) has a substantiated case of abuse and/or neglect and are suspected of having a developmental delay, or, (b) is affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.**

Service plans vary to meet the unique needs of every child. Below is a list of services that may be available to a child who is eligible for Part C:

- Audiology services
- Assistive technology
- Counseling/psychological assessments
- Family training, counseling and home visits
- Medical evaluations (for diagnostic purposes only)
- Nursing care
- Nutritional assistance
- Occupational therapy
- Physical therapy
- Service coordination
- Social work services
- Speech/language therapy
- Transportation services

[3] Blatt, S.D., Saletsky, R.D., Meguid, V., Church, C.C., O'Hara, M.T., Haller-Peck, S.M., & Anderson, J.M. (1997). A comprehensive, multidisciplinary approach to providing health care for children in out-of-home-care. *Child Welfare*, *76*(2).

Developmental Milestones for Infants (0-18 months)

PHYSICAL:	
0-3 months	
• Demonstrates sucking, grasping reflexes • Lifts head when held at shoulder	• Moves arms actively • Is able to follow objects and to focus
3-6 months	
• Rolls over • Holds head up when held in sitting position	• Reaches for objects • Lifts up knees, crawling motions
6-9 months	
• Sits unaided, spends more time in upright position • Learns to crawl	• Climbs stairs • Develops eye-hand coordination
9-18 months	
• Achieves mobility, has strong urge to climb, crawl • Stands and walks • Learns to walk on his or her own	• Learns to grasp with thumb and finger • Feeds self • Transfers small objects from one hand to another
SOCIAL-EMOTIONAL:	
• Wants to have needs met • Develops a sense of security • Smiles spontaneously and responsively • Likes movement, to be held and rocked • Laughs aloud • Socializes with anyone, but knows mother or primary caregiver • Responds to tickling	• Prefers primary caregiver • May cry when strangers approach • Consistently anxious • Extends attachments for primary caregivers to the world • Demonstrates object permanence; knows parents exist and will return • Tests limits
INTELLECTUAL/COGNITIVE:	
• Vocalizes sounds (coos) • Smiles and expresses pleasure • Recognizes primary caregiver • Uses both hands to grasp objects • Has extensive visual interests • Puts everything in mouth • Solves simple problems, e.g., will move obstacles aside to reach objects • Transfers objects from hand to hand	• Responds to changes in environment and can repeat action that caused it • Begins to respond selectively to words • Demonstrates intentional behavior, initiates actions • Realizes objects exist when out of sight and will look for them (object permanence) • Is interested and understands words • Says words like “mama,” “dada”

Source: National Resource Center for Permanency and Family Connections
Hunter College School of Social Work • 129 E. 79th Street • New York, NY 10021
Tel. 212/452-7053 • Fax. 212/452-7051 • www.nrcfcppp.org

ACT EARLY: CONTACT THE CHILD'S PEDIATRICIAN IF:

By 2 months the child...

- Doesn't respond to loud sounds
- Doesn't watch things as they move
- Doesn't bring hands to his moth
- Can't hold head up while on stomach and pushing up

By 4 months the 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

By 6 months the child...

- Doesn't try to get things that are in reach
- Shows no affection for caregivers
- Doesn't respond to sounds
- Has difficulty getting things to mouth
- Doesn't make vowel sounds ("ah", "eh", "oh," etc.)
- 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

By 9 months the child...

- Doesn't bear weight on legs with support
- Doesn't sit with help
- Doesn't babble ("mama", "baba", "dada," etc.)
- 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

By 1 year the child...

- Doesn't crawl
- Can't stand when supported
- Doesn't search for things that he or 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 previously achieved skill sets/abilities

By 18 months the 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 previously achieved skill sets/abilities

Source: The Centers for Disease Control and Prevention: "Learn the Signs. Act Early. Milestones 18 months – NCBDD." Published online at: http://www.cdc.gov/ncbddd/actearly/milestones/milestones-18mo.html

Developmental Milestones for Toddlers (18-36 months)

<table>
<tr><th colspan="2">PHYSICAL:</th></tr>
<tr><td colspan="2">• Enjoys physical activities such as running, kicking, climbing, jumping, etc.
• Beginnings of bladder and bowel control develop towards latter part of this stage
• Increasingly able to manipulate small objects with hands</td></tr>
<tr><th colspan="2">SOCIAL-EMOTIONAL:</th></tr>
<tr><td>• Becomes aware of limits; says “no” often
• Begins establishing a positive, distinct sense of self through continuous exploration of the world
• Continuing to develop communication skills and experiencing the responsiveness of others</td><td>• Needs to exhibit autonomy and achieve some simple tasks for him/herself
• Making simple choices such as what to eat, what to wear and what activity to do</td></tr>
<tr><th colspan="2">INTELLECTUAL/COGNITIVE:</th></tr>
<tr><td>• Has a limited vocabulary of 500-3,000 words and is able to form three to four word sentences
• Has a basic grasp of prepositions (in, on, off, out, away, etc.)
• Most toddlers can count, but they do so from memory, without a true understanding of what the numbers represent
• Cognitively, children in this age range are very egocentric and concrete in their thinking and believe that adults know everything. This means that they look at everything from their own perspective</td><td>• They assume that everyone else sees, acts and feels the same way they do, and believe that adults already know everything. This results in their feeling that they don’t need to explain an event in detail
• Toddlers might have a very clear picture of events as they relate to themselves but may have difficulty expressing thoughts or providing detail. Because of this, most of the questions will need to be asked of their caregivers
• Toddlers are able to relate their experiences, in detail, when specifically and appropriately questioned
• Learning to use memory and acquiring the basics of self-control</td></tr>
</table>

Source: National Resource Center for Permanency and Family Connections
Hunter College School of Social Work • 129 E. 79th Street • New York, NY 10021
Tel. 212/452-7053 • Fax. 212/452-7051 • www.nrcfcppp.org

ACT EARLY: CONTACT THE CHILD’S PEDIATRICIAN IF:

By 2 years the 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, etc.
- Doesn’t copy actions and words
- Doesn’t follow simple instructions
- Doesn’t walk steadily
- Loses previously achieved skill sets/abilities

Source: The Centers for Disease Control and Prevention: “Learn the Signs. Act Early. Milestones 2 Years – NCBDD.” Published online at: http://www.cdc.gov/ncbddd/actearly/milestones/milestones-2yr.html

Developmental Milestones for Pre-Schoolers (3-6 years)

<table>
<tr><th colspan="2">PHYSICAL:</th></tr>
<tr><td colspan="2">• Is able to dress and undress
• Has refined coordination and is learning many new skills
• Is very active and likes to do things like climb, hop, skip and do stunts</td></tr>
<tr><th colspan="2">SOCIAL-EMOTIONAL:</th></tr>
<tr><td>• Develops capacity to share and take turns
• Plays cooperatively with peers
• Is developing some independence and self-reliance
• Is developing ethnic and gender identities</td><td>• Learning to distinguish between reality and fantasy
• Learning to make connections and distinctions between feelings, thoughts and actions</td></tr>
<tr><th colspan="2">INTELLECTUAL/COGNITIVE:</th></tr>
<tr><td>• With preschoolers, their ability to understand language usually develops ahead of their speech
• By age 6, their vocabulary will have increased to between 8,000 and 14,000 words but it is important to remember that children in this age group often repeat words without fully understanding their meaning
• They have learned the use of most prepositions (up/down, ahead/behind, etc.) and some basic possessive pronouns (mine, his, ours, etc.) and have started to master adjectives
• Pre-school children continue to be egocentric and concrete in their thinking. They are still unable to see things from another's perspective, and they reason based on specifics that they can visualize and that have importance to them (i.e. "Mom and Dad" instead of "family").</td><td>• When questioned, they can generally express who, what, where and sometimes how, but not when or how many.
• They are also able to provide a fair amount of detail about a situation.
• It is important to keep in mind that children in this age range continue to have trouble with the concepts of sequence and time. As a result, they may seem inconsistent when telling a story simply because they hardly ever follow a beginning-middle-end approach</td></tr>
</table>

Source: National Resource Center for Permanency and Family Connections
Hunter College School of Social Work • 129 E. 79th Street • New York, NY 10021
Tel. 212/452-7053 • Fax. 212/452-7051 • www.nrcfcppp.org

ACT EARLY: CONTACT THE CHILD'S PEDIATRICIAN IF:

By 3 years the 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 handles, etc.)
- 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 previously achieved skill sets/abilities

By 4 years the 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 previously achieved skill sets/abilities

By 5 years the 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 previously achieved skill sets/abilities

Source: The Centers for Disease Control and Prevention: "Learn the Signs. Act Early. Milestones – NCBDD." Published online at: http://www.cdc.gov/ncbddd/actearly/milestones/index.html

Key developmental skills for young children to master include the following:

- Ability to manage impulses and regulate their own behavior;
- Learn to identify and start to understand their own feelings;
- Learn to manage strong emotions and express them in a constructive manner;
- Learn to recognize emotions and emotional cues in others;
- Learn to develop empathy for others;
- Ability to establish and sustain close relationships and friendships; and
- Learn to develop confidence, cooperativeness, and the capacity to communicate.

Attachment

Understanding the Importance of Attachment in the Early Years

Attachment helps develop a sense of safety, encourages socialization, stimulates intellectual and psychological growth, and influences identity. It is a reciprocal, bi-directional tie between two or more people which typically starts with primary caregiver and gradually broadens to others. Infants are capable of developing multiple attachments (e.g., to mothers, fathers, grandparents). Usually however, they have one parent who is their "primary attachment figure."

Stable, caring relationships are essential for healthy development. Children develop in an environment of relationships that begin in the home and include extended family members, natural supports, early care and education providers, and members of the community. Numerous scientific studies around attachment support the following conclusions: ***providing supportive, responsive relationships as early in life as possible can prevent or reverse the damaging effects of toxic stress.***

The quality of the attachment is one of the strongest predictors of later development.

Parental behaviors typically associated with secure attachment include:

THE KEY FACTOR IN PROMOTING A SECURE ATTACHMENT IS PARENTING BEHAVIOR

- Sensitive and responsive care;
- Clear, consistent, developmentally appropriate expectations and supervision;
- Warm, positive, and responsive verbal interaction;
- Seeing the child as a unique individual, having insight into the child (i.e., why he does what he does); and
- "Holding the child in mind" (i.e., awareness of and ability to reflect on the parent's own feelings and responses to the child)

Infant and early childhood behaviors associated with secure attachment include:

- Comfort exploring in presence of an attachment figure;
- When hurt, going to an attachment figure for comfort (i.e., not a stranger);
- Seeking help when needed;
- Willingness to comply with requests with minimal conflict; and
- No pattern of controlling or directing the behavior of caregivers (no role-reversal)

Insecure Attachment – disrupted relationships.

An **insecure attachment** is characterized by the child's inability to use his or her parent for comfort or as a secure base. Insensitive, rejecting, or inconsistent parenting has been linked to insecure attachment.

Parental behaviors typically associated with insecure attachment include:

- Interfering with the child's attempts at exploration (i.e., intrusive, overly controlling);
- Unclear, inconsistent, developmentally inappropriate expectations and supervision;
- Ignoring the child's needs and cues;

- Inconsistent, unreliable responsiveness;
- Hostile, threatening, and frightening behaviors;
- Prioritizing the parent's needs over the child's (i.e., self-absorbed);
- Behaving like a child or treating the child as though he/she is in charge (i.e., role-reversal);
- Marked withdrawal, fright, hesitance or timidity around the child; and
- Sexualized or overly intimate behaviors

Infant and early childhood behaviors associated with insecure attachment include:

- Excessive dependence;
- Marked shyness, withdrawal, or unfriendliness;
- Failure to seek contact, comfort when needed;
- Indiscriminate friendliness or contact seeking;
- Punitive, bossy behaviors;
- Over-concern with the parent's well-being (i.e., role reversal);
- Disoriented or frightened in presence of the parent, such as approaching while looking away, stilling, freezing, or rocking; and
- Promiscuous, sexualized behavior

There are **three basic types of insecure attachment** as follows:

Ambivalent Attachment

Ambivalent or Resistant Attachment stems from the infant's experience of inconsistent parenting when the child is never quite sure if his or her expressions of anxiety and distress will be suitably attended to. There is a lack of consistent nurturing and protection from the parent that makes it hard for the infant to feel that exploring the world is a safe option. As such, the child has a low threshold for distress, but no confidence that comfort will be forthcoming. When upset he or she tries to get close to the caregiver, but only to become angry and resist contact. This pattern can be carried into adulthood and there it reveals itself in relationship difficulties where there is either a withdrawal from others or a compulsion to be dependent. This is the hysterical personality who "flees from intimacy", and, like the ambivalent child, tends to be demanding or clingy, immature, and easily overwhelmed by her own emotions.

The insecure-resistant infant is very likely to cry during the separation episodes. When the mother returns he or she often continues to cry; he or she often looks at and reaches for the mother with little or no active approach. When picked up, he or she does not actively cling and is not easily comforted. If the mother offers a toy he or she often shows continued distress by slapping at it or at her but this is not accompanied by active turning in or by clinging.

This attachment style is considered relatively uncommon, affecting an estimated 7-15% of U.S. children. Research suggests that ambivalent attachment is a result of poor maternal availability. These children cannot depend on their mother (or caregiver) to be there when the child is in need. Avoidant attachment is a strategy often developed by an infant whose parents have discouraged overt signs of either affection or distress, and who do not readily offer sympathy or comfort. The insecure avoidant infant rarely cries when separated from the primary caregivers and avoids contact upon his or her return. The avoidant infant does not react with protest to the mother's departure in an unfamiliar

setting. Instead, the infant typically diverts attention from her exit, explores actively while she is out of the room. This independent appearing behavior often looks quite positive to an observer. However, an avoidant infant also does not immediately acknowledge the mother's return to the room, averting his or her gaze when the mother enters and initially moves away from her if she approaches. When offered a choice, these children will show no preference between a caregiver and a complete stranger.

Disorganized Attachment

Disorganized/disoriented attachment refers to children who seem frightened or disorganized in the presence of their parents. Children with a disorganized attachment often display a confusing mix of behavior and may seem disoriented, dazed, or confused. Children may both avoid or resist the parent.

Disorganized attachment occurs when the parent either has so many unresolved emotional issues from their own past that they have no mental space left over for their baby or, when the threat is graver. The baby is biologically impelled to seek safety through closeness to the caregiver. When the parent is the source of fear he or she is left with no coherent means of relating to other people.

Abuse and neglect in the first years of life have a particularly pervasive impact. Prenatal development and the first two years of life are the time when the genetic, organic, and neurochemical foundations for impulse control are being created. It is also the time when the capacity for rational thinking and sensitivity to other people are being rooted - or not - in the child's personality. The impact can be visible almost straight away, as it has been found that the rate of disorganized attachment associated with failure to thrive is extremely high.

Babies with disorganized – disoriented attachment often show inconsistent, contradictory behaviors. They greet the mother brightly when she returns but then turn away or approach without looking at her. They seem confused and afraid. Some researchers believe that the lack of a clear attachment pattern is likely linked to inconsistent behavior from caregivers. In such cases, parents may serve as both a source of comfort and a source of fear, leading to disorganized behavior.

A child who was insecurely attached in infancy is more likely in childhood to have poor social skills (e.g., withdrawal or aggression), to act out and be disobedient, to have poor communication skills, to be impulsive and easily distracted, and to lack curiosity and motivation in school. It is important to note that an insecure attachment does not fate a child to failure. Change certainly can occur. The longer a child is on a specific path, however, the harder it is to alter the course.

Assessing Attachment and Bonding: Birth to Age 1

Does the Child…?	Does the Parent…?
• Appear alert • Respond to people • Show interest in the human face • Track with his/her eyes • Vocalize frequently • Exhibit expected motor development • Enjoy close physical contact • Signal discomfort • Appear to be easily comforted • Exhibit normal or excessive fussiness • Appear outgoing or id he/she passive and withdrawn • Have good muscle tone	• Respond to the infant's vocalization • Change voice tone when talking to or about the baby • Engage in face to face contact with the infant • Exhibit interest in and encourage age appropriate development • Respond to the child's cues • Demonstrate the ability to comfort the infant • Enjoy close physical contact with the baby • Initiate positive interactions with the infant • Identify positive qualities in the child Source: a Child's Journey Through Placement, Vera I Fahlberg, MD, p 41

Assessing Attachment and Bonding: Age 1 to Age 5

Does the Child…?	Does the Parent…?
• Explore his/her surroundings • Respond positively to parents • Keep himself/herself occupied • Show signs of reciprocity • Seem relaxed and happy • Look at people when communicating • Show emotions in a recognizable manner • React to pain and pleasure • Engage in age appropriate activities • Use speech appropriately • Respond to parental limit setting • Demonstrate normal fears • React positively to physical closeness • Show a response to separation • Note the parent's return • Exhibit signs of pride and joy • Show signs of empathy • Show signs of embarrassment, shame, or guilt	• Use disciplinary measures appropriate for the child's age • Respond to the child's overtures • Initiate affection • Provide effective comforting • Initiate positive interactions with the child • Accept expressions of autonomy • See the child as positively "taking after" a family member • Seem aware of child's cues • Enjoy reciprocal interactions with the child • Respond to child's affection • Set age appropriate limits • Respond supportively when the child shows fears Source: a Child's Journey Through Placement, Vera I Fahlberg, MD, p 42

Symptoms that are Commonly Seen in Children with Attachment Problems	
Psychological or Behavioral Problems	
Conscience development	• May not show normal anxiety following aggressive or cruel behavior • May not show guilt on breaking laws or rules • May project blame on others
Impulse Control	• Exhibits poor control; depends upon others to provide • Exhibits lack of foresight • Has a poor attention span
Self-esteem	• Is unable to get satisfaction from tasks well done • Sees self as undeserving • Sees self as incapable of change • Has difficulty having fun
Impersonal interactions	• Lacks trust in others • Demands affection but lacks depth in relationships • Exhibits hostile dependency • Needs to be in control of all situations • Has impaired social maturity
Emotions	• Has trouble recognizing own feelings • Has difficulty expressing feelings appropriately – especially anger, sadness and frustration • Has difficulty recognizing feelings on others

Cognitive Problems	**Developmental Problems**
• Has trouble with basic cause and effect • Experiences problems with logical thinking • Appears to have confused thought processes • Has difficulty thinking ahead • May have an impaired sense of time • Has difficulties with abstract thinking	• May have difficulty with auditory processing • May have difficulty expressing self well verbally • May have gross motor problems • May experience delays in fine motor adaptive skills • May experience delays in personal social environment • May have inconsistent levels of skills in all of the above areas Source: a Child's Journey Through Placement, Vera I Fahlberg, MD, p 53

Encouraging Attachment for Children in Placement

Responding to the Child	Initiating Positive Interactions
• Using the child's tantrums to encourage attachment • Responding to the child when he/she is physically ill • Accompanying the child to doctor and dentist appointments • Helping the child express and cope with feelings of anger and frustration • Sharing the child's excitement over his/her achievements • Helping the child cope with feelings about placement • Helping the child cope with ambivalent feelings about his/her birth family • Responding to a child who is hurt or injured	• Making affectionate overtures: hugs, kisses, physical closeness • Reading to the child • Playing games • Going shopping together for clothes/toys for child • Going on special outings • Supporting the child's outside activities and interests • Helping the child with homework when he/she needs it • Teaching the child about extended family members through pictures and talk • Teaching the child to participate in family activities Source: a Child's Journey Through Placement, Vera I Fahlberg, MD, p 62

Resources on Children's Social and Emotional Competence

Zero to Three:
Tips and tools for supporting your child's social and emotional development
Contains a lot of helpful resources for promoting social and emotional development like podcasts, tip sheets, scholarly articles and info sheets, including:

- Tips for Promoting Social-Emotional Development - Discusses how parents can support their child's social-emotional development through everyday interactions.
- **Social-Emotional Development From Birth to Three** – Information about social-emotional development at three different ages:
  - Birth to 12 months
  - 12 to 24 months
  - 24 to 36 months
- **How Young Children Begin Learning Self-Control from Birth to Three** - These age-based handouts focus on how children begin learning self-control—the ability to manage their emotions and stick to the limits that are set.
  - Birth to 12 months
  - 12 to 24 months
  - 24 to 36 months

Center on the Social and Emotional Foundations for Early Learning (Pyramid Model)
Resources: Family Tools, which include several training modules, such as:

- Infant/Toddler Training Modules
- Pre-School Training Modules
- Pre-School Parent Training Modules

- Infant/Toddler Parent Training Modules

Pyramid Model Consortium – Promotes public health 'triage' approach to social emotional supports and interventions
http://www.pyramidmodel.org/

American Academy of Pediatrics
Tips to Promote Social-Emotional Health Among Young Children

www.AbilityPath.org
How to Support Your Child's Social-Emotional Development
Contains an overview of some ways to support a child's social-emotional development

Center for Early Childhood Mental Health Consultation
Georgetown University Center for Child and Human Development
Tutorial 6 · Recognizing and Supporting the Social and Emotional Health of Young Children Birth to Age Five
Contains a detailed understanding of the behaviors related to social and emotional health in infants and young children, as well as strategies that adults can use to support these behaviors within every day routines in the home and within early care and education settings.

Syracuse University
Mid-State Central Early Childhood Direction Center Bulletin Summer 2009
Understanding Social and Emotional Development in Young Children
Provides information about social and emotional development and answers key questions.

Cultural Considerations

In order to fully assess the parenting skills and needs of parents, including adolescent parents, their cultural background must also be understood. Culture and one's own family history, play critical roles in the development of parenting beliefs including, expectations of children, discipline, parenting roles, and the understanding of child development and children's needs. It is important to engage parents in a discussion about their culture to understand how this may influence their parenting style and values.

When asking parents to describe their cultural background, the social worker shall consider the following:

- Primary language
- Religion
- Food
- Traditions
- Holiday/birthday celebrations
- Role of extended family and friends
- Hair and skin care

When asking parents to describe how their race and culture influence their parenting style and values, the social worker shall consider the following:

- Roles and expectations of mothers, fathers, partners and extended family members
- Discipline/encouragement of children/respect for elders

- Understanding of child development (milestones, feeding, sleeping, activity)
- Safe sleep practices
- Parent interaction/nurturing children
- Displays of affection with children
- Supervision of their children
- Definitions of abuse/neglect
- Meaning of child behavior/cues
- Asking for help
- Self-advocacy

These discussions should occur not only with the parent or parenting adolescent in DCF care, but also with the parenting teen's partner/parent of the young child to complete a full assessment of child safety. Adolescent fathers and mothers should be encouraged to explore their cultural, spiritual, and linguistic identity formation through the use of culturally competent services to meet their needs. They should also be afforded the opportunity to discuss cultural/generational norms when it comes to parenting. Assessment should also include issues of immigration that might be impacting the family, such as adaptation due to recent arrival in the country, legal resident or undocumented families. Additionally, families coming from countries with an unstable government, may have trust issues which may impact assessment and connection to services.

Assessing the Home Environment:

Observations of the home environment are a critical component of any assessment of individual and family functioning. Meeting with clients in their community and in their home environment allows us to engage children and families in their own space and offers workers the opportunity to learn more about their clients beyond just what is reported to them. Observations of a home environment can help support an assessment and what a client tells us, or it may raise questions about issues that would require further exploration. Through in home visitation we are able to assess how a client's environment impacts their functioning and well-being. Social workers should pay attention to what they see, hear, and smell during home visits. The home environment should be assessed for indicators of mental health, substance use, and intimate partner violence. In addition, the home itself should be observed for any potential safety hazards that may present a risk to the children and adults residing there. Social workers should be mindful of the family's cultural and religious beliefs and practices and how these may influence the appearance of the home environment.

Social workers should consider the child's perspective and experience within the home environment and with their caretakers.

Social workers are reminded to be aware of anything in the home visit that may be a risk to their own safety and to make their supervisor aware. Consideration should also be given to a family's cultural, linguistic, and religious practices and how these may place expectations on visitors to their home (i.e. removing one's shoes).

The following questions have been developed by staff in the field to gather information designed to inform the assessment. Please note these questions are not research based – or been validated.

Below is a list of factors social workers are advised to consider on home visits:

1. Are there smokers in the home?
2. Is the caretaker able to keep up with the daily responsibilities of maintaining the home?

3. Is the home clean?
4. Is the home cluttered or are there any indications of hoarding?
5. Is the home childproofed? (Gates, outlet covers, pool cover/gate, screens on windows, etc.)
6. Are the child's beds near the window? Are children able to climb up to the window?
7. Are there any infestations? (rodents/ bugs)
8. Are there any signs of substance abuse in the home? (smell, ashtrays, empty bottles/cans, drug paraphernalia)
9. Are there any signs of violence in the home? (holes in walls, broken items or furniture)
10. Are there broken windows, exposed wires, working utilities, running water and working plumbing?
11. Are there any weapons or firearms in the home? Do they have a pistol permit?
12. Are there visitors to the home or different people present in the home during home visits?
13. How is the living environment financially supported? Sources of income? Expenses?
14. What is the heat source? (gas, electric, pellet stove, space heaters)
15. Who lives in the home? Get names and dates of birth of all household members, boyfriends/girlfriends, babysitters, frequent visitors to the home, relative or kin resources (complete criminal checks and CPS checks on all household members)
16. Are any doors to rooms locked in the home or is the parent unwilling to allow access to any area of the home?
17. Are there any additional people living in the home or renters, who the parent would not necessarily consider a household member but who have access to the child(ren)?
18. Are there any pets or exotic animals in the home?

Infancy and Young Children

1. Is there an adequate supply of formula, food, diapers, wipes and clothing for child?
2. Do you ever keep your child in a soiled diaper longer than desired due to a lack of supply of diapers?
3. Are there age appropriate toys in the home? Is there space and time for 'tummy time' and physical activity versus infant seats and strollers?

Safe sleep

1. Where does your child sleep?
2. What do you understand about the dangers of co-sleeping with infants?
3. Do you ever bring your baby into your bed to sleep?
4. When your baby wakes up during the night, who tends to the baby and how is your baby put back to sleep?
5. Does your baby wake up to eat during the night? Where is the baby fed at that time? Do you ever fall asleep while feeding your baby in the middle of the night?
6. Does your baby use a pacifier?

Assessing Parenting and the Parent/Child Relationship

Observation

1. Parent initiates behaviors that foster attachment and bonding.
2. Parent makes eye contact with child.
3. Parent positions child to engage in physical and verbal exchange (i.e. talks, sings, rocks infant).
4. Parent shows pleasure toward infant in gaze, voice, or smile.
5. Parent responds positively toward infant's cues.
6. Parent engages in pleasurable give and take with infant during play.

7. Parent is able to meet the physical needs of child (i.e. feeding, changing diaper, and changing soiled clothing).
8. Parent recognizes infant's cry and responds immediately.
9. Parent uses appropriate response toward negative behaviors.
10. Parent encourages the child and allows the child to safely explore their environment without punishment.
11. Where is the child during the HV? Does the parent hold the child? Is the child generally in a car seat or a crib during the visit?
12. What are your observations of the parents caring for the baby? Do they seem natural, awkward, frustrated, or angry?
13. Does the caretaker seem to be knowledgeable of the baby's needs?

Observation

1. Child initiates behaviors that foster attachment and bonding.
2. Child makes eye contact with parent.
3. Child positions self to engage in physical and verbal exchange (i.e. appears comfortable, relaxed when held, blows bubbles, coos, babbles, engages easily in 'serve and return' with parent.)
4. Child shows pleasure at the sound of parent's voice, touch.

Assessing Parental Capacity

1. What do you like most/least about your child?
2. What do you like most/least about being a parent?
3. Do you ever leave your child with people you don't know very well just to [get a break], [use drugs or drink] or [go to work]?
4. Do you know the names and addresses of others who provide care for your child (ren)?
5. Is there anything you would like to change about your caregiving/parenting style or how you and your child interact?
6. We all know, parenting young children can be very difficult. What do you do or how do you handle those moments when it is the most difficult?
7. What do you do when your baby won't stop crying?
8. What do your child's other caretakers when he/she won't stop crying?
9. What does your best day with your kids look like?
10. What does your worst day with your kids look like?
11. What does your child do when he/she is content/happy? How does the child show that he/she is upset, hurt, sad or afraid? What helps to soothe your child?
12. Is there anything about your child's behavior or development that worries you or makes it hard for you to parent?
13. What things do you enjoy most about your child? What things frustrate you about your child or your parenting experience?
14. How have you and your household/family adjusted to having a young child in the home?
15. How do you support your child's social and emotional growth?
16. How do you set limits and consequences with your child?
17. What are your expectations of your child for their age?
18. What is different about your child or parenting experience than you thought it would be?

19. How do you plan or multi-task to meet the needs of the child and get things done for yourself, partner/spouse and in the home? How do you think you are doing with handling the demands of parenting?
20. How would you like your child's experience to be the same as or different from your own?
21. How does your race/culture influence your parenting style/values?
22. Who is responsible for making medical appointments for the baby? Who goes to the appointments and ensures that any recommendations are followed?
23. Has the child (ren) had any visits to the hospital, ER or other emergency care center?
24. Please tell me about your child's:
    a) **Temperament:** amount of crying, tantrums, ability to be soothed (by who & how), ability to adjust to changes in routine or environment
    b) **Eating:** what (breastfeeding, formula or solid foods), how much and how often in a day
    c) **Sleeping:** morning wake up time, nap schedule, bedtime routine, night time wake ups (who gets up, how often, what helps the child get back to sleep), safe sleep
    d) **Diapers:** # of diapers used per day, diaper supply, toilet training progress
    e) **Activity level:** tummy time, rolling over, sitting, crawling, walking, running, interest in objects/environment
    f) **Social:** smiling, eye contact, babbling/talking, separation anxiety
    g) **Describe a typical day for your child**

Assessment of the Parent's Perception of the Child

These are sample questions from the Working Model of the Child Interview (Zeanah, Benoit, Barton, 1993). The interview questions are designed to help the interviewer develop an assessment of the parent's relationship to their child. The interviewer should encourage the parent to reflect on their relationship with their child when thinking about their answers to the questions. This interview format can assist the social worker in gaining a better understanding of the parent's feelings in regards to their child, their perception of their child and should be used as a tool to further assess the parent/child relationship.

1. Tell me about your CHILD's personality. What kind of a kid is _____?
2. Pick 5 words to describe your CHILD.
3. Now try to remember one particular moment or memory that shows why you chose each of those words to describe _____.
4. Whom does your CHILD remind you of?
5. Which of his/her parents if your CHILD most like?
6. In what ways is he/she like you? Like his/her other parent?
7. How did you decide on your CHILD's name?
8. Pick 5 words to describe your relationship with your child.
9. Now try to remember one particular moment or memory that shows why you chose each of those words to describe your relationship with _____.
10. What do you enjoy most about your relationship with your CHILD?
11. What do you wish you could change about your relationship with your CHILD?
12. How do you feel your relationship with your CHILD has affected his/her personality?
13. Tell me a favorite story about your CHILD.
14. Think for a moment of your CHILD as an adult. What hopes do you have for his/her future?
15. What fears do you have about his/her future?

When reviewing the parent's responses to the questions, the social worker shall consider the parent's emotional tone, facial expressions, and affect. For example, is the parent angry when talking about their child; does the parent talk about the child in a primarily negative way, or is the parent smiling and expressing joy and pleasure in talking about their child? Social workers shall pay attention to whether there are any distortions in the parent's thinking about the child - if the parent views the child as a problem or whether the parent is attributing motives to the child's behavior that would usually be associated with adult behavior and emotions. It is also important to examine the parent's sensitivity to the child's experience and whether the parent has the capacity to reflect on the meaning of the child's behavior. For example how does the parent make sense of a child's behavior and is the parent open to a different view? Parenting young children can present many challenges. When thinking about the parent's answers, consider whether the parent is able to see the good and bad of situations, and whether they are able to separate their experience as a parent from that of their child's experience.

Failure to Thrive

Failure to Thrive in children, primarily infants results from inadequate nutrition to maintain physical growth and development.

The following factors contribute to the infant being diagnosed as Failure to Thrive:

Parental Factors	Infant Factors	Environmental Factors
✓ Substance Abuse ✓ Domestic Violence/IPV ✓ Poor Parenting Skills and Knowledge ✓ Parental depression and stress ✓ Poor parent/child bond ✓ High risk pregnancy and delivery ✓ CPS History ✓ Lack of social supports	✓ Premature birth or low birth weight ✓ Chronic illness or disability ✓ Feeding difficulties or food aversions ✓ Behavioral or developmental problems	✓ Poverty ✓ Lack of support ✓ isolation

Failure to Thrive may be due to:

- poor understanding of the baby's needs and how to respond
- inability to provide appropriate nutrition and stimulation
- poor parenting role models
- increased stress experienced by parents when they are unable to meet or understand the child's basic needs
- frustration when attempting to deal with difficult feeding issues or complications in feeding due to illness or disability

Abusive Head Trauma (Shaken Baby)

Abusive Head Trauma formerly known as Shaken Baby, is one of the most deadly and devastating forms of child abuse and is caused by sudden and repeated violent shaking of an infant. This vigorous shaking causes the brain to pull away, tearing brain cells and blood vessels. Violent shaking is especially dangerous to infants and young children because their neck muscles are not fully developed and their brain tissue id exceptionally fragile.

Often the outward signs of injury to an infant or young child are not obvious as the injuries are internal, particularly in the area of the head or eyes. These injuries can include:

- brain swelling and damage
- subdural hemorrhage
- mental retardation or developmental delays
- blindness, hearing loss, paralysis, speech and learning difficulties
- death

The following risk factors have been identified:

Infant Factors	Perpetrator Factors
✓ premature birth or low birth weight ✓ disability ✓ incessant crying ✓ toileting problems ✓ colic ✓ multiple birth pregnancy ✓ poor sleeping routine ✓ behavioral/developmental problems ✓ age under 1 ✓ male ✓ step-child	✓ failed repeated efforts to stop the baby from crying ✓ poor impulse control ✓ unrealistic expectations of child ✓ feelings of inadequacy and isolation ✓ substance use ✓ unemployment ✓ lack of social supports ✓ no understanding of consequences for repeated shaking ✓ inability to cope with stress ✓ young age ✓ rigid attitudes and impulsivity ✓ depression ✓ negative childhood experiences including abuse, neglect or domestic violence ✓ low educational status ✓ domestic violence ✓ sleep deprivation

Foster Care Resources & Connections for Children in the 0-5 Age Group (Information given to Foster Parents which can be reviewed during visits).

As a licensed foster parent for children in the 0-5 age group, you are being entrusted to care for the most vulnerable children. Many of you have personal parenting experience which will help you in caring for young children in foster care however; caring for a child that is not yours will present challenges to even the most experienced parent.

As parents you know there are continuous changes taking place for children such as safety laws, health standards, educational laws, new baby products and what resources are available for families and children in the community to name a few.

Within 5 days of a child being placed in your home, your support social worker is required to make what is called an *Initial Placement Visit*. The purpose of this visit is to review everything regarding the child just placed in your home, discuss any concerns or issues you may have and to ensure you have

everything you need to effectively care for the child. The worker will also observe the child's sleeping area to make sure it is safe and meets regulations.

Below are some key points your support social worker and the child's worker will review and or discuss following the placement of a new child.

- Multidisciplinary Evaluation (MDE) appointment. A child entering care for the first time is referred for a MDE. The MDE is a full evaluation done on the child at a local clinic; and is separate from any physical completed by the child's pediatrician. A coordinator from that program will contact the foster family to schedule the evaluation with a few days of placement. Prior to the evaluation, a questionnaire will be sent to the foster family for completion to the best of their ability. It is the expectation that the foster family make arrangements to bring the child to this evaluation as there may be other questions during the evaluation that only the foster parent is able to answer. Following the MDE, recommendations are written up in a report and sent to the child's worker for follow through. Newborns placed directly from the hospital or a child who was previously placed in foster care does not require this evaluation.
- Review of the medical passport and the 469 placement request for important historical and demographic information regarding the child. The child's medical insurance card may not arrive for several days; however you use the child's EMS # for appointments.
- Review the child's primary care physician contact information
- Discuss Safe Sleep Environment and sign the SIDS Pledge Agreement Form
- Car Seat Safety: making sure the car seat for the child is not expired, it is the appropriate type of car seat depending on the child's age and weight, and it is properly installed
- If the child was enrolled in the WIC program, as a foster parent you qualify to receive this assistance which provides formula, baby food and other nutritional food items for the child in your care.
- If you work outside of the home and require early care and education, the Dept. can assist you in securing a provider. Infants cannot enroll in early care until they are over 6 weeks of age. Your support social worker can help identify another licensed foster family who is a stay-at-home parent to watch the child should you not be able to take the time off. A child in care can only attend a "licensed" early care and education program, whether it is a family child care or center program. Children in foster care are categorically eligible for Head Start and Early Head Start family child care or center-based programs at no cost. If another early care and education provider is chosen, working families are required to apply for the Care4Kids subsidy to help cover the expense of care. If you have identified a personal friend to help with care, they can only provide care to the child in your home and background checks have had to be completed on that individual.
- CPR Certification: It is imperative that as foster parents caring for young children, you are certified in CPR and first aid. If you are not certified at time of placement, you can ask your support social worker for assistance to receive the training.
- CST (Caregiver Support Team) program: this program is specific for relative/kin foster families to support the child's placement. It can also be utilized for Core Foster Families to decrease the chance of disruption.

Resources for Families

Need	*Contact*
Early Care and Education	Infoline: 211 or DCF SW
Early Care Subsidies	Care 4 Kids: 211
Formula/Baby Food	WIC office @ 203-574-6785

Diaper Bank	Catholic Charities of Waterbury 203-596-9359
Developmental Concerns	Birth 2 Three: 1-800-505-7000 or birth23.org
Ethnic Hair Care	Can inquire w/ biological parent or DCF SW
Support Groups	Monthly English & Spanish Support Groups & CAFAP
Ongoing Training	CAFAP & Foster Parent College-online courses
In-home support	Caregiver Support Team (CST) Program
School Readiness	Child's SW/Intake Center for programs 203-574-8024
Summer Safety	ctsafekids.org
Counseling/Mental Health	Various agencies; consult with SW
EMPS	211s

Foster families should advocate for what they feel is in the child's best interest. If there is a program or service you as a foster parent feel is helpful or can be explored further, please let either your support social worker or the child's worker know.

Fatherhood Initiative Programs at CJTS

The Connecticut Juvenile Training School (CJTS) offers three fatherhood initiatives programs to enhance the parenting of current and future fathers. At CJTS, the rehabilitation staff take the lead on these programs, with the support of clinical, medical, and residential staff. All three programs are offered year round.

The **Dr. Dad** program, is a curriculum available to all interested residents and focuses on critical knowledge and techniques central to childrearing. Youth do not have to be current fathers to take this course.

Topics include:

- **The Well Child**: Crying Flowchart, Infant Nutrition, Immunization, Temperament, and more
- **The Sick Child**: Fevers, The Common Cold, Dehydration, and more
- **The Injured Child**: Burns, Scrapes, Choking, and more
- **The Safe Child**: Safety in the car, Safety in the Kitchen, Parental Anger, and more

Just Beginnings (Formerly called Baby Elmo Program), is a parenting education and support program for incarcerated teen parents and their children. Through research-based parenting instruction and structured weekly visits, the program supports young parents as they become committed parents and build a strong relationship with their child. The fathers have the opportunity to apply the concepts they have learned during semi-structured visits with their children. The focus of Just Beginnings is on building and maintaining a relationship between the teen parent and his child which is supplemented by the Dr. Dad materials that focus on learning more didactic parenting information. Some key objectives of the Just Beginnings program are:

- Offering parenting classes paired with visits from their child(ren)
- Curriculum designed to help teen fathers develop a positive relationship with their child

Just Beginnings teaches four important skills (attachment, following the lead, praise, and labeling) that improve the connection a father feels with his child.

The Rehabilitation Therapy Department also offers a group on relationships **– Love Notes.** This is a 13 session program to help youth make wise decisions about relationships and sexual choices. The program is geared towards high risk youth aged 15 to 24 years of age who are at risk for early and

unplanned pregnancy, are already a parent or are soon to be. The groups will help youth learn to make wise choices about partners, sex, and relationships decisions.

Also offered is **CPR certification** (adult, infant and child) for all fathers.

Resources for Children 0-5

Statewide Resources	
Service Type	Covenant to Care
Agency Name	Covenant To Care
Brief Description of Services Provided	This is a statewide, faith based outreach service linking an "adopted" DCF Social Worker with a faith-based or other "covenant organization" to assist with meeting the basic material needs of DCF involved families (those with protective service Social Workers as well as foster, adoptive and kinship care families). Meeting the needs of children with, for example, beds, cribs, clothing and household furnishings, will help achieve stabilization of families and permanency for the children.
Target Population	All DCF involved families
Address	
Phone Number	860-560-5010
Contact PDOC	Gus Guevara
Email	Gustavo.Guevara@CTgov
Web Address	www.covenanttocare.org
Service Type	Car Seats
Agency Name	Kids in Safety Seats (KISS)-CT - St. Francis Hospital
Address	
Phone Number	860-714-5477 (For more information and the location of car safety seat workshops)
Contact Person	
Email	
Web Address	http://www.stfranciscare.org/Programs_and_Services/Violence_and_Injury_Prevention/Kids_In_Safety_Seats_(KISS)_-_CTaspx
Brief Description of Services Provided	KISS-CT provides families with education and practical assistance in the installation of their child's safety seat by Nationally Certified Child Passenger Safety technicians who have the technical expertise needed to protect children in motor vehicle crashes.
Target Population	
Service Type	Car Seats
Agency Name	Connecticut Safe Kids Child Passenger Safety – CT Children's Medical Center (CCMC)
Address	
Phone Number	860-837-5318
Contact Person	
Email	
Web Address	www.ctsafekids.org
Brief Description of Services Provided	The Injury Prevention Center staff at CCMC are certified National Child Passenger Safety Technicians and provide expert advice, education and training, informational materials and resources to parents and community based organizations. IPC staff conduct monthly car seat check events at the Connecticut Children's Primary Care Center & support child passenger safety at Hartford Hospital's Newborn Nursery and Connecticut Children's Neonatal Intensive Care Unit.
Service Type	Child Abuse Centers of Excellence
Agency Name	Yale and Connecticut Children's Medical Centers
Brief Description of Services Provided	The Child Abuse Centers of Excellence provide expert consultation on cases of suspected child abuse or neglect through a variety of venues: weekly child abuse team meetings; directly seeing children and families; reviewing medical records, x-rays, pictures and other materials; or discussing cases in person or by phone with DCF staff and community providers. Services include direct inpatient and outpatient consultations; Careline, DCF AO and community consultation; record review; MDT participation; training and education
Target Population	Any child who presents in need of these services in the community and at hospitals.
Address	
Phone Number	860-550-6643
Contact PDOC	Dr. Fredericka Wolman
Email	Fredericka.Wolman@CTgov
Web Address	

Service Type	Child Care Financial Support
Agency Name	Office of Early Childhood:
Brief Description of Services Provided	Care 4 Kids helps moderate income families pay for child care costs.
Target Population	Children need to be under age 13 (or under age 19 if the child has special needs).
Address	1344 Silas Deane Highway, Rocky Hill, CT 06067
Phone Number	1-888-214-KIDS (5437)
Contact Person	1-888-214-KIDS (5437)
Email	http://www.ctcare4kids.com/contact-us/
Web Address	www.ctcare4kids.com
Service Type	Child Care Locator
Agency Name	Office of Early Childhood
Brief Description of Services Provided	2-1-1 Child Care has current lists of: • Licensed child care centers • Licensed family child care homes • Nanny agencies • Nursery schools • Play groups • Summer camp programs By calling 2-1-1- Child Care, a Child Care Referral Specialist who will help you find the services that will best fit the needs of you and your family, all at no cost.
Target Population	
Address	
Phone Number	Dial 2-1-1 or 1-800-505-1000
Contact Person	Dial 2-1-1 or 1-800-505-1000
Email	
Web Address	www.211childcare.org
Service Type	Child Development Infoline
Agency Name	United Way of Connecticut
Brief Description of Services Provided	• A specialized call center of the United Way of CT 2-1-1. • A free and confidential service creating a safe environment for callers to discuss concerns or issues regarding a child's health, development or behavior. • Available Monday – Friday from 8am -6pm, except on holidays. Messages can be left 24 hrs. a day, 7 days a week, and are returned promptly. • Staffed by bilingual care coordinators who have degrees and a background in child development. • Helping families to access and understand a variety of important services available for CT children, including Birth to Three, Early Childhood Special Education, *Help Me Grow* and Children and Youth with Special Health Care Needs services. • Connecting families to other 2-1-1 call centers if additional needs are identified during a call. The other call centers are: 2-1-1 Health and Human Services, Husky Infoline, 2-1-1 Child Care and Care 4 Kids. • Offering parents a child monitoring program—the Ages & Stages Questionnaire (ASQ). It is a fun, interactive way to understand the many changes a child goes through, and to screen for possible developmental delays.
Target Population	
Address	
Phone Number	1-800-505-7000
Contact Person	
Email	
Web Address	http://www.ctunitedway.org/cdi.html

Service Type	Child First
Agency Name	Child First
Brief Description of Services Provided	This service provides home based assessment, family plan development, parenting education, parent-child therapeutic intervention, and care coordination/case management for high-risk families with children under six years of age in order to decrease social-emotional and behavioral problems, developmental and learning problems, and abuse and negleCT DCF and the Office of Early Childhood have 14 contracted Child First sites across the state: • Bridgeport Hospital • Child Guidance Center of Southern CT • Child Guidance Center Mid-Fairfield • Clifford Beers • Middlesex Hospital • United Communities and Family Services • The Village for Children and Families • Wellmore • Parent Child Resource Center • The Village for Children and Families • InterCommunity Inc • Family and Children's Aid • Charlotte Hungerford Hospital • Wheeler Clinic • Child Guidance Clinic for Central CT
Target Population	Children ages 0 - 6
Address	
Phone Number	(860) 560-7078
Contact PDOC	Kim Somaroo-Rodriguez
Email	S.Kim.Somaroo@CTgov
Web Address	www.childfirst.com
Service Type	Community Support for Families
Agency Name	Child and Family Guidance Center, Clifford Beers, Communicare, CHR, The Village, Wheeler Clinic, Wellmore Behavioral Health
Brief Description of Services Provided	This service will engage families who have received a Family Assessment Response from the Department and connect them to concrete, traditional and non-traditional resources and services in their community. This inclusive approach and partnership, places the family in the lead role of its own service delivery. The role of the contractor is to assist the family in developing solutions, identify community resources and supports based on need and help promote permanent connections for the family with an array of supports and resources within their community.
Target Population	Ages 0 - 18
Address	
Phone Number	860-550-6463
Contact PDOC	Kim Nilson
Email	Kimberly.Nilson@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	CT Medical Home Initiative for Children & Youth with Special Health Care Needs
Agency Name	Department of Public Health
Address	410 Capitol Avenue Hartford, CT 06134
Phone Number	United Way of Connecticut's Child Development Infoline 1-800-505-7000
Contact Person	Mark Keenan, RN, MBA Supervising Nurse Consultant Connecticut Title V CYSHCN Director Community, Family and Health Equity Section Adolescent and Child Health Unit
Email	mark.keenan@CTgov
Web Address	www.CTgov/dph/medicalhome

Brief Description of Services Provided	All families of eligible children and youth ages 0 to 21 with special health care needs regardless of income, will receive a respectful working partnership with the child's medical home, care coordination services and family support referrals.
Service Type	Emergency Mobile Psychiatric Services (EMPS)
Agency Name	
Brief Description of Services Provided	EMPS-Crisis Intervention Service System - Statewide 211 Call Center Serves as the entry point for access to the Emergency Mobile Psychiatric Service System for children and youth in the State of Connecticut. The Statewide 211 Call Center receives calls, collects relevant information from the caller, determines the initial response that is needed, and links the caller to the information or service required. Dialing the 211 Call Center allow callers to access the statewide network of 6 EMPS providers who cover all CT cities and towns. EMPS responds with a face to face assessment within 45 minutes of the referral for children and adolescents experiencing a behavioral or mental health crisis. In addition to these primary functions, the Statewide 211 Call Center also collects data regarding calls received, triage responses and referrals to EMPS contractors. The 211 Call Center analyzes data and compiles reports for use by DCF, the Statewide 211 Call Center, EMPS contracted service providers, and other entities as determined by DCF. The Statewide 211 Call Center operates 24 hours per day, 365 days per year.
Target Population	Any child 0 - 18
Address	
Phone Number	860-550-6393
Contact PDOC	Arnie Trasente, Ph.D.
Email	Arnold.Trasente@CTgov
Web Address	www.empsCTorg/
Service Type	Diapers
Agency Name	The Diaper Bank
Brief Description of Services Provided	The Diaper Bank (TDB) centralizes the fundraising and distribution of free diapers to poor families through existing service providers, including local food pantries, soup kitchens, daycare centers, social service agencies and shelters. Through its extensive Diaper Distribution Network (DDN) of over 50 agencies, TDB provides free diapers to poor and low-income families in New Haven, Fairfield, Hartford and Middlesex Counties.
Address	370 State Street, North Haven, CT
Phone Number	203-934-7009
Contact Person	Yury Maciel-Andrews
Email	information@thediaperbank.org
Web Address	www.thediaperbank.org
Service Type	Early Childhood Consultation Partnership (ECCP)
Agency Name	
Brief Description of Services Provided	Facilitates the early identification of behavioral challenges and mental health needs in children who participate in daycare and early childhood education settings. Once needs are identified, strategies which prevent children from disrupting from their homes and day care settings are implemented. Families are given opportunities to partner as active participants at multiple levels including: home visits, center-based planning, child specific intervention strategies and collaborative planning and implementing strategies and activities within the classroom.
Target Population	Early childcare and education staff, DCF-involved biological parents, foster, and adoptive parents, and any other caregivers in a child's life providing services to families and children ages Birth to 60 months (5 years old) and Birth to 72 months (6 years old) for DCF children in Foster Care, with challenging behaviors and/or social and emotional needs. Services may also be provided to DCF-involved women and their children housed in substance abuse residential programs.
Address	
Phone Number	860-550-6682
Contact PDOC	Charlie Slaughter
Email	Charlie.Slaughter@CTgov
Web Address	http://www.eccpCTcom
Service Type	Early intervention home visiting program for children with developmental delays

Agency Name	Office of Early Childhood/ Birth to Three
Brief Description of Services Provided	Birth to Three is an entitlement program for families whose children are under three years of age, have a significant developmental delay or disability and meet eligibility criteria. Birth to Three providers from one of our 36 statewide programs will work directly with families to guide them in ways to embed early intervention strategies into the daily activities of their child's day.
Target Population	Children under the age of three with significant developmental delay or disability and who meet eligibility criteria.
Address	460 Capitol Ave Hartford CT 06106
Phone Number	Birth to Three Central Office 866-888-4188 INTAKE AND REFERRAL: 800-505-6155
Contact PDOC	
Email	
Web Address	www.birth23.org
Service Type	Early intervention home visiting program for children with developmental delays
Agency Name	Office of Early Childhood/ Birth to Three
Brief Description of Services Provided	Birth to Three is an entitlement program for families whose children are under three years of age, have a significant developmental delay or disability and meet eligibility criteria. Birth to Three providers from one of our 36 statewide programs will work directly with families to guide them in ways to embed early intervention strategies into the daily activities of their child's day.
Target Population	Children under the age of three with significant developmental delay or disability and who meet eligibility criteria.
Address	460 Capitol Ave Hartford CT 06106
Phone Number	Birth to Three Central Office 866-888-4188 INTAKE AND REFERRAL: 800-505-6155
Service Type	Family Based Recovery
Agency Name	
Brief Description of Services Provided	This service is an intensive, in-home clinical treatment program for families with infants or toddlers (birth to 36 months) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance abuse.
Target Population	The family must meet the following admission criteria: i. the mother and/or father report substance use within the last 30 days (The adult client can either self-report use or the referral source can have lab results showing a positive drug test; ii. the parent's drug use should not be a onetime occurrence but substance use that currently meets criteria for substance abuse or dependence; iii. the index child is from birth to 36 months old, resides in the parent's home, or is placed outside the home with a plan for imminent reunification; iv. the parent is not involved in another treatment program or is willing to discharge from that program to enter FBR; v. the family is willing to have FBR provide treatment in their home; vi. the parent has the cognitive capacity to utilize the FBR tools, but does not need to know how to read. The following criteria will exclude participation: i. a parent who is actively psychotic; ii. a parent whose psychiatric symptoms require immediate attention and stabilization prior to entering treatment; iii. a parent who requires a medically monitored detoxification prior to entering treatment. The overarching goal of the intervention is to promote stability, safety and permanence for these families. Treatment and support services are provided in a context that is family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family. The clinical team provides intensive psychotherapy and substance abuse treatment for the parent(s) and attachment-based parent-child therapy to the parent-child dyad. An infant (birth – 3 years) who is at risk of an out-of-home placement due to parental substance abuse. A parent who has used substances within past 30 days.
Address	

Phone Number	860-550-6534
Contact PDOC	Tere Foley
Email	Tere.l.Foley@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Head Start & Early Head Start
Agency Name	US Department of Health and Human Services, Administration for Children and Families, Office of Head Start (federally administered direct funding to local programs)
Brief Description of Services Provided	Head Start and Early Head Start provide comprehensive child development services and family support and engagement through primarily center-based programs but also through family child care and, for pregnant women and some infants and toddlers, through home visiting. Head Start services are available statewide and Early Head Start is available in most communities in the state. Comprehensive services include health, dental, nutrition, disability, mental health, social service, parent/father engagement, education (development & learning) and community partnership.
Target Population	Services are targeted to families with income at or below federal poverty and prioritized for children in foster care and those experiencing homelessness or having identified disabilities.
Address	Statewide – Check Head Start Program Locator at https://eclkc.ohs.acf.hhs.gov/hslc
Phone Number	1-866-763-6481 (toll free) or Head Start Program Locator
Contact Person	Varies
Email	Varies
Web Address	Office of Head Start, Early Childhood Learning and Knowledge Center: https://eclkc.ohs.acf.hhs.gov/hslc
Service Type	Intensive Family Preservation
Agency Name	
Brief Description of Services Provided	This service provides a short-term, intensive, in-home service designed to intervene quickly in order to reduce the risk of out of home placement and or abuse and/or negleCT Services provided include case management, improvement of parental capacity and crisis response. An initial joint home visit (by provider and DCF) within 72 hours of referral. Contact with families entail a minimum of 2 home visits per week for the first four weeks and a minimum of 1 home visit per week for the remaining eight weeks. Staff work a flexible schedule, adhering to the needs of the family. Support to families in crisis on their active caseload 24 hours per day, seven days a week including weekends and holidays. Standardized assessment tools are used to develop a treatment plan. As needed families are linked to other therapeutic interventions and assisted with basic housing, education and employment needs including making connections with non-traditional community supports and services.
Target Population	DCF active in-home cases only. This service is delivered when there is an emerging removal concern for children from birth through 17 years of age.
Address	
Phone Number	860-550-6438
Contact PDOC	Jenny Vesco
Email	Jenny.Vesco@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Multidisciplinary Team
Agency Name	
Brief Description of Services Provided	Promotes the coordination of investigations of and interventions for cases of child abuse/neglect among agencies, including DCF, police, medical, mental health, victim advocates, and prosecutors. Cases are referred to the regularly scheduled team meetings by DCF, law enforcement or other agency members of the team. A team Coordinator assumes the coordination and administrative responsibilities in addition to being an active member of the team. Training in aspects of child abuse and the investigation process is provided to the team members.
Target Population	Any child in Connecticut that is a victim of sexual abuse including child sex trafficking, severe physical abuse or death of a child.

Address	
Phone Number	860-550-6471
Contact PDOC	Tammy Sneed
Email	Tammy.Sneed@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Outpatient Psychiatric Clinics for Children
Agency Name	
Brief Description of Services Provided	Outpatient Psychiatric Clinics for Children offer an array of individual and family based community-based mental health services in a clinic-based setting for children and youth, ages 3 to 19 who present with a range of emotional and behavioral disturbances. Services include: psychosocial assessment; psychiatric evaluations/medication management; and individual/family/group psychotherapies. Services are designed to maintain children in their communities by promoting mental health and improving functioning in children, youth and families and by decreasing the prevalence of and incidence of mental illness, emotional disturbance and social dysfunction.
Target Population	Children from 3 to the age of 19. • DCF-involved children who are referred through local systems of care, care coordinators, and Emergency Mobile Psychiatric Services; • children who are the victims of trauma and/or physical and/or sexual abuse and/or neglect and/or witness to violence in the home or external to the home and/or who have experienced multiple separations from loved ones; • children who are at risk of psychiatric hospitalization or placement into residential treatment or are being discharged from psychiatric hospitals or residential treatment; • children with severe emotional disturbances such as conduct disorders and oppositional defiant disorders; • children who are court involved; and • children whose families are financially unable to obtain mental health services elsewhere in the community.
Address	
Phone Number	860-550-6539
Contact PDOC	Bethany Zorba
Email	Bethany.Zorba@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Respite Care
Agency Name	
Brief Description of Services Provided	This service provides brief and temporary home and community based care for children and youth who have serious emotional disturbance (SED). This service is offered to families in order to provide relief from the continued care of a child or youth complex behavioral health care needs, to limit stress in the home environment and to prevent family disruption and/or the need for out of home care for a child with SED. This care is part of an integrated behavioral health care plan. Up to 45 hours of respite can be given to a family within a 12 week period with any extension based upon DCF approval. When respite is provided in a group setting, there is at least one (1) respite worker for every three children.
Target Population	Non-DCF involved youth ages 4-17
Address	
Phone Number	(860) 550-6478
Contact PDOC	Mary Cummins
Email	Mary.Cummins@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Reunification and Therapeutic Family Time
Agency Name	
Brief Description of Services Provided	Reunification Readiness Assessment, Reunification Services, and Therapeutic Family Time are designed for families with children (from birth to age 17) who were removed from their home due to protective service concerns. These three service types are available to families as three separate components based on the needs of the family. Families can be referred for this service immediately following a child's removal from the home or at any time during their placement.

	Reunification Readiness Assessment uses a standardized assessment tool to develop service plan. Therapeutic Family Time is made available for families and assists the provider in assessment by using the Visit Coaching model. This component provides feedback and recommendations to the Department regarding the family's readiness for reunification. (30 days) Reunification Services also uses a standardized assessment tool to develop the service plan, delivers a staged reunification model to support families throughout the reunification process, adopts the Wraparound Model design to engage the family and build their networks of support, delivers Therapeutic Family Time component using the Visit Coaching model and offers a Step Down option, if families require additional supports. (4-6 months) Therapeutic Family Time – Uses the Visit Coaching Model, uses the Keys to Interactive Parenting Scale (KIPS), an evidence based tool to effectively measure parent child interaction and parenting behaviors, preserves and restores parent/child attachment and facilitates permanency planning and emphasizes a continuity of relationships. (2-3 months) For all services except Therapeutic Family Time, the permanency goal for the referred child must be reunification. Therapeutic Family Time can be provided to children who have a permanency goal other than reunification, but the focus must be establishing or re-establishing a relationship that will aid them in achieving their permanency goal.
Target Population	The target population includes only those families whose children are in imminent danger of out of home placement or cannot return home without intense services. Families to be served include biological and adoptive families referred by DCF and includes DCF active families only.
Address	
Phone Number	860-550-6438
Contact PDOC	Jenny Vesco
Email	Jenny.Vesco@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Supportive Housing for Families
Agency Name	
Brief Description of Services Provided	Subsidized housing and intensive case management services to DCF families statewide for whom inadequate housing jeopardizes the safety, permanency, and well-being of their children. Intensive case management services are provided to assist individuals to develop and utilize a network of services in the following areas: economic, social, and health. Housing is secured in conjunction with the family and the Department of Housing (DOH) provides a Section VIII voucher. Priority access is determined by the chronological order of referrals.
Target Population	DCF involved families with housing barriers who are homeless or at risk of homelessness.
Address	
Phone Number	860-560-7078
Contact PDOC	Kim Somaroo-Rodriguez
Email	S.Kim.Somaroo@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Therapeutic Child Care
Agency Name	
Brief Description of Services Provided	Therapeutic Child Care: Services for children in a specialized therapeutic child care licensed facility The target population is children ages birth to 5 years old.
Target Population	Children aged 0-5 with behavioral issues transitioning to regular day care or kindergarten.
Address	
Phone Number	860-550-6475
Contact PDOC	Wendy Kwalwasser
Email	Wendy.Kwalwasser@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Therapeutic Foster Care
Agency Name	
Brief Description of Services Provided	Therapeutic Foster Care (TFC) is an intensive, structured, clinical level of care provided to children with serious emotional disturbance (SED) within a safe and nurturing family environment. Children in TFC receive daily care, guidance, and modeling from specialized, highly trained, and skilled foster parents.

Target Population	Children, ages 6-17, with SED and complex behavioral health care needs who require placement outside of their home and who are at risk of placement in a more restrictive placement setting are eligible for TFC services.
Address	
Phone Number	860-723-7203
Contact PDOC	Jennifer Sisk
Email	Jennifer.Sisk@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Therapeutic Foster Care (Medically Complex)
Agency Name	
Brief Description of Services Provided	This service provides specialized training, support services and certifies families to care for children with complex medical needs.
Target Population	Within the Department of Children and Families, under the direction of Fredericka Wolman, MD, MPH, Chief of Pediatrics, there is a small group of children who have medical care needs that go beyond routine well-child care and common childhood illnesses. These children may have care needs that range from a child who requires daily medications for mild-persistent asthma to a child who must have assistance with all of their care due to severe cerebral palsy or other complex medical conditions. DCF designates the care needs of children with complex medical needs into a 4 tiered classification system. Children who are in classification four are the children with the most complex medical and associated care needs while children in Classification 1, have fewer care needs and less medical risk.
Address	
Phone Number	860-550-6636
Contact PDOC	Linda Clark (formerly Linda Raitt)
Email	Linda.Clark@CTgov
Web Address	**www.ct.gov/dcf**
Service Type	Triple P
Agency Name	
Brief Description of Services Provided	This service utilizes the evidenced-based model, Triple P (Positive Parenting Program®) of the University of Queensland, to provide an in-home parent education curriculum along with support and guidance so that parents will become resourceful problem solvers and will be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Within the multi-tiered Triple P system, this service will use Triple P's Level 4 Standard and Level 4 Standard Teen courses. In addition to Triple P, this service will provide short term case management supports to help parents fully utilize the parenting services.
Target Population	Parents with children 0-17 years of age. Priority is given to parents involved with DCF or Community Support for Families. Caseload permitting and in consultation with the DCF area office, providers may serve parents referred by other community providers.
Address	
Phone Number	860-550-6682
Contact Person	Charlie Slaughter
Email	Charlie.Slaughter@CTgov
Web Address	http://www.triplep.net/glo-en/home
Service Type	WIC
Agency Name	Department of Public Health
Address	
Phone Number	1-800-741-2142
Contact Person	Marjorie Chambers
Email	
Web Address	http://www.fns.usda.gov/wic/women-infants-and-children-wic
Brief Description of Services Provided	The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

The Child Care Licensing Program of the Division of Licensing is responsible for the licensing of child care programs, and offers these tips on what to look for in a program for your child.

- Types of licensed child care programs
- Parent Guidelines for Choosing a Child Care Program (PDF)
    - Also available in Spanish - Seleccionando un buen Cuidado de Niños (PDF)
- Check if a Program is Licensed

Region 1 (Bridgeport/Norwalk)	
Bridgeport	
Service Type	School Readiness
Agency Name	ABCD
Brief Description of Services Provided	Early childhood education
Target Population	3-5
Address	1070 Park Avenue, Bridgeport
Phone Number	203 366-8241 x244

Contact Person	Ms. Eaddy
Email	EEaddy@ABCD.org
Web Address	
Service Type	Infant and Toddler Child care
Agency Name	ABCD
Brief Description of Services Provided	Child care for infants and toddlers
Target Population	0-3
Address	1070 Park Avenue, Bridgeport, CT
Phone Number	203 366-8241
Contact Person	Tamara Coyle
Email	TZCoyle@ABCD.org
Web Address	
Service Type	School Readiness
Agency Name	Bridgeport Alliance for Young Children
Brief Description of Services Provided	Obtaining and Managing funds for early childhood educ.
Target Population	3-5
Address	45 Lyon Terrace, Bridgeport, CT
Phone Number	203 275-1265
Contact Person	Leigh Heimrich
Email	LHeimrich@BridgeportEdu.org
Web Address	
Service Type	Child and Family Interagency Resource, Support, Training
Agency Name	Child First
Brief Description of Services Provided	Clinician and case management of assigned cases
Target Population	Birth to Six
Address	1470 Barnum Avenue, Bridgeport, CT
Phone Number	203 384-5298
Contact Person	Alice Malowkowski
Email	HTTP://childfirst.com
Web Address	

Service Type	Therapeutic early childhood education
Agency Name	TLCC
Brief Description of Services Provided	Individual and group therapy for children in classroom
Target Population	3-5
Address	1070 Park Avenue, Bridgeport, CT
Phone Number	203 366-8241x 244
Contact Person	Everlee Eaddy
Email	EEaddy@ABCD.org
Web Address	
Service Type	Education, support and parenting groups
Agency Name	The Nurturing Program
Brief Description of Services Provided	Expectant parents and parents of children under five
Target Population	Birth to five
Address	180 Fairfield, Avenue, Bridgeport, CT
Phone Number	203-367-5361
Contact Person	Carmen Delgado
Email	ndunphy@cfguidance.org
Web Address	
Service Type	Support services for teachers and parents
Agency Name	Early Childhood Consultation Partnership
Brief Description of Services Provided	On site classroom support and in home assistance to parents.
Target Population	0-5

Address	180 Fairfield, Avenue, Bridgeport, CT
Phone Number	203 367-5361
Contact Person	Norleen Dunphy
Email	ndunphy@cfguidance.org
Web Address	
Service Type	Assessment and assistance to children under 3
Agency Name	Birth to Three
Brief Description of Services Provided	Home visiting and direct work with children with limitations.
Target Population	0-3
Address	460 Capitol Avenue, Hartford, CT
Phone Number	1-800-505-7000
Contact Person	Cheryl Stewart
Email	
Web Address	
Service Type	Supportive Housing Fairfield
Agency Name	The Connection
Brief Description of Services Provided	Assistance in locating and financing housing
Target Population	Parents and their children
Address	1062 Fairfield Ave. Bridgeport, CT
Phone Number	203 336-6571 or 203 331-0067
Contact Person	Sandra Hill
Email	
Web Address	
Service Type	Diapers for needy families
Agency Name	The Diaper Banks of Hall Neighborhood House
Brief Description of Services Provided	Provide diapers free of cost for families
Target Population	0-4
Address	18 sites in Bridgeport
Phone Number	203 696-0787 or at FSW 203 696-0787
Contact Person	Karen Seferi
Email	KSeferi@lifebridge.Cf.org
Web Address	

Norwalk	
Service Type	
Agency Name	Norwalk Housing Authority (2 sites)
Brief Description of Services Provided	
Target Population	
Address	Ben Franklin Center, 165 Flax Hill Road, Norwalk, CT - 06854
Phone Number	203-899-8560
Contact Person	Liaison: Yvette Tajudeen, 203-956-6216
Email	atajudeen@norwalkha.org
Web Address	
Service Type	
Agency Name	Nathaniel Ely Center
Brief Description of Services Provided	
Target Population	
Address	11 Ingalls Avenue, Norwalk, CT 06854
Phone Number	203-852-9625
Contact Person	Yvette Tajudeen (203-956-6216)
Email	atajudeen@norwalkha.org
Web Address	
Service Type	
Agency Name	Childcare Learning Center

Brief Description of Services Provided	
Target Population	
Address	
Phone Number	203-989-0228
Contact Person	Kari Guterrez
Email	kariguttierrez@clcstamford.org
Web Address	
Service Type	
Agency Name	Early Childhood Consultation Partnership (ECCP)
Brief Description of Services Provided	The Early Childhood Consultation Partnership (ECCP®) is a statewide, evidence-based, mental health consultation program designed to meet the social and emotional needs of children birth to five in early care or education settings. The program builds the capacity of caregivers at an individual, family, classroom, or center-wide level. It provides support, education, and consultation to caregivers in order to promote enduring and optimal outcomes for young children.
Target Population	Ages 3-5
Address	100 East Avenue, Norwalk, CT
Phone Number	203-299-1315 x 115
Contact Person	Betsy Perry
Email	
Web Address	
Service Type	
Agency Name	St. Joseph's Parenting (Norwalk/ Stamford)
Brief Description of Services Provided	
Target Population	
Address	566 Elm Street, Norwalk, CT
Phone Number	203-588-1934
Contact Person	Carmen Seleme-McDermott
Email	cselememcdermott@sjpcenter.org
Web Address	
Service Type	
Agency Name	Child First
Brief Description of Services Provided	
Target Population	
Address	103 West Broad Street, Stamford, CT
Phone Number	
Contact Person	Erica Pomerantz - Director
Email	Erica.Pomerantz@childguidanceCTorg
Web Address	
Service Type	
Agency Name	Child First Mid Fairfield
Brief Description of Services Provided	
Target Population	
Address	100 East Avenue, Norwalk, CT
Phone Number	203-299-1315
Contact Person	
Email	
Web Address	www.childguidancemfCTorg
Service Type	
Agency Name	Nurturing Families - FCA
Brief Description of Services Provided	
Target Population	
Address	9 Mott Avenue, Norwalk, CT
Phone Number	203-855-8765

Contact Person	
Email	
Web Address	www.familyandchildrensagency.org
Service Type	
Agency Name	Crisis Parent Aide – Exchange Club
Brief Description of Services Provided	
Target Population	
Address	141 Franklin Street, Stamford, CT
Phone Number	203-327-9419 / (F) 203-359-8677
Contact Person	
Email	
Web Address	www.exchangeclubparentingskillscenter.com
Service Type	
Agency Name	FBR – Child Guidance in Bridgeport
Brief Description of Services Provided	
Target Population	
Address	180 Fairfield Avenue #2, Bridgeport, CT
Phone Number	203-367-5361
Contact Person	Liaison: Melissa McShane (203) 899-1443)
Email	Melissa.mcshane@CTgov
Web Address	

Region 2 (Milford / New Haven)	
Milford	
Service Type	Child First
Agency Name	Parent Child Resource Center
Brief Description of Services Provided	An intensive early childhood, home visiting intervention that works with a community's most vulnerable young children and their families. The goal is to identify children at the earliest time to decrease emotional and behavioral problems, developmental and learning problems, and abuse and negleCT
Target Population	0-6
Address	30 Elizabeth St. Derby CT
Phone Number	203-954-0543 X151
Contact Person	Jean Schoenleber
Email	J.Schoenleber@lnvpcrc.org
Web Address	www.Lnvpcrc.org
Service Type	PPSP
Agency Name	Jewish Family Services
Brief Description of Services Provided	Provides therapeutic supervised visitation for parents and their children in DCF care They also work with parents on improving parenting skills and on increasing their understanding of child development. Circle of security is offered as well, which focus on the importance of attachment. This is also offered to foster families.
Target Population	0-18
Address	1440 Whalley Ave. New Haven, CT
Phone Number	203-389-5599
Contact Person	Margaliet Ligtenstein
Email	ml@jfsnh.org
Web Address	www.jfsnh.org/index.php
Service Type	Early Head Start
Agency Name	Maternal Infant & Early Childhood home visiting (MIECHV)
Brief Description of Services Provided	A free program for families that are expecting a child and or have children both up to 3 years old.
Target Population	0-3
Address	30 Elizabeth St. Derby, CT
Phone Number	203-736-5420 X205
Contact Person	Michele Holovach
Email	mholovach@teaminc.org
Web Address	www.teaminc.org
Service Type	Child and family outpatient treatment program
Agency Name	Bridges
Brief Description of Services Provided	The outpatient child and family service is dedicated to providing behavioral health services to children and their families. The program provided individual, family and group therapy modalities. Services include comprehensive psychosocial assessments, developmental evaluations, crisis intervention, psychotherapy, psychiatric consultations, collaboration with the school system and other service providers and case management.
Target Population	0-18
Address	949 Bridgeport Ave. Milford, CT
Phone Number	203-878-6365 ext. 312
Contact Person	Melissa Jacob
Email	MJacob@bridgesmilford.org
Web Address	www.bridges.org
Service Type	Interventions for families with children prenatal-5
Agency Name	Branford Family Resource Center

Brief Description of Services Provided	Full day early care and education programs for children ages prenatal-5, follow ELDS standards and are NAEYC accredited, parent involvement, snacks, health/education services.
Target Population	Prenatal to 5
Address	12 Melrose Ave, Branford, CT
Phone Number	(203)315-3799
Contact Person	Michele Krumenacker
Email	mkrumenacker@brandfordschools.org
Web Address	
Service Type	Parent Child Resource Center
Agency Name	ECCP
Brief Description of Services Provided	The Early Childhood Consultation Partnership is a state wide program offering free service in mental health consultation. The service is focused on the birth through 5 (preschool) population and the child care programs that serve them. The service consists of classroom consultation to programs regarding social, emotional and behavioral issues. Trainings are offered. Child consultation services are also offered with support offered to parents and the child's program.
Target Population	birth through preschool aged
Address	
Phone Number	PCRC provides three consultants • Linda Flach 203-954-0543 X 186, Covering the towns of: Ansonia, Derby, Seymour, Bethany, Woodbridge, Hamden, Orange, and West Haven • Mary Diamond- 203-954-0543 X 187, New Haven, East Haven, Branford, North Haven, Guilford, Northford and North Branford • Rebecca Gardner 203-954-0543 X 184
Contact Person	
Email	
Web Address	www.eccpCTcom
Service Type	
Agency Name	East Haven Family Resource Center
Brief Description of Services Provided	The FRC offers an integrated system of family support services that enhance parenting, promote family involvement with the schools, and help children to succeed cognitively, socially, and emotionally with the goal that all children will be school ready. Services offered include weekly playgroups, individual home visits using Parents As Teachers curriculum, referring to other area agencies, providing quality preschool for East Haven 3-4 year olds.
Target Population	0-5
Address	82 Elliot St. East Haven, CT
Phone Number	203-468-3898
Contact Person	Marissa Velazquez
Email	mvelazquez@east-have.k12.CTus
Web Address	
Service Type	
Agency Name	East Shore District Health Department Nurturing Families Network
Brief Description of Services Provided	A free program for all families that are expecting a child or have a child under 3 months old. Families participate in weekly 60-minute visits in the home that utilizes the Parents as Teachers curriculum. Trained Family Support Providers offer activities and resources that support healthy child development, parent-child interaction and family well-being. Families also have access to playgroups and monthly workshops through program collaborations. Fatherhood services are offered to all fathers with children six months and younger.
Target Population	0-6 months
Address	14 Business Park Dr. Branford, CT

Phone Number	203-466-1958
Contact Person	Alison Tyliszczak
Email	atyliszczak@east-haven.k12.CTus
Web Address	
Service Type	Intensive Family Preservation Services (IFP)
Agency Name	Bridges
Brief Description of Services Provided	IFP is a short term, intensive, in-home service designed to intervene with targeted families in order to reduce immediate risk factors for future abuse and/or neglect and to assess the need for our of home placement. The staff provides case management services with two home visits per week for three months.
Target Population	0-18
Address	949 Bridgeport Ave. Milford, CT
Phone Number	203-878-3635 ext. 516
Contact Person	Pat Giordano
Email	PGiordano@bridgesmilford.org
Web Address	www.bridgesCTorg
Service Type	
Agency Name	QIC-CT Safe Babies Court Team
Brief Description of Services Provided	Engage with families with a child 0-3 years old who has been removed from their home and in DCF care. Individualized service plans including increased visitation, monthly family team meetings, referral to Child Parent Psychotherapy or other parent/child relational and bonding program, child referral for developmental screening through Birth To Three
Target Population	0-36 months, the family's case is overseen by the New Haven Family and Juvenile Court
Address	
Phone Number	203-258-2851
Contact Person	Desirée Caporaso
Email	dcaporaso@zerotothree.org
Web Address	www.zerotothree.org
Service Type	
Agency Name	TEAM Preschool Program
Brief Description of Services Provided	Part day and full day early care and education programs for children ages 3-5. Part day programs at no cost; full day programs at reduced rates (income and eligibility guidelines apply). Individualized teaching and curriculum, parent involvement-social services, snacks and meals provided, health/education screenings and services, NAEYC accredited.
Target Population	3-5
Phone Number	203-734-8609
Service Type	
Agency Name	Young Parent Program of Milford
Brief Description of Services Provided	Prenatal and post-delivery guidance and emotional support to young mothers and young fathers up to age 22 years by master level clinicians experienced with adolescents. Child birth classes, parenting and child development information. Home visitation program and community resource support mobilized, school retention, vocational plans, and self-sufficiency is guided.
Target Population	0-3
Phone Number	203-876-4285
Contact Person	Karen Schur
Email	karen.schur@milfordhospital.org
Web Address	www.youngparentprogram.org
Service Type	Reunification and Therapeutic Family Time (RTFT)
Agency Name	Boys & Girls Village

Brief Description of Services Provided	RTFT delivers a staged model to support families throughout the reunification process. Adopts a wraparound model design to engage the family and build their network of support. Therapeutic family time implements a visit coaching model and occurs in the least restrictive, most homelike setting possible. Preserves and restores the parent/child attachment and reduces the child's sense of abandonment and loss. Facilitates permanency planning and emphasizes continuity of relationships. Services can also offer a step down option if families require additional supports.
Target Population	0-18
Phone Number	203-877-0300
Contact Person	Stacy Guisto
Email	GuistoS@bgvillage.org
Web Address	www.bgvillage.org
Service Type	Parent Child Resource Center
Agency Name	Triple P In Home Services
Brief Description of Services Provided	Standard Triple P curriculum is for families of children ages 0-12. It is a multi-level parenting and family support strategy. Triple P aims to prevent behavioral, emotional and developmental problems in children and adolescents by enhancing knowledge, skills and confidence of parents. Child must be residing with the parent or the parent must have several visitations a week to participate.
Target Population	0-12
Address	30 Elizabeth St. Derby CT
Phone Number	203-954-0543 ext. 183
Contact Person	Laruen Firimonte
Email	lfirimonte@lnvpcrc.org
Web Address	www.lnvpcrc.org
Service Type	
Agency Name	Visiting Nurse Association of South Central CT, Inc. Nurturing Families Network
Brief Description of Services Provided	NFN utilizes two methods of intervention, the first is telephone support where trained experts provide parents with knowledge of vital healthcare and childcare information the parents will need prior to the birth of their child and thereafter. Ongoing support and contact will continue for 6 months to 1 year. The second method is home visiting where staff provides pregnancy and parenting information on child development, healthcare, accident prevention and additional help. Home visiting helps to ease the transition new parents may face through education encouragement, and practical information. Parents get linked to a network of community resources.
Target Population	0-5
Address	
Phone Number	203-859-6059
Contact Person	Pam Lorenzo
Email	plorenzo@vnascc.org
Web Address	www.VNASCC.org
Service Type	Parent Child Resource Center
Agency Name	Valley Diaper Bank
Brief Description of Services Provided	Education on child development and diaper supply
Target Population	0-4
Address	30 Elizabeth St. Derby CT
Phone Number	203-736-5420 ext. 208
Contact Person	Ayana Smith
Service Type	Parent Child Resource Center
Agency Name	Help me Grow
Brief Description of Services Provided	Families can call with developmental and behavioral questions. Ages and Stages Developmental Questionnaires can be mailed to families (2 months-60 months of age)

Target Population	2 months- 60 months
Phone Number	1-800-505-7000

New Haven	
Service Type	
Agency Name	'r Kids
Brief Description of Services Provided	Readiness Assessment; Reunification Services; Therapeutic Family Time; Permanency Planning Support Programs; Adoption Services
Target Population	
Address	45 Dixwell Avenue, New Haven, CT 06511
Phone Number	203 865 5437
Contact Person	
Email	rkids@rkidsCTorg
Web Address	www.rkidsCTorg
Service Type	
Agency Name	Project Launch
Brief Description of Services Provided	Outreach to promote wellness of young children ages birth-8 by addressing the physical, social, emotional, cognitive and behavioral aspects of development to promote prevention, early identification, and intervention
Target Population	
Address	
Phone Number	
Contact Person	Kim Nilson
Email	Kimberly.nilson@CTgov
Web Address	
Service Type	
Agency Name	Jewish Family Services
Brief Description of Services Provided	Children's Psychiatric & Counseling Services; Individual Assessment & Treatment; Parent Counseling; Family Therapy; Group Therapy; Psychiatric Evaluations
Target Population	
Address	1440 Whalley Avenue, New Haven, CT 06515
Phone Number	203 389 5599
Contact Person	
Email	
Web Address	www.jfsnh.org
Service Type	
Agency Name	Birth To Three
Brief Description of Services Provided	Strengthen the capacity of families to meet the developmental and health-related needs of their infants and toddlers who have delays or disabilities
Target Population	
Address	
Phone Number	860 505 7000
Contact Person	
Email	
Web Address	www.birth23.org
Service Type	
Agency Name	LULAC Head Start
Brief Description of Services Provided	Early Childhood Education; Health, Mental Health & Nutrition; Prevention & Early Intervention; Child Development Workshops for Parents; Social Service for Parents; Early Detection Screenings; Prenatal Program; Services for Children with Disabilities
Target Population	
Address	250 Cedar Street, New Haven, CT 06519
Phone Number	203 777 4006

Contact Person	
Email	
Web Address	www.lulacheadstart.org
Service Type	
Agency Name	Crossroads Inc.
Brief Description of Services Provided	Inpatient Substance Abuse Treatment (parent & child); Outpatient Substance Abuse & Mental Health Treatment
Target Population	
Address	54 East Ramsdell Street, New Haven, CT 06515
Phone Number	203 821 3040
Contact Person	
Email	
Web Address	www.crossroadsrecoveryCTorg
Service Type	
Agency Name	The Diaper Bank
Brief Description of Services Provided	Free Diapers for Struggling Families
Target Population	
Address	PO Box 9017, New Haven, CT 06532
Phone Number	203 934 7009
Contact Person	
Email	information@thediaperbank.org
Web Address	www.thediaperbank.org
Service Type	
Agency Name	New Haven Free Public Library
Brief Description of Services Provided	Engaging young people, ages birth to 16, to enlighten and encourage them in their academic and personal lives
Target Population	
Address	133 Elm Street, New Haven, CT 06510
Phone Number	203 946 8130
Contact Person	
Email	mjarry@nhfpl.org
Web Address	www.nhfpl.org
Service Type	
Agency Name	Polly T. McCabe Center
Brief Description of Services Provided	Program for pregnant teens, offers help for teens who need child care, developmental program for infants and toddlers
Target Population	
Address	400 Canner Street, New Haven, CT 06511
Phone Number	203 694 3484
Contact Person	Belinda Carberry (principal)
Email	Belinda.carberry@newhaven.k12.CTus
Web Address	
Service Type	
Agency Name	Family Centered Services of Connecticut (Family CT)
Brief Description of Services Provided	Care Coordination for Children & Youth with Special Health Needs; Caregiver Support Team; Empowerment & Literacy Groups; Family Based Recovery; Integrated Family Violence Services; Neighborhood Victim Advocacy Program; New Haven Family Partnership; Nurturing Families Network; Positive Parenting Program
Target Population	
Address	235 Nicoll Street, Building E, New Haven, CT 06511
Phone Number	203 624 2600
Contact Person	
Email	

Web Address	www.familyCTorg
Service Type	
Agency Name	Reachout Inc.
Brief Description of Services Provided	Speech Therapy; Physical Therapy; Occupational Therapy; Special Education Services
Target Population	
Address	60 Connolly Parkway, Hamden, CT 06514
Phone Number	203 230 2815
Contact Person	
Email	reachout@reachoutinc.org
Web Address	www.reachoutinc.org
Service Type	
Agency Name	Clifford Beers Clinic
Brief Description of Services Provided	Child First In-Home Support; Outpatient Therapy; School Based Clinics; EMPS Crisis Services; Care Coordination; Project CATCH; Wraparound New Haven
Target Population	
Address	93 Edwards Street, New Haven, CT 06511
Phone Number	203 772 1270
Contact Person	
Email	
Web Address	www.cliffordbeers.org
Service Type	
Agency Name	Yale Child Study Center
Brief Description of Services Provided	Anxiety & Mood Disorders; Autism/PDD Clinic; Child Development/Community Policing; Child Psychiatry Inpatient Services; Corner School Development Program; Day Care Programs; Early Childhood Clinic; Family Support Services; Outpatient Psychiatric Clinic; Psychological Assessment Services; Toddler Developmental Disorder Clinic; TS/OCD Clinic
Target Population	
Address	230 South Frontage Road, New Haven, CT 06519
Phone Number	203 785 2540
Contact Person	
Email	
Web Address	www.Childstudycenter.yale.edu
Service Type	
Agency Name	Minding The Baby
Brief Description of Services Provided	Intensive in-home visiting for first time young mothers and families to promote positive health mental health, life course and attachment
Target Population	
Address	230 South Frontage Road, New Haven, CT 06519
Phone Number	203 785 5589
Contact Person	
Email	
Web Address	www.mtb.yale.edu
Service Type	
Agency Name	Read To Grow
Brief Description of Services Provided	Promotes language building and literacy for children beginning at birth
Target Population	
Address	53 School Ground Road, Branford, CT 06405
Phone Number	203 488 6800
Contact Person	
Email	readtogrow@readtogrow.org
Web Address	www.readtogrow.org

Service Type	
Agency Name	MOMS Partnership
Brief Description of Services Provided	An agency collaboration across New Haven that works together to support the well-being of mothers and families living in the city
Target Population	
Address	40 Temple Street, Suite D, New Haven, CT 06510
Phone Number	203 764 8601
Contact Person	
Email	
Web Address	www.Medicine.yale.edu/psychiatry/moms
Service Type	
Agency Name	New Haven Health Department
Brief Description of Services Provided	Provides bicultural/bilingual health information and services for pregnant women and their families in New Haven and surrounding towns; Husky health insurance; outreach support for pregnant and parenting women; referrals to medical facilities, coordination of care, case management, home visits, outreach and education; pediatric immunization and outreach information
Target Population	
Address	54 Meadow Street, New Haven, CT 06519
Phone Number	203 946 8187
Contact Person	
Email	
Web Address	www.Cityofnewhaven.com/health/maternal.asp
Service Type	
Agency Name	Zero To Three (ZTT) Safe Babies Court Team Project
Brief Description of Services Provided	Program works with court, DCF, parents and service providers to improve outcomes for maltreated infants and toddlers to reduce the recurrence of substantiated reports of abuse/neglect of infants and toddlers in court jurisdictions
Target Population	
Address	
Phone Number	203 786 0565
Contact Person	Ebony Manning
Email	Ebony.manning@CTgov
Web Address	
Service Type	
Agency Name	Early Childhood Assessment Team (ECAT)
Brief Description of Services Provided	Program provides support for children ages 3-kindergarten. Evaluations are provided of preschool-aged children to determine if they qualify for special education services
Target Population	
Address	
Phone Number	203 946 7019
Contact Person	Typhanie Jackson
Email	
Web Address	www.nhps.net/node/1054
Service Type	
Agency Name	Text for Baby
Brief Description of Services Provided	Free mobile service to help women have healthy babies. Provides texts throughout pregnancy and during the first year
Target Population	
Address	
Phone Number	Text BABY or BEBE (for Spanish) to 511411
Contact Person	
Email	Info@textforbaby.org

Web Address	www.text4baby.org

Region 3 (Middletown / Norwich/Willimantic)	
Middletown	
Service Type	Advocacy Info
Agency Name	CT Parent Advocates Center
Brief Description of Services Provided	Provides advocacy information for parents of children with disabilities
Target Population	Children with disabilities
Address	
Phone Number	1-800-445-2722

Contact Person	
Email	
Web Address (if they have one)	
Service Type	Birth to Three
Agency Name	Various Agencies
Brief Description of Services Provided	Home visiting by developmental specialists for children who screen in as developmentally delayed
Target Population	Developmental concerns for children ages birth to 3
Address	
Phone Number	211 Infoline
Contact Person	
Email	Birth23.org
Web Address (if they have one)	
Service Type	Building Bridges Program
Agency Name	Generations Family Health Center
Brief Description of Services Provided	Free home visit services
Target Population	Prenatal to age 5
Address	
Phone Number	Willimantic - 860-450-0585 x 6507 and Putnam - 860-963-7917 x4141
Contact Person	
Email	
Web Address (if they have one)	
Service Type	Child First
Agency Name	Middlesex Hospital, UCFS, Child & Family Agency
Target Population	Pregnant women and families with children up to age 6
Address	
Phone Number	Daphne Donahue 860-358-4069 Karen Viggiani 860-822-4766
Contact Person	
Email	
Web Address (if they have one)	
Service Type	Circle of Security
Agency Name	Madonna Place DCF
Brief Description of Services Provided	A relationship-based early intervention program designed to enhance attachment security between parents and children. May be offered in groups or individually; usually 8 weeks in duration.
Target Population	Parents of young children
Address	
Phone Number	
Contact Person	Wendy Yagarich 860-886-6600 Charlie Slaughter 860-550-6682
Email	
Web Address (if they have one)	
Service Type	Early Head Start
Agency Name	ACES/Middlesex Hospital
Brief Description of Services Provided	Weekly home visits focus on parent education, support, parent/child interaction, child development, community referrals
Target Population	Low income families with child prenatal through 3 years of age
Address	
Phone Number	860-704-0725
Contact Person	Becky Cuevas
Email	
Web Address (if they have one)	

Service Type	ECCP (Early Childhood Consultation Partnership)
Agency Name	Statewide
Target Population	Families with children aged birth to five
Address	
Phone Number	860-704-6378
Contact Person	
Email	eccpct.com
Web Address (if they have one)	
Service Type	EMPS
Agency Name	Statewide
Target Population	Youth in Crisis
Address	
Phone Number	211
Contact Person	
Email	
Web Address (if they have one)	
Service Type	EvenStart
Agency Name	Middletown BOE
Brief Description of Services Provided	Provides comprehensive family centered education programs to improve children's academic success and increase parent's economic opportunities through parent education, early childhood education and home visits
Target Population	Parents with children 3 years of age or younger without a high school diploma
Address	
Phone Number	860-343-6046
Contact Person	Elizabeth Frasier
Email	
Web Address (if they have one)	
Service Type	Family Based Recovery
Agency Name	UCFS, CHR
Target Population	Families with co-occurring caregiver substance abuse and infants age B-2 who are at risk of removal from their homes *Need DCF referral
Address	
Phone Number	860-822-4266
Contact Person	John Eckstein, 860-221-977
Email	
Web Address (if they have one)	
Service Type	Family Resource Centers
Agency Name	Middletown Board of Education Norwich Public School Willimantic
Brief Description of Services Provided	Primary focus on enrichment programs for parents and children including support groups, playgroups, parenting education
Target Population	Families with children ages birth to 5 years
Address	
Phone Number	860-347-6971 x3662 860-886-6600
Contact Person	
Email	
Web Address (if they have one)	
Service Type	Headstart
Agency Name	Multiple agencies

Brief Description of Services Provided	Provides center-based programs and some home visiting
Target Population	Preschool program (ages 3-5) offered on a sliding scale for low-income families
Address	
Phone Number	
Contact Person	Middletown - Lisa Golibiewski 860-346-1284 Hampton - Hillary Murtagh 860-455-1586 Killingly - Dawn McQuade 860-779-0410 Plainfield - Jessica Haeseler 860-564-7787 Putnam- Teresa Lambert 860-963-5357 Windham - Nusie Halpine 860-465-2627 New London - 860-889-1365 or 211
Email	
Web Address (if they have one)	
Service Type	Help Me Grow
Agency Name	Child Development Infoline
Brief Description of Services Provided	Ensures that children and their families have access to a system of early identification, prevention and intervention services. Links child health providers, parents and service providers with existing community resources. Also Ages and Stages Monitoring Program
Target Population	Birth to age 5
Address	
Phone Number	800-505-7000
Contact Person	
Email	
Web Address (if they have one)	
Service Type	Maternal Infant Early Childhood Home Visiting Program (MIECHV)
Agency Name	Madonna Place – Great Beginnings
Brief Description of Services Provided	Home visiting program designed to improve birth outcomes and foster early childhood development. Services must begin in pregnancy, through age 3
Target Population	Pregnant women/fathers, and their children
Address	860-886-6600
Phone Number	
Contact Person	Anna Figueroa-Gilbert
Email	
Web Address (if they have one)	
Service Type	Mid-Level Developmental Assessment
Agency Name	Village for Families and Children
Brief Description of Services Provided	The assessment results in a comprehensive Service Plan for specific interventions for the child and parent/caretakers (e.g., therapy, special education, health care follow-up). Treatment length 1 - 2 office visits for assessment and 1 feedback session
Target Population	The child assessment covers traditional developmental skill areas including gross and fine motor, cognition, adaptive, and communication and also assesses psychosocial development and behavior. Case Management services provided; children ages birth - 6 years
Address	
Phone Number	
Contact Person	Susan Vader
Email	svader@villageforchildren.org
Web Address (if they have one)	
Service Type	Middlesex County Early Childhood Councils
Agency Name	United Way

Brief Description of Services Provided	Information about programs regarding early childhood development and school readiness
Target Population	Prenatal through age 5
Address	
Phone Number	
Contact Person	Chris Fahey 860-346-7354 or 860-346-8695
Email	
Web Address (if they have one)	
Service Type	Nurse-Family Partnership
Agency Name	Visiting Nurse Association of Southeastern CT
Brief Description of Services Provided	Program introduces first-time parents to maternal and child health nurses, supports moms to have a healthy pregnancy, become responsible parents, and provide babies with the best possible start in life.
Target Population	First-time mothers and their babies
Address	
Phone Number	860-444-1111
Contact Person	
Email	nursefamilypartnership.org
Web Address (if they have one)	
Service Type	Nurturing Families Network- Home Visiting Parenting and Pre-natal Groups Nurturing Connections
Agency Name	Madonna Place Middlesex Hospital Generations Health Center Day Kimball Hospital Lawrence & Memorial Hospitals Generations Family Health (Windham)
Brief Description of Services Provided	Weekly home visits focus on parent education, support, parent/child interaction, child development, community referrals. Treatment length once enrolled may be provided through primary child's fifth birthday; groups and phone support available
Target Population	First time parents demonstrating several psychosocial risk factors; parents may enroll prenatally through 3 months post-partum
Address	
Phone Number	Deirdre Cotter Garfield 860-886-6600 Linda McDonald 860-358-6743 Kimm Paluska 860-450-0585 Christine Millett 860-928-6541 x2077 Laurie Read 860-442-0711 Barbara Kingsbury 860-456-6258
Contact Person	
Email	
Web Address (if they have one)	
Service Type	Perinatal Case Management
Agency Name	Middlesex Hospital
Brief Description of Services Provided	Provides case management, counseling, and resource connections
Target Population	Pre-natal women and children ages 0-3
Address	
Phone Number	860-358-6427
Contact Person	Mary Doyle
Email	
Web Address (if they have one)	
Service Type	School Readiness

Agency Name	Middletown BOE
Brief Description of Services Provided	Access/resources for parents, educational opportunities, screening, and coordination of services
Target Population	3 & 4 year old children
Address	
Phone Number	860-346-7354
Contact Person	Chris Fahey 860-346-7354
Email	
Web Address (if they have one)	
Service Type	School Readiness Councils
Agency Name	Children First - Norwich
Brief Description of Services Provided	Access/resources for parents, educational opportunities, screening, and coordination of services
Target Population	Families with children ages 3 and 4
Address	
Phone Number	
Contact Person	Sherry Bryant 860-823-3782 or Anne Jerome 860-859-5015x149
Email	
Web Address (if they have one)	

Norwich

Service Type	Nurturing Families Network
Agency Name	
Brief Description of Services Provided	Provides screening and assessment, group support and intensive home visiting for new (1st time) parents who are at high risk for child abuse and negleCT
Target Population	Prenatal -5yrs.
Address	Statewide program funded by Children's Trust Fund -DSS
Phone Number	860-886-6600 (Norwich)
Contact Person	
Email	
Web Address	
Service Type	MIECHV Home visiting Programs
Agency Name	Lawrence and Memorial Hospital
Brief Description of Services Provided	Maternal, Infant, and Early Childhood Home visiting enrolls pregnant women and families with newborns to 3 months of age; and helps connect parents to resources and develop the skills they need to raise their child.
Target Population	Serves pregnant women and families with children from birth to age 5, with focus on families at risk.
Address	365 Montauk Ave. New London CT 06320
Phone Number	860-442-0711
Contact Person	
Email	
Web Address	www.imhospital.org
Service Type	Family Resource Centers
Agency Name	
Brief Description of Services Provided	Promote comprehensive, integrated, community-based systems of family support and child development services located in public school buildings; including playgroups, Home-visits, Developmental Screenings.
Target Population	Birth to School age:
Address	
Phone Number	860-823-4207 & 860-823-4210
Contact Person	
Email	
Web Address	

Service Type	Families First –Nurturing Families Network Program
Agency Name	UCFS -Madonna Place
Brief Description of Services Provided	The program offers the Nurturing Families Network to families having their first child who live in the greater Norwich area. It provides child development education for Mothers and fathers to increase their confidence and support them in raising healthy children.
Target Population	Pre-natal to 5yr. Families must enroll before their first child reach 3 months.
Address	240 Main street Norwich Ct 06360
Phone Number	860-886-6600
Contact Person	
Email	Madonna.place@snet.net
Web Address	
Service Type	Healthy Start
Agency Name	UCFS
Brief Description of Services Provided	Healthy Start provides assistance to income eligible pregnant women and children up to age three with Medicaid health insurance assistance (HUSKY), linkages with community resources and focused health related case management for high-risk situations.
Target Population	Children up to age 3
Address	47 Town Street, Norwich CT
Phone Number	860-822-4222
Contact Person	Yolanda Bowes
Email	ybowes@ucfs.org
Web Address	

Willimantic	
Service Type	Parenting Services
Agency Name	Nurturing Families Network
Brief Description of Services Provided	Aims to identify and enhance family strength while providing parents with knowledge and tools to monitor and promote their child's growth and brain development. Telephone support offered as well as home visitation and parenting series.
Target Population	First time parents of children under the age of three months.
Address	Day Kimball Healthcare, Family Advocacy Center, 255 Pomfret St., Putnam, CT
Phone Number	860-928-6541, ext. 7019
Contact Person	
Email	
Web Address	
Service Type	Parenting Services
Agency Name	Generations Family Health Center/Nurturing Families Network Program
Brief Description of Services Provided	Information, guidance and assistance to parents.
Target Population	Zero to age five
Address	40 Mansfield Ave., Willimantic, CT
Phone Number	860-450-7471
Contact Person	
Email	
Web Address	
Service Type	Fatherhood Initiative
Agency Name	Generations Family Health Center-Building Bridges Program
Brief Description of Services Provided	For expectant father's and father's parenting infants up to three months of age.
Target Population	Fathers
Address	40 Mansfield Ave., Willimantic, CT and 202 Pomfret St., Putnam, CT
Phone Number	860-450-7471
Contact Person	DCF Liaison, Carissa Lebrun, PM, 860-456-6612
Email	

Web Address	
Service Type	Parenting Services~Intensive in-home services.
Agency Name	Child First (UCFS)
Brief Description of Services Provided	Intensive in-home services for children ages birth to six who are experiencing social, emotional and behavioral difficulties within their home.
Target Population	Birth to under the age of six.
Address	322 Main St., Willimantic, CT
Phone Number	860-822-4905
Contact Person	Sarah DeLuca
Email	sdeluca@ucfs.org
Web Address	
Service Type	Parenting Services
Agency Name	Triple P~UCFS
Brief Description of Services Provided	Home-based, strength focused services that will promote stability and empower parents through the development of positive parenting skills. Services offer in English and Spanish
Target Population	
Address	
Phone Number	860-456-6628
Contact Person	DCF Liaison, Jo el Fernandez, SWS
Email	
Web Address	
Service Type	Intensive Family Preservation, (IFP)
Agency Name	IFP
Brief Description of Services Provided	Short term, up to twelve weeks, intensive homes based services. Primary goal is to stabilize the family and enable the child to remain safely at home.
Target Population	
Address	
Phone Number	860-456-6629
Contact Person	DCF Liaison, Diane LaGrega, SWS
Email	
Web Address	
Service Type	Substance Abuse Treatment - In Home
Agency Name	Family Based Recovery (FBR)~UCFS
Brief Description of Services Provided	Intensive and comprehensive in-home based program for families who have co-occurring caregiver substance abuse and an infant (birth to two) who is at risk of removal or poor developmental concerns
Target Population	Birth to age two
Address	
Phone Number	860-456-6668
Contact Person	DCF Liaison, Mary Cay Whewell, ARG
Email	
Web Address	
Service Type	
Agency Name	EASTCONN Head Start
Brief Description of Services Provided	
Target Population	
Address	226 Putnam Pike, Dayville, CT
Phone Number	860-779-6620
Contact Person	
Email	
Web Address	
Service Type	

Agency Name	Killingly Head Start and Early Head Start
Brief Description of Services Provided	
Target Population	
Address	1620 Upper Maple St., Danielson, CT
Phone Number	860-779-0410
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Plainfield Head Start at Moosup Gardens
Brief Description of Services Provided	
Target Population	
Address	10B Gorman St., Moosup, CT
Phone Number	860-564-7199
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Plainfield Head Start at the Plainfield Early Childhood Center
Brief Description of Services Provided	
Target Population	
Address	651 Norwich Rd., Plainfield, CT
Phone Number	860-564-7787
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Putnam Head Start
Brief Description of Services Provided	
Target Population	
Address	33 Wicker St., Putnam, CT
Phone Number	860-928-0004
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Windham Early Childhood Center
Brief Description of Services Provided	
Target Population	
Address	449 Boston Post Rd., No. Windham, CT
Phone Number	860-465-2601
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Windham Early Childhood Center
Brief Description of Services Provided	
Target Population	
Address	322 Prospect St., Willimantic, CT
Phone Number	860-465-2627
Contact Person	
Email	
Web Address	

Service Type	
Agency Name	Windham Early Head Start Program
Brief Description of Services Provided	
Target Population	
Address	10 Commerce Dr., Columbia, CT
Phone Number	860-228-0132
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	EASTCONN Birth to Three
Brief Description of Services Provided	
Target Population	
Address	Statewide info line~1-800-505-7000
Phone Number	
Contact Person	Program Coordinator, Maribeth Stearns, 860-455-1557
Email	
Web Address	

Region 4 (Hartford / Manchester)	
Hartford	
Service Type	Diaper Bank
Agency Name	Mercy Housing and Shelter
Brief Description of Services Provided	
Target Population	
Address	
Phone Number	(860) 808-2111
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Gifts of Love
Brief Description of Services Provided	
Target Population	
Address	34 E Main St, Avon, CT 06001
Phone Number	860-676-2323
Contact Person	
Email	
Web Address	

Service Type	Energy Assistance
Agency Name	Community Renewal Team (CRT)
Brief Description of Services Provided	
Target Population	
Address	395 Wethersfield Avenue, Hartford, CT 06114
Phone Number	860-560-5800
Contact Person	
Email	
Web Address	
Service Type	Weatherization
Agency Name	Community Renewal Team (CRT)
Brief Description of Services Provided	
Target Population	
Address	330 Market Street, Hartford, CT 06120
Phone Number	860- 560-5354
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Catholic Charities/IHF
Brief Description of Services Provided	Basic Needs; Family Centers; Fatherhood Initiative; General Parenting Education; School Readiness; Food Pantry
Target Population	
Address	45 Wadsworth Street, Hartford, CT 06106
Phone Number	860-527-1124
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Village for Families and Children
Brief Description of Services Provided	Child First: This intensive, therapeutic home visiting program serves families with children, birth to 6, who show the earliest signs of emotional, behavioral, or developmental problems, or who are at risk for these difficulties because of exposure to trauma, toxic stress or family mental health difficulties. Early childhood learning center; FatherWorks; Maternal, Infant, and Early Childhood Home Visiting/Parents as Teachers (MIECHV PAT); Nurturing Families Network; RAMBUH Family Center; Mid-Level Developmental Assessment: comprehensive developmental assessment for children from birth to six. It is a family-centered evaluation.
Target Population	
Address	1680 Albany Avenue, Hartford, CT 06105
Phone Number	860-236-4511
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Hartford Public Library
Brief Description of Services Provided	First-School; Preschool Activities and Crafts; Early Childhood; Early Learning and Childhood Basics; Tumble books Learning.
Target Population	
Address	500 Main Street, Hartford, CT 06103
Phone Number	860-695-6300
Contact Person	

Email	
Web Address	
Service Type	
Agency Name	Hartford Hospital
Brief Description of Services Provided	Baby Care Class; Enjoying Infants Together; Happiest Baby; Sibling Preparation; Time for Toddlers; Infant Massage.
Target Population	
Address	80 Seymour St., Hartford, CT 06106
Phone Number	860-545-5000
Contact Person	
Email	
Web Address	

Service Type	
Agency Name	St. Francis Hospital
Brief Description of Services Provided	Nurturing Families Network; Saint Francis Hospital Family Enrichment Services (formerly known as Parent Aide)
Target Population	
Address	114 Woodland St., Hartford, CT 06105
Phone Number	860-714-4000
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	CT Children's Medical Center
Brief Description of Services Provided	ArtReach: Connecticut Children's ArtReach program supports the healing and wellness of our pediatric patients and their families through art and music. Child Family Support: Family Support includes medical social workers who assess the bio-psycho-social functioning of patients and families and intervene as necessary. Kidsline: Connecticut Children's Kidsline is a telephone referral service provided for parents which links them to the physicians, programs and services offered by Connecticut Children's Medical Center. Special Kids Support Center: Connecticut Children's Special Kids Support Center empowers families of special needs children. Support Group: Having support from other families who share similar experiences can help families cope with the distress and challenges that come with child illness.
Target Population	
Address	280 Washington Street, Hartford, CT 06106
Phone Number	860-545-9000
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Wheeler Clinic
Brief Description of Services Provided	Circle of Security® Parenting Program: is a group intervention that helps parents of young children, birth to 8, better understand and respond to their child's emotional needs and behaviors, and develop more secure parent-child attachments. Early Childhood Consultation Partnership: This program provides consultation services for parents/guardians and early care and education providers who are

	caring for children, birth through 5, with challenging behaviors and/or social and emotional needs. Parent Connection: Parent Connections is a no-cost in-home service that provides information, support and guidance to families with young children ages birth to 5 who have concerns about their young child's development.
Target Population	
Address	30 Arbor Street, Second Floor, South Building, Hartford, CT 06106
Phone Number	860-523-9788
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	My People Clinical Services
Brief Description of Services Provided	Father to Father Program; Mother to Mother Program Food and Nutrition Program: The Food and Nutrition Program includes the food pantry and Weekend Food Backpack Program. The food pantry enables clients to "shop" for food once per month and is stocked with a wide variety of non-perishable foods, paper goods, personal hygiene items, meats and fresh produce, including fruits and vegetables grown at Community Farm of Simsbury. The Weekend Food Backpack Program distributes backpacks to nearly 200 students receiving free or reduced cost lunch in need in Avon, Canton, Farmington, Simsbury and West Hartford with easy-to-prepare meals and drinks for the family for the weekend and snacks for the student for the week. Students receive their backpacks from their schools on Fridays and return them to their schools on Mondays. Clothes Closet: Clients can "shop" for in-season clothing for their families once per month. Linen Closet and Household Room: Offers clients an array of bed linens, towels, curtains, pots, pans, dishes and small appliances, which are particularly important to clients who are leaving a shelter, experiencing a divorce or have suffered a fire. Furniture Program: Accepts and delivers furniture to meet the needs of clients. Clients may need furniture due to an addition to the family, moving to a home from a shelter, suffering a fire or exiting an abusive situation. We accept twin sized and full-sized beds, dressers and kitchen tables and chairs. Holiday Program: The Holiday Program enables clients to "shop" for new items for their family members for the holidays. Back-to-School Program: In August, Gifts of Love provides in-need children with fully-stocked backpacks, including pencils, paper, dictionaries and other necessary school supplies so they can start the school year ready for academics.
Target Population	
Address	111 Gillett Street; Hartford, CT 06105
Phone Number	860- 656-0450
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Department of Health
Brief Description of Services Provided	Family Development Training; Family Empowerment Programs; Help Me Grow; Kinship and Respite Fund; MIOP; Nurturing Families; The Stranger you Know; The Pediatric Rehabilitation Program addresses the specialized needs of children ages 4 and up.

	Make the First Five Count: child development services to help guide all parents through these early years. We know during this time, a child's brain develops connections that serve as the basis for language, reasoning, problem solving, social skills and emotional well-being. As an expert partner in your child's well-being, we've enlisted the help of five active animals who represent each of the key growth areas most important to a child's development.
Target Population	
Address	
Phone Number	860-509-8000
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Oak Hill
Brief Description of Services Provided	Children with intellectual, developmental, and physical disabilities, including visual and hearing impairments.
Target Population	
Address	120 Holcomb St., Hartford, CT 06112
Phone Number	860-242-2274
Contact Person	
Email	
Web Address	
WEST HARTFORD	
Service Type	
Agency Name	West Hartford Public Library
Brief Description of Services Provided	1000 Books Before Kindergarten Birth to age 5: This multi-year, pre-literacy program encourages West Hartford residents to READ to their little ones before they enter Kindergarten. "The single most important activity caregivers and teachers can do to help children become successful readers is to read aloud to them every day. Being Mindful While Parenting: Make parenting a more mindful experience! Parenting is more enjoyable when you are calm - achieve this with mindfulness. Parenting mindfully means parenting in the present moment, non-judgmentally, without the need to reaCT Raising a family creates stress that can be reduced with the practice of mindfulness. Toddler Time: For children ages 13-23 months with adult. Join us for an informal gathering of toys and conversation and a brief program of finger games and music. A parent or caregiver must accompany each child. Due to overwhelming response to these programs, only West Hartford residents may attend. Baby Time: For children ages newborn to 12 months with adult. Join us for an informal gathering of toys and conversation and a brief program of finger games and music. A parent or caregiver must accompany each child. Due to overwhelming response to these programs, only West Hartford residents may attend. Prime Time with Piper & Mrs. Breen: All ages welcome - child(ren) with adult. Drop-in for stories, songs, dancing, flannels and finger plays! Enjoy Piper's silliness and sneak in some creativity. Family fun! Open to all ages. Book selections are generally planned for ages 2-5. Yoga for You 2: for preschool aged child(ren) with adult. Drop-in, casual yoga for you and your little one. Bring your yoga mat or beach towel and find your calm center this summer.
Target Population	
Address	20 South Main Street; West Hartford, CT 06107
Phone Number	860-561-6950 (main) 860-561-6980 (children's)
Contact Person	

Email	
Web Address	
BLOOMFIELD	
Service Type	Operation Fuel
Agency Name	Social and Youth Services Department
Brief Description of Services Provided	
Target Population	
Address	330 Park Avenue; Bloomfield, CT 06002
Phone Number	860-242-1895; 860-242-1895l (Operation Fuel)
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Social and Youth Services Department
Brief Description of Services Provided	Eviction & Ejectment Receivership and Processing per Connecticut General Statutes; Fee Discounts / Waivers for Bloomfield Leisure; Services sponsored summer programs; Food Bank; Holiday giving: Thanksgiving Baskets and Christmas Toy Drive for Bloomfield families with children
Target Population	
Address	330 Park Avenue; Bloomfield, CT 06002
Phone Number	860-242-1895
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	The Alliance for Bloomfield's Children (ABC)
Brief Description of Services Provided	This is a committed group of parents, early childhood professionals and community members who are interested in ensuring that all children in Bloomfield enter school ready to learn and have a happy, healthy start to life. The Alliance was formed in order to empower parents to move the public will in the interest of Bloomfield's children. The Alliance is now a collaborative that consists of what were once three separate councils: Bloomfield Discovery Council, Bloomfield School Readiness Council and the Laurel Family Resource Center Advisory Committee.
Target Population	
Address	Laurel School; 1 Filley Street; Bloomfield, CT 06002
Phone Number	860-849-1787
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Library Programs
Brief Description of Services Provided	Small Talk: Children and their caregivers are welcome to drop in for playtime, conversation, and a child-centered program. For this evening story time. Children ages 3 - 6 are invited to wear their pajamas and bring a favorite sleep toy or pillow to enjoy bedtime stories, a craft and a movie. Free summer meals to children and teens, 18 and under. Playhouse and Special Book Collection: Dedicated in memory of Lori Jean Watson this collection offers fiction and nonfiction titles related to African American history. Story Bags: The Children's Department offers Early Literacy Story Bags, thanks to an Every Child Ready to Read @ Your Library grant. The thematic Story Bags

	include books, movies, and educational toys aimed at children ages birth – three, contained in easy-to-transport bags. Baby Bags: Please visit us today to pick up this very special gift for your baby. To encourage the early use of the library, our "welcome new baby" bag comes with a new book, early literacy tips, and a variety of items for your newborn!
Target Population	
Address	1 Tunxis Avenue, Bloomfield, CT 06002;
Phone Number	860-242-2972 (children services)
Contact Person	
Email	
Web Address	
WINDSOR	
Service Type	
Agency Name	Library
Brief Description of Services Provided	Sunny Side Up: This drop-in program from 10:30 AM to 11:15AM is for children ages 2-6 and their caregivers. Come enjoy stories, songs, movement activities, and a simple craft. Sunny Side Up Story time meets every Tuesday. Talk & Toys: A wonderful way for you and your children to meet new friends. It's held in an extra-large sunny room and provides both large and small toys for your child's muscle development. This drop-in group meets each Monday from 10:30 AM to 11:30 AM. Tumble Books: are animated, talking picture books with fiction, non-fiction and foreign language titles. E-books for e-kids. True Flix: features the popular True Books content for kids to read online, along with videos, activities, and projects from a list of great topics.
Target Population	
Address	232 Broad Street, Windsor, CT 06095
Phone Number	860-285-1910
Contact Person	
Email	
Web Address	
Service Type	The Pediatric Rehabilitation Program
Agency Name	Easter Seals Capital Region & Eastern Connecticut
Brief Description of Services Provided	The Pediatric Rehabilitation Program: is part of Easter Seals. Addresses the specialized needs of children ages 4 and up.
Target Population	Ages 4 and up
Address	100 Deerfield Road; Windsor, CT 06095
Phone Number	860-552-2002; 860-270-0600 (The Pediatric Rehabilitation)
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Easter Seals Capital Region & Eastern Connecticut
Brief Description of Services Provided	Make the First Five Count: child development services to help guide all parents through these early years. We know during this time, a child's brain develops connections that serve as the basis for language, reasoning, problem solving, social skills and emotional well-being. As an expert partner in your child's well-being, we've enlisted the help of five active animals who represent each of the key growth areas most important to a child's development.
Target Population	
Address	100 Deerfield Road; Windsor, CT 06095
Phone Number	860-552-2002
Contact Person	
Email	

Web Address	
Service Type	Parent Support Center through CRT
Agency Name	CRT
Brief Description of Services Provided	Offers parenting classes, support groups, book and toy lending libraries, drop-in programs, and special events for parents and their children. Milo W. Peck Child Development Center; 860-285-1410
Target Population	
Address	114 Palisado Avenue; Windsor, CT 06095
Phone Number	860-285-1441
Contact Person	
Email	
Web Address	
Service Type	Parent Support Center through CRT
Agency Name	Milo W. Peck Child Development Center (CRT)
Brief Description of Services Provided	Offers parenting classes, support groups, book and toy lending libraries, drop-in programs, and special events for parents and their children.
Target Population	
Address	114 Palisado Avenue; Windsor, CT 06095
Phone Number	860-285-1441; 860-285-1410 (Milo W. Peck)
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Birth Support Education & Beyond, LLC
Brief Description of Services Provided	Doula, childbirth, and parent education services; must be an active DHMAS/YAS client
Target Population	
Address	
Phone Number	
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	Early Childhood Consultation Partnership (ABH)
Brief Description of Services Provided	Designed to improve the overall social and emotional health of children birth to age five.
Target Population	Birth to 5 years old
Address	
Phone Number	
Contact Person	
Email	
Web Address	
Service Type	
Agency Name	United Healthcare Children's Foundation
Brief Description of Services Provided	Awarded up to an annual max of $5000 and a lifetime max of $10000 per child. Used for assistance with conditions such as Autism, Cerebral Palsy, Diabetes, Down Syndrome, hearing loss, speech delay, ADD/ADHD; and digestive disorders.
Target Population	
Address	
Phone Number	
Contact Person	
Email	
Web Address	www.UHCFF.org

Service Type	Multi-Service Agencies
Agency Name	The Hispanic Health Council
Brief Description of Services Provided	Breastfeeding peer counseling, diabetes case management, parenting support and child abuse prevention, pre-natal case management and support, and nutrition education and assistance.
Target Population	
Address	175 Main St, Hartford, CT 06106
Phone Number	860-527-0856
Contact Person	
Email	
Web Address	
Service Type	Multi-Service Agencies
Agency Name	The Salvation Army
Brief Description of Services Provided	Young parents' program; grandparent support groups; soup kitchens; feeding and nutrition programs; and food and clothing banks.
Target Population	
Address	217 Washington Street, Hartford, CT 06106
Phone Number	(860) 543-8413
Contact Person	
Email	
Web Address	
Service Type	Multi-Service Agencies
Agency Name	CT Council of Family Service Agencies
Brief Description of Services Provided	Services are provided to low income, middle class, and the affluent. Provide parenting education.
Target Population	
Address	1310 Silas Deane Hwy # 219, Wethersfield, CT 06109
Phone Number	860-571-0093
Contact Person	
Email	
Web Address	www.ctfsa.org
Service Type	Multi-Service Agencies
Agency Name	Connecticut Library for the Blind and Physically Handicapped
Brief Description of Services Provided	Lends books and magazines in Braille and recorded format, along with the necessary playback equipment to any CT adult or child.
Target Population	
Address	198 West Street, Rocky Hill, CT 06067
Phone Number	860-721-2020 or toll free 800-842-4516
Contact Person	
Email	
Web Address	
Service Type	Multi-Service Agencies
Agency Name	American School for the Deaf
Brief Description of Services Provided	Offers students full-range of education from pre-school to 12th grade, serving deaf and hard of hearing students.
Target Population	3 to 21 years old
Address	139 N Main St, West Hartford, CT 06107
Phone Number	(860) 570-2300
Contact Person	
Email	
Web Address	www.asd-1817.org
Service Type	Multi-Service Agencies
Agency Name	CT Parent Advocacy Center

Brief Description of Services Provided	Offers information and support to families from birth to age 26 with any disability or chronic illness.
Target Population	Birth to 26 years old
Address	338 Main Street, Niantic, CT 06357
Phone Number	800-445-2722
Contact Person	
Email	
Web Address	
Service Type	Fatherhood Resources
Agency Name	Connecticut Clearinghouse
Brief Description of Services Provided	
Target Population	
Address	334 Farmington Ave, Plainville, CT 06062
Phone Number	860-793-9791
Contact Person	
Email	
Web Address	
Service Type	Fatherhood Resources
Agency Name	Community Health Services, Inc.
Brief Description of Services Provided	
Target Population	
Address	500 Albany Ave, Hartford, CT 06120
Phone Number	860-249-9625
Contact Person	
Email	
Web Address	
Service Type	Fatherhood Resources
Agency Name	Families in Crisis, Inc.
Brief Description of Services Provided	
Target Population	
Address	60 F J Popieluszko Ct, Hartford, CT 06106
Phone Number	860-727-5800
Contact Person	
Email	
Web Address	
Service Type	Fatherhood Resources
Agency Name	
Brief Description of Services Provided	The Family Resource Center at Charter Oak
Target Population	
Address	425 Oakwood Ave, West Hartford, CT 06110
Phone Number	860-233-8506
Contact Person	
Email	
Web Address	
Manchester	
Service Type	Headstart & Early Headstart
Agency Name	CT-HS State Collaboration Office
Brief Description of Services Provided	
Target Population	
Address	165 Capitol Ave, Hartford, CT 06106
Phone Number	860-713-6767
Contact Person	Grace Whitney
Email	Grace.whitney@CTgov
Web Address	

Service Type	Early Headstart
Agency Name	ECHN
Brief Description of Services Provided	Provides educational home visits, child development assessments, social activities, child development services, health, dental, nutritional and mental health services and links to community resources.
Target Population	At risk expectant parents 0-3mos Manchester, Vernon, Rockville
Address	57 Hartford Tpke, Manchester, CT 06042
Phone Number	860-432-5278 Ext 137
Contact Person	Jennie Shea
Email	jshea@echn.org
Web Address	

Service Type	Early Headstart
Agency Name	Eastern CT Health Network (ECHN)
Brief Description of Services Provided	Provides educational home visits, child development assessments, social activities, child development services, health, dental, nutritional and mental health services and links to community resources.
Target Population	Designed for income eligible expectant families and those with children birth to three.
Address	71 Haynes Street, Manchester, CT 06040
Phone Number	860-872-0501 Ext 5779
Contact Person	Jennie Shea
Email	jshea@echn.org
Web Address	www.echn.org

Service Type	Headstart
Agency Name	East Hartford Headstart
Brief Description of Services Provided	A comprehensive pre-school program for children 3-5 – provides family support services, school readiness, and health and development screenings.
Target Population	Children 3-5yo
Address	95 Willowbrook Road, E. Hartford, Ct 06118
Phone Number	860-622-5226
Contact Person	Penny Richards
Email	Richard.pc@easthartford.org
Web Address	www.easthartford.org

Service Type	Headstart – Vernon
Agency Name	EASTCONN
Brief Description of Services Provided	A comprehensive pre-school program for children 3-5 – provides family support services, school readiness, and health and development screenings.
Target Population	Child ages 3-5
Address	23 Elm Street, Vernon, CT 06066
Phone Number	860-560-3108
Contact Person	Jen Snyder
Email	jsnyder@astconn.org
Web Address	www.eastconn.org

Service Type	Headstart – Stafford Springs
Agency Name	Stafford Family Resource Center
Brief Description of Services Provided	A comprehensive pre-school program for children 3-5 – provides family support services, school readiness, and health and development screenings.
Target Population	3-5
Address	153 West Stafford Road, Stafford Springs, CT 06076
Phone Number	860-684-6927
Contact Person	Linda Allegro
Email	allegrol@stafford.k12.CTus

Web Address	
Service Type	Headstart
Agency Name	Manchester Preschool Center
Brief Description of Services Provided	A comprehensive pre-school program for children 3-5 – provides family support services, school readiness, and health and development screenings.
Target Population	3-5
Address	60 Washington Street, Manchester, CT 06042
Phone Number	860-647-3502
Contact Person	Nydia Einsiedel
Email	B08neins@mpspride.org
Web Address	
Service Type	Headstart – Enfield
Agency Name	Enfield Public Schools
Brief Description of Services Provided	A comprehensive pre-school program for children 3-5 – provides family support services, school readiness, and health and development screenings.
Target Population	3-5
Address	1270 Enfield Street, Enfield, CT 06082
Phone Number	860-253-6597
Contact Person	Debbie Clement, Director
Email	dclement@enfieldschools.org
Web Address	www.enfieldschools.org
Service Type	Child First
Agency Name	Intercommunity, Inc.
Brief Description of Services Provided	Home based services for children with behavioral or developmental problems. Provide parental guidance and comprehensive assessment.
Target Population	Children 0-6yo
Address	281 Main Street, East Hartford, CT 06108
Phone Number	860-291-1341
Contact Person	Rick Amaral
Email	richardamaral@intercommunityCTorg
Web Address	www.intercommunity.org
Service Type	Early Childhood Consultation Partnership (ECCP)
Agency Name	CHR
Brief Description of Services Provided	Early childhood consultation program. Provides support, education and consultation to daycare and pre-school settings serving young parents as well as parents and caregivers.
Target Population	0-5
Address	587 East Middle Tpke, Manchester, CT 06040
Phone Number	860-646-3888 or 860-704-6387
Contact Person	Tracy Smith
Email	trsmith@chrhealth.org
Web Address	www.chrhealth.org or www.eccpCTcom
Service Type	Early Childhood Consultation Partnership
Agency Name	Catholic Charities
Brief Description of Services Provided	Early childhood consultation program. Provides support, education and consultation to daycare and pre-school settings serving young parents as well as parents and caregivers.
Target Population	Birth to 3, 3-5
Address	45 Groton, Hartford, CT
Phone Number	860-206-9265 or 860-704-6378
Contact Person	Cara Billman
Email	cbillman@ccaoh.org
Web Address	www.eccpCTcom

Service Type	East Hartford School Readiness
Agency Name	East Hartford Board of Education
Brief Description of Services Provided	Provides Pre-K readiness and family involvement
Target Population	3-5
Address	1110 Main Street, East Hartford, CT
Phone Number	860-622-5975
Contact Person	Mindy D'Andrea
Email	Dandrea.mj@easthartford.org
Web Address	
Service Type	Nurturing Families Network
Agency Name	Manchester Memorial Hospital
Brief Description of Services Provided	Home based parenting education
Target Population	At risk pregnant parents, 0-3months, Manchester, E Hartford, Vernon
Address	71 Haynes Street, Manchester, CT 06040
Phone Number	860-432-5278 Ext 138
Contact Person	Elizabeth Conklin
Email	
Web Address	www.Echn.org
Service Type	Nurturing Families Network
Agency Name	Hartford Hospital
Brief Description of Services Provided	Home-based parenting education
Target Population	At risk pregnant parents, 0-3 months, Hartford area
Address	111 Park Street, Hartford, CT 06106
Phone Number	860-972-3131
Contact Person	Leslie Escobales
Email	Leslie.escobales@hhchealth.org
Web Address	www.harthosp.org
Service Type	Nurturing Families Network
Agency Name	St. Francis Hospital
Brief Description of Services Provided	Home based parenting education
Target Population	At risk pregnant parents, 0-3months, Hartford Area
Address	114 Woodland Street, Hartford, CT 06105
Phone Number	860-714-5613
Contact Person	Jenessa Benoit, BSW
Email	
Web Address	www.Stfranciscare.org

Region 5 (Danbury / Torrington / Waterbury)	
Danbury	
Service Type	Postpartum Support
Agency Name	Postpartum Support Internation
Brief Description of Services Provided	Provides support to new mothers and their families
Target Population	New mothers and their families
Address	
Phone Number	203-439-2001
Contact Person	Teresa Twomey
Email	Tmtwomey2@gmail.com
Web Address	www.postpartum.net
Service Type	Infant and Toddler Services
Agency Name	Education Connection
Brief Description of Services Provided	Provides services to children and information to families
Target Population	Infants and toddlers with developmental delays
Address	355 Goshen Rd., Litchfield, CT 06759
Phone Number	860-567-0863 x170
Contact Person	Bruni Edwards
Email	www.educationconnection.org
Web Address	www.birth23.org
Service Type	Preschool
Agency Name	Danbury Public Schools Early Childhood Program
Brief Description of Services Provided	Play and learning program
Target Population	Danbury children ages 3 -4 years old
Address	17 Cottage St., Danbury, CT
Phone Number	203-797-4832
Contact Person	Fran Tyluk, Early Childhood Specialist
Email	
Web Address	www.Danbury.k12.CTus
Service Type	Preschool
Agency Name	Danbury School Readiness Program
Brief Description of Services Provided	Education and play
Target Population	Danbury children ages 3-5 years old
Address	
Phone Number	203-791-1904 x 168

Contact Person	Eileen Costello
Email	costello@educationconnection.org
Web Address	www.danburysr.org
Service Type	Preschool
Agency Name	Head Start of Northern Fairfield County
Brief Description of Services Provided	Preschool education
Target Population	Low income children 3-5 years old and their families
Address	7 Old Sherman Tpke., Ste. 212, Danbury, CT
Phone Number	203-743-3993
Contact Person	Ana Marin
Email	marina@ct-institute.org
Web Address	www.headstartprogram.us
Service Type	Infant and Toddler Services
Agency Name	Theracare
Brief Description of Services Provided	Assessment and education of children, services for family
Target Population	3-5 year olds with developmental delays
Address	50 Washington St., #502, Norwalk, CT
Phone Number	888-355-3255 x 2003
Contact Person	Deborah Mastronardi
Email	DeborahMastronardi@theracare.com
Web Address	www.birth23.com
Service Type	Preschool
Agency Name	Wellmore –ECCP
Brief Description of Services Provided	Identifies and works on social, educational, & emotional
Target Population	Birth to 5 years old
Address	213 Court St., Middletown, CT 06457
Phone Number	203-755-1143 x 4335
Contact Person	Eileen Donnelly-Phillips
Email	edonnelly-phillips@wellmore.org
Web Address	www.fca.org
Service Type	Parenting Support
Agency Name	Family and Children's Aid
Brief Description of Services Provided	Parent support and education
Target Population	Parents of children ages birth to 18 years old
Address	12 Harmony St., Danbury, CT
Phone Number	203-205-2623
Contact Person	Angela Allen
Email	angela.allen@fcaweb.org
Web Address	www.fca.org
Service Type	Parenting Support
Agency Name	Family Resource Center – Danbury Public Schools
Brief Description of Services Provided	Play groups – English, Spanish, Portuguese
Target Population	Mothers with children ages birth to 5 years old
Address	28 Morris St., Danbury, CT
Phone Number	(203) 790-2682
Contact Person	Estrela Camacho
Email	
Web Address	www.danbury.k12.CT.us
Torrington	
Service Type	ECCP
Agency Name	Community Mental Health Affiliates Northwest Center for Family Services
Brief Description of Services Provided	Consultation service that focuses on the healthy social and emotional development of children birth to five. The services are based on a continuum

	from brief phone consultation to classroom based consultation to child specific consultation.
Target Population	Child Specific service: a. Children ages 0 - 5 *currently in a day care center who are experiencing social-emotional challenges*. b. Children ages 0 - 5 *in DCF Foster Care* (with or without a daycare component). c. Children ages 0 - 3 *remaining in their parents' custody following a DCF investigation after the investigation has been closed or a disposition has been made* (with or without a daycare component). d. Parents/Legal Guardians must give written permission and sign a Consent for Release of Confidential Information in order to receive the Child Specific Service. Core Classroom service: Infant - Pre-K classrooms within a daycare center that are experiencing challenges, or want to enhance the Social – Emotional Development of their classroom.
Address	350 Main Street, PO Box 153, Lakeville, CT 06039
Phone Number	Phone: (860) 435 – 2529; Fax: (860) 435 – 8084
Contact Person	Elizabeth Rhodes
Email	erhoades@cmhacc.org
Web Address	www.Cmhacc.org
Service Type	Child First
Agency Name	Charlotte Hungerford
Brief Description of Services Provided	Child First program provides intensive in-home therapeutic and care management services to families with children prenatal through age 6. The primary focus of treatment is two-fold: To decrease the stress within the home by linking the family to helpful community resources and to increase parenting skills and confidence through family and school assessment and treatment within the parent-child relationship. It is an evidence based therapeutic model of treatment aimed at working with high risk families who have experienced chronic or acute trauma, mental/physical illness or other stressors.
Target Population	Parents can be any age. Children may be prenatal through age 6.
Address	50 Litchfield St. Torrington, CT 06790
Phone Number	(860) 496-0867 ext. 229
Contact Person	Rebecca Parilla
Email	Rparilla@hungerford.org
Web Address	www.Charlottehungergord.org
Service Type	Birth to Three
Agency Name	Education Connection
Brief Description of Services Provided	Deliver early intervention services and full developmental evaluations to infants and toddlers with developmental delays.
Target Population	Children under age 3 can receive a free developmental evaluation to determine eligibility. A child can be eligible for services in one of the following ways: A developmental delay was identified during a multidisciplinary evaluation assessing 5 domains of development (cognitive, physical, communication, social/emotional, adaptive skill) or a specific medical diagnosis that has a high likelihood of affecting development was identified by a professional.
Address	355 Goshen Rd. Litchfield, CT 06759
Phone Number	860-567-0863 x 170
Contact Person	Bruni Edwards, Program Manager
Email	edwards@educationconnection.org
Web Address	www.Educationconnection.org
Service Type	Supportive Housing for Families

Agency Name	Education Connection, Inc.
Brief Description of Services Provided	Case Management services with a housing assistance component. Working with DCF families towards reunification or preservation.
Target Population	The Family must have an open DCF case at the time of referral and be referred by a DCF Social Worker from an ongoing services unit or, if in Intake there must be a documented plan to transfer the case for ongoing services to a treatment unit. Be homeless or at risk of homelessness and /or housing must be a barrier to reunification or preservation of the family. Neither a TPR nor TOG must not be pending or planned. Meet general RAP, Section 8 Family Unification Program or other subsidy requirements. The client, or anyone over the age of 18 in the home, must not be on the sex offender registry or have any pending felony charges within 3 years.
Address	
Phone Number	
Contact Person	Heidi Novajosky
Email	hnovajosky@educationconnection.org
Web Address	
Service Type	Head Start (Prenatal to 5)
Agency Name	Education Connection Inc.
Brief Description of Services Provided	Prenatal to Three- home based child development program provided during weekly home visits and ongoing play groups. Three to Five-comprehensive center based early childhood services provided in a variety of program options that include full day, part day as well as combination home/center. Offer supports to families in the areas of health, nutrition, education, social services and family engagement.
Target Population	Low Income families-100% federal poverty guidelines Families Receiving TFA or SSI; Foster Children; Homeless Families Children with Special Needs; *Over income families are welcome to apply; Applications are given a score based on selection criteria. Families with higher needs receive preference for placement.
Address	355 Goshen Rd. Litchfield, CT
Phone Number	Phone 860-567-0863; Fax 860-567-3381
Contact Person	Donna Farr, Family Service Manager
Email	farr@educationconnection.org
Web Address	www.educationconnection.org
Service Type	Early Head Start
Agency Name	Early Head Start Torrington Collaborative
Brief Description of Services Provided	Parent Trainings, Preschool Staff Professional Development, Community Outreach Events.
Target Population	Birth to age 8
Address	PO Box 854, Torrington CT 06790
Phone Number	860-806-1410
Contact Person	Donna Labbe
Email	torringtonearlychildhood@gmail.com
Web Address	www.torringtonchildren.org
Service Type	Family Strides Inc.
Agency Name	Nurturing Families Visiting Network, Husky, WIC
Brief Description of Services Provided	The focus of the Nurturing Families Network Home Visiting Program is to promote positive parenting and reduce incidents of child abuse and neglect by providing education in nurturing parenting, healthy families, parent life outcomes, and school readiness. Family Strides also offers Healthy Start/HUSKY Health Insurance, Nurturing Connections, Women Infants and Children (WIC), Childbirth Education, Father Involvement, and Parenting Programs.

Target Population	Nurturing Families Network is open to all first-time parents, including those who are prenatal. Healthy Start is open to those in need of medical insurance through HUSKY and who meet income requirements. Nurturing Connections is open to all prenatal and new parents at the time of delivery. WIC is open to all pregnant and breastfeeding women, as well parents of children up to age 5 who meet income requirements. Father Involvement Program is open to fathers with children of all ages both with and without custody of their children. Parenting Today Class are available
Address	350 Main Street, Suite D, Torrington, CT 06790
Phone Number	(860) 482-3236; Fax: 860.482.3238
Contact Person	Courtney Hosking
Email	Chosking@familystrides.org
Web Address	www.Familystrides.org
Service Type	Brooker Memorial
Agency Name	The Maria Seymour Brooker Memorial
Brief Description of Services Provided	Mission is to prepare children for lifelong success through education, health services, family support, and programs of excellence. We have three major program areas: Pediatric dentistry (which is bi-lingual), a Child Care and Learning Center, and Outreach Services.
Target Population	Children are eligible for dental services if they are on Husky or have no dental insurance. Outreach services are not child specific but cover other health care and services to enhance supports to families in our service area. Children 1-20 yrs. Also eligible for dental services are pregnant women of all ages who are on WIC, or are non-insured. Children can attend child care full or part time from 6 weeks of age through Kindergarten.
Address	157 Litchfield Street, Torrington, CT 06790
Phone Number	(860) 489-1328
Contact Person	Jan Lyons, Outreach Director
Email	Jlyon@brookermemorial.org
Web Address	www.Brookermemorial.org
Service Type	Maternal Infant Early Childhood Home Visiting (MIECHV); Parents as Teachers (PAT) Program
Agency Name	Educational Connection Inc. Parents as Teachers (PAT)
Brief Description of Services Provided	Positive birth outcomes, healthy growth & development for parents and child, prevent abuse & neglect, promote parenting skills, through education, group support and case management.
Target Population	Families from Torrington and Winchester; may be over-income for Head Start, involved with DCF, have additional older children, speak Spanish.
Address	350 Main Street,, Suite E, Torrington CT 06790
Phone Number	860.489.0772; Fax: 860.567.3381
Contact Person	Lisa Candels, Clinical Supervisor
Email	candels@educationconnection.org
Web Address	
Service Type	Positive Parenting Program (Triple P)
Agency Name	CMHA (FBR and Triple P, Intensive Family Preservation)
Brief Description of Services Provided	Triple P is an in-home, evidenced based program that helps parents manage their child's behavior and become independent, resourceful problem solvers. Parents/Caregivers are given the tools to create a positive and safe home learning environment that will help develop and nurture their child's behavioral, emotional, and cognitive strengths. Triple P builds upon the conviction that a positive and safe home environment can be preserved by increasing positive parent-child interaction within the home.
Target Population	Families who are active with the Department of Children and Families (DCF) and/or Community Partner Agencies. The standard Triple P program serves

	parents/caregivers of children 0-12 years of age. The Standard Teen Triple P program serves parents/caregivers of adolescents 13-17 years.
Address	100 Commercial Blvd., Torrington, CT 06790
Phone Number	860-482-8561 X 1378, Cell) 860-502-9100; (Fax) 860-489-5261
Contact Person	Dawn Zabek
Email	DZabek@cmhacc.org
Web Address	
Service Type	Winsted Family Resource Center
Agency Name	Family Resource Center
Brief Description of Services Provided	Seven Components: some direct service, some collaborative 1. Parents as Teachers: prenatal to kindergarten parent education & support program in an early education center-Direct 2. Before & After School Care-Collaboratively 3. Services to Home Childcare Providers-Direct 4. Adult Education- Collaboratively 5. Positive Youth Development- Both 6. Preschool Childcare- Collaboratively. 7. Resource & Referral- Direct
Target Population	Only Winsted families. Service until entry to Kindergarten, but are available to provide resources to any family in the school distriCT
Address	201 Pratt Street, Winsted, CT
Phone Number	(860) 379-0828
Contact Person	Ruthann Horvay
Email	ruthann.horvay@winchesterschools.org
Web Address	www.Winsted@winchesterschools.org
Service Type	Torrington Soup Kitchen
Agency Name	Trinity Church (basement)
Brief Description of Services Provided	We are committed to providing a nutritious meal to any individual who, for whatever reason, is unable to provide a proper meal for himself or herself.
Target Population	The soup kitchen serves people from all walks of life, including homeless individuals and families and the working disadvantaged.
Address	P.O. Box 852, 220 Prospect St., Torrington, CT
Phone Number	(860) 482-0130
Contact Person	Lisa Hageman
Email	TorringtonSoupKitchen@gmail.com
Web Address	
Service Type	Family Resource Center (Vogel-Wetmore School)
Agency Name	Education Connection
Brief Description of Services Provided	It provides families with young children opportunities to enhance their children's school readiness. This is offered through resource and referral, adult education, support to family daycare providers, family literacy/ESL classes for parents, parenting education and other forms of family support. Our positive youth development programming helps school age children bolster their self-esteem and foster academic achievement.
Target Population	Birth to Adults
Address	68 Church St, Torrington, CT 06790
Phone Number	(860) 489-4552
Contact Person	Michelle Anderson
Email	torringtonfrc@educationconnection.org
Web Address	
Waterbury	
Service Type	Birth to Three
Agency Name	Children's Therapy Services
Brief Description of Services Provided	Early intervention

Target Population	0-2.9
Address	46 Roxbury Ct, Cheshire, CT 06410
Phone Number	203-271-3288
Contact Person	Cindy Jackson
Email	Jackcts01@yahoo.com
Web Address	www.childrenstherapyservices.org
Service Type	Birth to Three
Agency Name	Rehabilitation Associates of CT, Inc.
Brief Description of Services Provided	Early intervention
Target Population	0-2.9
Address	1931 Black Rock Turnpike, Fairfield, CT 06825
Phone Number	203-384-8681
Contact Person	Kate Stowell
Email	k.stowell@rehabassocinc.com
Web Address	www.rehabilitationassociatesinc.com
Service Type	Child First
Agency Name	Wellmore Behavioral Health
Brief Description of Services Provided	Intensive in-home parenting
Target Population	0-6
Address	141 East Main St. 3rd Floor, Waterbury, CT 06702
Phone Number	203-575-0466 x1211
Contact Person	Diane Britz
Email	Dbritz@wellmore.org
Web Address	www.wellmore.org
Service Type	Early Child Consultation Partnership
Agency Name	Wellmore Behavioral Health
Brief Description of Services Provided	Child/family/classroom consultation
Target Population	0-5
Address	141 East Main Street, 3rd floor, Waterbury, CT 06702
Phone Number	203-575-0466
Contact Person	TBD
Email	
Web Address	www.Wellmore.org
Service Type	Family Based Recovery
Agency Name	CMHA
Brief Description of Services Provided	In-home substance abuse recovery
Target Population	0-3
Address	*270 John Downey Drive, New Britain, CT 06051*
Phone Number	860-826-1358
Contact Person	gatekeeper
Email	
Web Address	www.cmhacc.org/program-services/family-services
Service Type	Family Resource Center
Agency Name	(BOE) Wilson Elementary School
Brief Description of Services Provided	Community-based play-groups, screening, home visits
Target Population	0-5
Address	235 Birch St Waterbury, CT 06704
Phone Number	203-573-6664
Contact Person	Jessica Reho
Email	jreho@waterbury.k12.CTus
Web Address	www.waterbury.k12.CTus/school_home.aspx?schoolID=29
Service Type	Family Resource Center

Agency Name	(BOE) Reed Elementary School
Brief Description of Services Provided	Community-based play-groups, screening, home visits
Target Population	0-5
Address	33 Griggs St., Waterbury, CT 06704
Phone Number	203-574-8180
Contact Person	Jessica Reho
Email	jreho@waterbury.k12.CTus
Web Address	www.waterbury.k12.CTus/school_home.aspx?schoolID=22
Service Type	Head Start, Early Head Start
Agency Name	TEAM
Brief Description of Services Provided	Early education and family support services
Target Population	0-5
Address	25 Rumford St., Waterbury, CT 06704
Phone Number	203-575-8888 x 212
Contact Person	Gia Lawe
Email	Glawe@teaminc.org
Web Address	www.teaminc.org/index.php/ourservices/education-youth/early-education
Service Type	Head Start
Agency Name	Naugatuck Head Start
Brief Description of Services Provided	Early education and family support services
Target Population	3-5
Address	28 Central Ave., Naugatuck, CT 06770
Phone Number	203-720-5239
Contact Person	Cheryl Woodruff
Email	WoodrufC@naugy.net
Web Address	www.naugatuck.k12.CTus/?DivisionID=5693
Service Type	Nurturing Families Network
Agency Name	Staywell
Brief Description of Services Provided	In-home parenting
Target Population	Pre-natal to age 5
Address	80 Phoenix Avenue, Waterbury, CT 06702
Phone Number	(203) 756-8021, extension 3064
Contact Person	
Email	
Web Address	www.CTgov/ctf/cwp/view.asp?a=1786&q=296678

Region 6 (Meriden / New Britain	
Meriden	
Service Type	Positive Parenting Program
Agency Name	Triple P
Target Population	
Address	
Phone Number	203-238-8437
Contact Person	Cathy Saja
Email	Cathy.saja@ct.gov
Web Address (if they have one)	
Service Type	Positive parenting program
Agency Name	Child First
Target Population	0-5
Address	165 Miller Street Meriden, CT 06450
Phone Number	203-238-8499
Contact Person	Melissa Giammarco
Email	Melissa.giammarco@ct.gov
Web Address (if they have one)	
Service Type	
Agency Name	IFP, Intensive Family Preservation
Target Population	2 month-60 months of age.
Address	
Phone Number	203-238-5458
Contact Person	Robert Hicinbothem
Email	Robert.hicinbothem@ct.gov
Web Address (if they have one)	
Service Type	
Agency Name	Help Me Grow
Brief Description of Services Provided	Help Me Grow is a prevention program of the Connecticut Office of Early Childhood designed to identify children at risk for developmental or behavioral problems and to connect these children to existing community resources. Families, health care providers and other community based providers can call Child Development Infoline (CDI) at 1-800-505-7000 with any concerns about a child's development or behavior. The care coordinators at CDI work with each family to find the best services available to meet their needs, including connecting to community resources, family support and education programs, and the Ages & Stages Developmental Monitoring Program in which more than 2,500 families are currently enrolled.
Target Population	0-5 years old
Address	
Phone Number	Development Infoline (CDI) 1-800-505-7000
Contact Person	
Email	*www.ctunitedway.org/CDI/*HelpMeGrow*.html*
Web Address (if they have one)	
Service Type	Family Enrichment Services
Agency Name	Child Guidance Clinic in Meriden

Brief Description of Services Provided	Provides home based education, advocacy and case management services to families who reside in Meriden and Wallingford. Through a diverse staff of Family Enrichment Specialist, the strength based approach provides support and encouragement while assisting families in mobilizing their personal resources. There is no fee to the families who participate in the program and service are available in English and Spanish.
Target Population	3-17
Address	384 Pratt Street, Meriden, CT
Phone Number	203-235-5767
Contact Person	Karen Delane
Email	Cgccentralct.org
Web Address (if they have one)	
Service Type	School readiness program for 3-5 years old
Agency Name	Head Start Program
Brief Description of Services Provided	A NAEYC Accredited School Readiness Program for ages 3-5 years old serving families from Meriden, Wallingford, Southington, and Berlin areas. Nutrition breakfast, lunch and snack are provided and are prepared on site. Full and part day classes care available. The program includes hearing, vision, and developmental screenings. It is a free program based on financial need.
Target Population	3-5
Address	398 Liberty Street, Meriden, CT
Phone Number	Christine Cattel
Contact Person	203-238-9133
Email	www.headstartprogram.us/city/ct-meriden.
Web Address (if they have one)	
Service Type	
Agency Name	Early Childhood Consultation Partnership (ECCP)
Target Population	0-5
Address	384 Pratt Street, Meriden, CT
Phone Number	203-235-2815 ext. 3313
Contact Person	Maren Odell
Email	www.abhct.com/programs_services/ECCP
Web Address (if they have one)	
Service Type	School readiness program
Agency Name	Catholic Charities in Meriden
Brief Description of Services Provided	Catholic Charities has been offering full-day, full-year School Readiness programming through the State Department of Education since 1996. The goal of the School Readiness program is to prepare children to enter kindergarten ready to learn and succeed. School Readiness programming combines a high quality early childhood education experience with comprehensive wrap-around services. These services may include family literacy, well-child screenings, developmental assessments, referrals for additional educational services, parent education/ support programs, referrals to educational opportunities, and family counseling. These services vary by location because they are designed to meet the needs of each local community. Parents are encouraged to participate, and each center offers opportunities and activities to engage families. All centers are handicap accessible.
Target Population	6 weeks to 3 years old

Address	61 Colony Street, Meriden, CT
Phone Number	203-235-2507
Contact Person	Tiffany Murasso
Email	
Web Address (if they have one)	Ccaoh.org
Service Type	0-5
Agency Name	Meriden Health Department
Brief Description of Services Provided	Provides education and healthy foods to eligible participants. The special supplemental nutrition program for women, infants and children-better known as the WIC program-services to safeguard the health of low income woman, infants, and children up to age 5 who are nutritional risk.
Target Population	0-5
Address	165 Miller Street, Meriden, CT 06450
Phone Number	203-630-6245
Contact Person	Pat Sullivan
Email	
Web Address (if they have one)	www.wicprograms.org
Service Type	Substance abuse, mental health and parenting skills.
Agency Name	Family Based Recovery
Target Population	0-3
Address	
Phone Number	203-238-8450
Contact Person	Zach Thorne
Email	
Web Address (if they have one)	
Service Type	1-3
Agency Name	Meriden Public Library
Brief Description of Services Provided	Provides preschool activities and crafts, early childhood, play groups for children 1-3 years old, bookmobile, story time program is designed for babies and children through 2 years old accompanied by a caregiver, stories, music and play are incorporated into an hour long program.
Target Population	1-3
Address	384 Pratt Street, Meriden, Ct 06450
Phone Number	203-235-5767
Contact Person	
Email	
Web Address (if they have one)	Meridenlibrary.org

New Britain

Service Type	Promising Starts/New Britain Project Launch
Agency Name	Wheeler Clinic
Brief Description of Services Provided	Federally funded program designed to meet the mental health needs of children, birth to 8, and their families in New Britain. Provides intensive, in-home visiting services to children and families through Child First in New Britain. Offers Circle of Security parenting groups that promote secure caregiver-child attachment and nurturing. Implements the Second Step program to promote healthy behaviors in early childhood. Implements the HALO (Health Alternatives for Little Ones) for children 3-6 years old to prevent substance abuse by teaching preschoolers about making healthy choices.
Target Population	Birth - 8
Address	180 Clinton Street New Britain
Phone Number	860-348-2216
Contact Person	Melissa Mendez
Email	mmendez@wheelerclinic.org
Web Address	

Service Type	Child First
Agency Name	Wheeler Clinic
Target Population	Birth - 6
Address	180 Clinton Street New Britain
Phone Number	860-348-2217
Contact Person	Damaris Colon
Email	DColon@wheelerclinic.org
Web Address	
Service Type	Circle of Security
Agency Name	Wheeler Clinic
Brief Description of Services Provided	Circle of Security Parenting Program is a 6-8 session group intervention for parents of young children, birth to 8. The program is designed to help parents better understand and respond to their child's emotional needs; help their child manager their emotions and behaviors; and increase parents' understanding of the importance of secure attachment for health child growth and development.
Target Population	Birth - 8
Address	180 Clinton Street New Britain CT
Phone Number	860-348-2217
Contact Person	Damaris Colon
Email	DColon@wheelerclinic.org
Web Address	
Service Type	Early Childhood Consultation Program
Agency Name	Wheeler Clinic
Target Population	Birth - 5
Address	180 Clinton Street New Britain CT
Phone Number	860-348-2291
Contact Person	To be determined
Email	
Web Address	
Service Type	Parent Connections for Early Childhood Development
Agency Name	Wheeler Clinic
Brief Description of Services Provided	The Parent Connections for Early Childhood Development Program is a free in-home service which provides information, support and guidance to families who have concerns about their young child's development. Services are available to families living in Bristol, Burlington, Plainville, and Plymouth with children ages 0 through 5 who have concerns about their child's progress and growth. These children may have had an assessment through a Birth to Three program, but were not eligible, or received services through Birth to Three, but have now turned three and are no longer eligible for specialized services. Families receive developmental guidance, connection to other resources and education on how to nurture their child effectively.
Target Population	Birth - 5
Address	88 East Street Plainville CT
Phone Number	860-793-3834
Contact Person	Donna Quallen
Email	dquallen@wheerlclinic.org
Web Address	
Service Type	Birth to Three
Agency Name	Wheeler Clinic
Brief Description of Services Provided	
Target Population	
Address	
Phone Number	Child Development Infoline 1-800-505-7000
Contact Person	

Email	
Web Address	
Service Type	Triple P – Positive Parenting Program
Agency Name	Wheeler Clinic
Target Population	
Address	
Phone Number	860-793-4657
Contact Person	
Email	
Web Address	
Service Type	Family Enrichment Center
Agency Name	Hospital of Central CT
Brief Description of Services Provided	M.O.M.S. (Mothers Offering Mothers Support) A weekly support program for mothers 21 years old and under. Members discuss being a mother, learn about their children and explore parenting roles. Meetings include a meal and playgroup for children. Program leaders are women who were also young mothers. Nurturing Families Network This program for first-time pregnant or parenting families provides information, guidance and assistance through: • Home visiting services help first-time parents learn how to care for their baby and adjust to the many demands of becoming a parent. In-home services focus on parent education, child development and child-reading readiness. • Nurturing Connections provides support and information via phone for new parents. Also includes monthly social groups. Discussion topics include getting babies to sleep; relaxation for baby and moms; and activities to stimulate baby's learning. • Parenting groups – Topics include parenting, relationships, development, nurturing and discipline. Parents as Teachers Program Provides support and education to increase parenting skills. Each service uses the nationally recognized Parents as Teachers curriculum. • Home visits help strengthen knowledge of child development, provide support, and teach activities to promote learning and explore child discipline strategies. • DADS services vary from small-group conversations about parenting topics, to in-home support and one-on-one teaching. • Play Today – monthly socials for families that include exploring reading and promoting creative play.
Target Population	
Address	32 Hawkins Street New Britain CT
Phone Number	860-224-5373
Contact Person	
Email	
Web Address	
Service Type	HRA Head Start
Agency Name	HRA
Brief Description of Services Provided	• Quality education • Individualized curriculum • Parent involvement • Family case management • Disability services and support • Behavioral health services for children & families • Healthy meals and snacks • Health screenings (including dental, vision & hearing) • Community partnerships

Target Population	3-4yo
Address	180 Clinton Street New Britain CT
Phone Number	860-225-8601
Contact Person	Claudette Talmadge
Email	
Web Address	
Service Type	
Agency Name	Neighborhood Fathers Unite
Brief Description of Services Provided	24/7 Dads curriculum Participant guided weekly father support groups Individual case management services and referrals Coordinator support at court hearing when possible These services are free of charge to fathers in New Britain and surrounding towns. Dads who want to participate in the 24/7 curriculum must commit to 12 weeks for each of the two parts of the curriculum.
Target Population	
Address	35 Oak Street New Britain
Phone Number	860-348-2231 or 860-225-8601
Contact Person	Bobby Sanchez
Email	
Web Address	
Service Type	
Agency Name	New Britain Public Library
Brief Description of Services Provided	Special programs and story time Terrific Tots and Super Kids Programs
Target Population	
Address	20 High Street New Britain
Phone Number	
Contact Person	
Email	
Web Address	www.nbpl.info
Service Type	
Agency Name	The Coalition for New Britain's Youth
Brief Description of Services Provided	A citywide collaborative committed to improving the lives of New Britain's youth, birth through age 24, and working to ensure they have what they need to succeed in all areas of life. They approach challenges with community data in order to develop and implement strategies, align efforts and evaluate progress. The Coalition collects and analyzes community data for its annual "Report Card" on child well-being in New Britain. The report card is used to develop strategies and programs to advance the Coalition's mission. *Coalition members include* parents, educators, government officials, health agencies, social service agencies *and* advocacy organizations. The Coalition's Early Learning and School Readiness Workgroup seeks to remove barriers to early learning services and programs. The group focuses on analyzing data and developing strategies that ensure early students are developmentally prepared to enter Kindergarten and are ready to learn successfully.
Target Population	
Address	
Phone Number	
Contact Person	
Email	
Web Address	www.coalitionnbc.org

Subgroups:

1. Careline
2. Intake
3. Ongoing Services
4. Adolescent Services/Juvenile Justice/FASU
5. Foster Care

Careline	
Dakibu Muley (PD)	Careline

Intake	
Dakibu Muley (PD)	Careline
Danielle Davis (SWS)	Norwalk
Ingrid Aarons (PM)	Norwalk
Rosemary Wieworka (PM)	Hartford
Amanda Beane (SW)	Hartford
Janet Aguilar (SWS)	Milford
Tricia Falcone (PM)	Milford
Donna Maitland-Ward (OD)	Hartford
Tracy Davis (Assistant Director)	Central Office –Academy for Workforce and Development
Danielle Caliandri	Meriden
Cindy Bowman (PM)	Hartford
Yadira Ijeh (PD)	Change Management

Ongoing Services	
Melissa Testa (SW)	Meriden
Cathy Waylen (PM)	Meriden
Lori Franceschini (PM)	Waterbury
Michelle Lumb	Willimantic
Annie Geddis	Willimantic
Julie Flemmig (PM)	SACWIS
Tracy Davis (Assistant Director)	Central Office –Academy for Workforce and Development
Julie Gonzalez	Waterbury
Wendy Kwalwasser	CO
Mary Painter	CO
Maria Hernandez – Young (SWS)	Manchester
Lorin Pasternak	Hartford
Elizabeth Stokes	Waterbury
Yadira Ijeh (PD)	Change Management
Barrett Seymour	
Sheila Negron	Torrington

Adolescent Services/Juvenile Justice/FASU	
Cathy Waylen (PM)	Meriden
Jill Ostapchuk (PM)	Bridgeport
Chris Gardner (PM)	Norwich
Melanie Mercado (SWS)	New Britain
Christine Martinez	CJTS

Tracey Johnson (SW)	New Britain
Lisa Fryer (SW)	Milford
Valerie Tanner (SW)	New Haven
Theresa Baskin (SWS)	New Haven
LaFreda Simuel-Carter (SW)	New Haven – FASU
Mike Palmeri (SW)	New Britain – FASU
Elizabeth Saez	Hartford – FASU
Sonia Williams	New Haven – FASU
Heather Jones	Waterbury – FASU
Eugenia Green	New Britain
Lisa Hofferth	CO
Tracy Davis (Assistant Director)	Central Office –Academy for Workforce and Development

Foster Care	
Lillian Marcano	Region 2
Fernanda Guerrera	Region 1
Melissa Robles	Region 5
Elizabeth Saez	Region 4
Melanie DeFranco	Region 1
Suzanne Gaither (PM)	SACWIS
Tracy Davis (Assistant Director)	Central Office –Academy for Workforce and Development
Donna Maitland – Ward (OD)	Hartford
Yadira Ijeh (PD)	Change Management
Pamela Kelley (PM)	Region 3
Amy Wiltsie	Region 1

Early Childhood COP	
Tracy Davis (Co-Chair)	CO
Donna Maitland - Ward (Co-Chair)	Hartford
Yadira Ijeh	CO
Janet Aguilar	Milford
Amanda Beane	Hartford
Jennifer Birden	Danbury
Melissa Camacho	OEC
Lisa Sedlock - Reider	Middletown
Janis Courter	CCWIS
Danielle Davis	Norwalk
Julia Davis	Meriden
Lisa Driscoll	CO
Julie Flemmig	CCWIS
Lori Franceschini	Waterbury
Linda Goodman	OEC
Maria Hernandez-Young	Hartford
Wendy Kwalwasser	CO
Linda Lukin	Willimantic
Michelle Lumb	Willimantic
Anne McIntyre-Lahner	CO
Sara Moon	Manchester
Margaret Munigle-Kunsch	Bridgeport
Sheila Negron	Torrington
Kim Nilson	CO
Velvette Royal	Careline
Melissa Sansone	New Haven
Charlie Slaughter	CO
Kim Somaroo – Rodriguez	CO
Shirley Terry	Norwich
Cathy Waylen	Meriden
Grace Whitney	Head Start
Ricka Wolman	CO
Dorothy Zyla	New Britain