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SUBMITTED TO THE HOUSE COMMITTEE ON EDUCATION AND LABOR
SUBCOMMITTEE ON HEALTHY FAMILIES AND COMMUNITIES

HEARING ON PREVENTING CHILD ABUSE AND IMPROVING RESPONSES TO FAMILIES IN CRISIS

November 5, 2009

Madam Chairwoman and Members of the Subcommittee:

I am pleased to submit the following testimony on best practices for the prevention of child abuse and neglect as well as strengthening responses for those families already touched by child maltreatment. My name is Matthew Melmed. For the last 14 years I have been the Executive Director of ZERO TO THREE, a national non-profit organization that has worked for over 30 years to advance the healthy development of America's babies and toddlers. I would like to start by thanking the Subcommittee for all of its work to ensure that our nation's infants and toddlers are safe. I commend you and the Subcommittee for tackling this difficult, yet extremely important issue.

I would like to start by addressing the effects of abuse and neglect on infants and toddlers and offer two sets of recommendations (prevention and treatment) for your consideration as you look at systemic changes to the way in which child abuse is addressed by this nation.

Vulnerability of Infants and Toddlers to Abuse and Neglect

Unfortunately, children between birth and three years of age have the highest rates of abuse and neglect in the United States.[1] Specifically, although infants only account for 5.6% of the child population, they represent double that percent of all child maltreatment victims.[2] In fact, infants are over four times more likely to enter foster care than children of all other ages. Infants and toddlers are particularly at risk, not only because they are physically vulnerable, but also because of the important brain development occurring during this period of life.

We know from the science of early childhood development that infancy and toddlerhood are times of intense intellectual engagement.[3] A child's first years set the stage for all that follows. During this time the brain undergoes its most dramatic development, and children acquire the ability to think, speak, learn, and reason. Future development in key domains – social, emotional, and cognitive – is based on the experiences and relationships formed during these critical years.

Contrary to the once-held belief that very young children do not remember, and therefore experience no lasting effects from maltreatment, infants and toddlers are *extremely* vulnerable to its long-lasting consequences. Research shows that young children who have experienced physical abuse have deficits in IQ scores, language ability, and school performance, even when the effects of social class are controlled.[4] Furthermore, physical abuse extracts a substantial toll on young children's social adjustment, as seen in elevated levels of aggression that are apparent even in toddlers.[5] The effects of maltreatment are not just seen in children who are abused, however. Neglected children may also exhibit a variety of emotional and behavioral problems as well, including: poor coping skills, high levels of dependence, self-abusive behaviors, unresponsiveness to affection, lethargy, low academic achievement, fewer interactions with peers, and unusual sleeping and eating patterns.[6] Long-term negative outcomes of abuse and neglect include school failure, juvenile delinquency, substance abuse, and the continuation of the cycle of maltreatment into new generations. In fact, one third of the individuals who are abused and neglected as children can be expected to abuse their own children.[7]

The effects of abuse and neglect are not just a bad memory, but affect the developing brain architecture in the young child – effects that we can actually see in Figure 1. This figure compares the PET scan of the brain of a healthy child (left) with that of an abused and neglected child in a Romanian orphanage (right). The brain of the healthy child shows high activity (depicted in red) in the temporal lobes. In contrast, the scan of the Romanian orphan shows very little activity in these areas which are responsible for regulating emotions and receiving input from the senses. Furthermore, the abused and neglected brain has smaller brain volume, larger fluid-filled cavities, and smaller areas of connection.

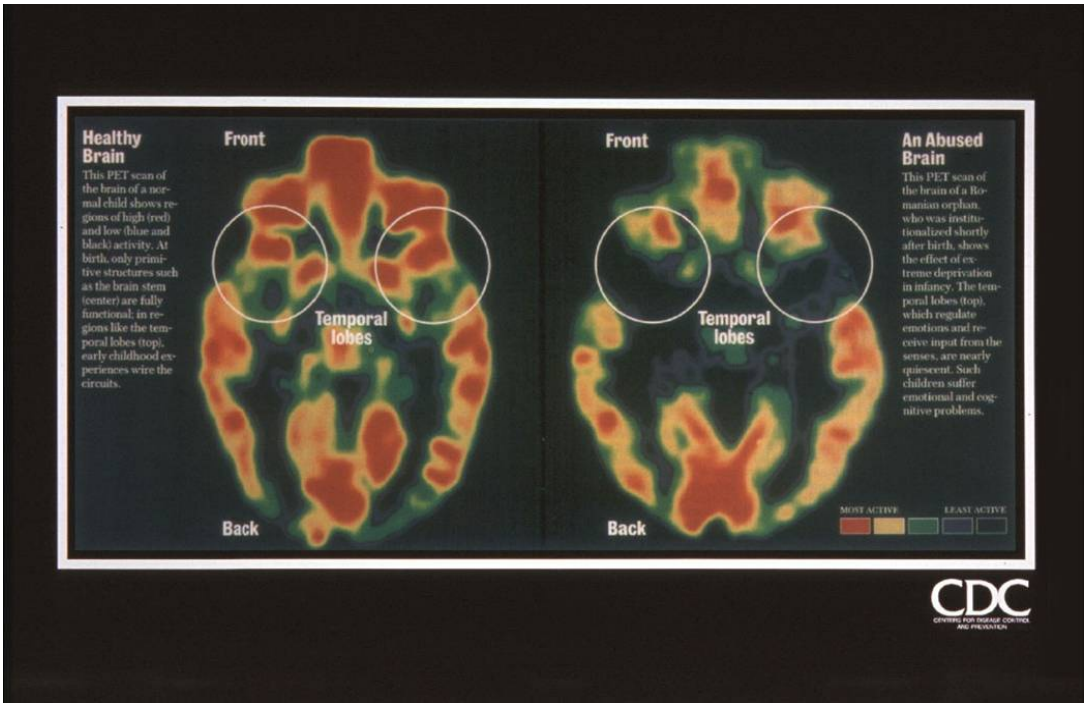

Figure 1
Image reproduced with permission. Harry Chugani, M.D., Children's Hospital of Michigan.

Although the developmental impact of child abuse and neglect is greatest among the very young, research confirms that the early years present an unparalleled window of opportunity to effectively intervene with at-risk children. Intervening in the early years can lead to positive outcomes (e.g., secure attachments, healthy relationships, school success, etc.) and significant cost savings over time through reductions in child abuse and neglect, criminal behavior, welfare dependence, and substance abuse. *It is critical that child well-being be the first priority in all child abuse and neglect cases.*

The Effects of Fetal Alcohol Spectrum Disorders

I particularly want to call the Subcommittee's attention to a condition that is a perennial problem, but often overlooked. Experts estimate that one out of every one hundred US citizens is a victim of Fetal Alcohol Spectrum Disorders (FASD), an array of physical disabilities that is 95% under-diagnosed.[8, 9] Although very little research has been done to document the prevalence of FASD among children in the child welfare and juvenile justice systems, one study suggests that almost one in four children in the juvenile justice system is a victim of FASD.[10]

The brain damage caused by prenatal exposure to alcohol results in poor judgment, impulsivity, difficulty learning from experience and an inability to foresee the consequences of one's behavior. Furthermore, children born with FASD are frequently premature and low birth weight, both of which are risk factors for healthy development.[11] Infants and toddlers in particular can be delayed in reaching developmental milestones, hyperactive, easily over-stimulated,[12] and victims of failure to thrive.[13] Consequently, academic failure and social impairments are common in childhood.

While policies often focus on *illegal* substance use and abuse, very little attention is given to *legal* substances such as alcohol and its effects on the healthy development of infants and toddlers. As with child abuse and neglect, intervening early can and does make a difference, both in terms of child development and in economic costs to society. In fact, children who are diagnosed before the age of six are much more likely to succeed in school, careers, and personal relationships.[14] In order to prevent developmental delays resulting from FASD down the road, we must look beyond the limited focus on illegal substances and include screening to detect FASD in infants.

Preventing Child Abuse and Neglect

In thinking about approaches to preventing child abuse and neglect, we must recognize that efforts to reach this goal often will not be labeled as child abuse prevention and, in fact, lie largely outside the formal child welfare system. Prevention means reaching out to families with risk factors and their accompanying stressors to connect them with comprehensive services that work to reduce the stress and promote the healthy early development of their young children. Except for a few narrowly targeted initiatives, there is no such thing as a separate program to prevent child abuse, another to promote cognitive development, another to help parents be better parents, and yet another to address social and emotional needs. For the very young child, especially, all aspects of development are inextricably intertwined and must be addressed as such.

I want to note that child maltreatment, in particular, does not occur only in low-income families. All parents need support in nurturing their children, just as all babies need supportive relationships to promote healthy development. But some families and their children are more at-risk because of poverty, substance abuse, precarious housing or nutritional situations, or lack of education, just to name a few hazards. We need to ensure that families who face multiple risk factors are connected to appropriate services in the community before abuse and neglect occur. In other words, there is not a separate category of families in which abuse and neglect occurs. These are the same families to whom we direct other early childhood interventions. So I encourage you to think broadly about expanding comprehensive solutions for early childhood development and family support in which preventing abuse and neglect will be a natural byproduct of connecting families to an array of resources.

While the bulk of funds to provide such services will not come from the Child Abuse Prevention and Treatment Act (CAPTA) or other child welfare funding streams, the limited funds available through Title II of CAPTA can be instrumental in developing mechanisms and promoting systems change to integrate services *outside the child welfare system* to meet the needs of at-risk children and families, provide outreach to those families, and help in accessing services.

I also want to emphasize the importance of social and emotional development in young children, which forms the foundation for later learning, and the mental health problems that can occur even when no abuse or neglect is pinpointed. Early social and emotional development is vulnerable to such factors as repeated exposure to violence, persistent fear and stress, abuse and neglect, severe chronic maternal depression, biological factors such as genetic prematurity and low birth weight, poverty, and conditions associated with prenatal substance abuse.

Healthy development occurs within the context of the family. Supportive early relationships can protect against the effects of stress and biological hazards beginning even prenatally. Therefore, problems with social and emotional development that occur in a young child need to be addressed using approaches that focus on the child's interaction with the caregiver. *Neurons to Neighborhoods* cites programs such as the Family Development Service Program in Los Angeles, where researchers "documented that a relationship-based intervention can have a significant impact on parent-child interaction and on the infant's security of attachment." Another program cited is the Infant-Parent Psychotherapy Program in San Francisco that emphasizes intergenerational patterns of attachments and helps the mother cope with life issues outside the family.[15]

PREVENTION POLICY RECOMMENDATIONS

Create a Broad and Comprehensive Policy that Supports Vulnerable Children and Families
I encourage the Subcommittee to consider building an integrated approach to addressing the needs of very young children and their families that would encompass outreach and support for parents, high quality early care and education, and supports for the professionals who serve them. In addition, we need the ability to better employ the tools that can identify children at-risk for problems that are more difficult to spot at a young age, but where early intervention can save both heartache and dollars at a later age. Some specific steps include:

1. Providing increased access to high quality family support programs by:

a. Expanding funding for Early Head Start, a program proven effective in reaching families with infants and toddlers and in promoting good parenting practices and healthy child development. Comprehensive early childhood programs, such as Early Head Start, that combine early learning experiences, parent support, home visitation, and access to medical, mental health and early intervention services can provide the specialized services that very young children in the child welfare system need. Results from the Congressionally-mandated Early Head Start Research and Evaluation Project – a rigorous, large-scale, random-assignment evaluation – concluded that parents who participated in Early Head Start had more positive interactions with their children than control group parents – they showed greater warmth and supportiveness, less detachment, more parent-child play interactions, more stimulating home environments, and less spanking by both mothers and fathers.[16]

While the American Recovery and Reinvestment Act provided additional funds for Early Head Start, even with that infusion of funding, we still will only reach *six percent* of eligible infants and toddlers. Increased funding to quadruple the size of Early Head Start, as the President pledged, will ensure that we reach the most at-risk infants and toddlers early in life when we have the best opportunity to reverse the trajectory of poor development that can occur in the absence of such supports. It will also help us ensure that parents have the supports they need to sufficiently nurture the healthy development of their infants and toddlers. Although it is the role of the appropriators to increase funding for Early Head Start, this Subcommittee can work to ensure that the authorizers and appropriators understand the importance of programs such as Early Head Start in reaching the most at-risk infants and toddlers.

b. Expanding funding to support other comprehensive approaches that reach out to families with young children. Some communities use programs that deliver parent support and early childhood services through home-based models. These home visiting programs offer information, guidance, and support directly to families in their home environments, eliminating many of the scheduling, employment, and transportation barriers that might otherwise prevent families from taking advantage of necessary services. While home visiting programs, such as Healthy Families America, the Nurse-Family Partnership, the Parent-Child Home Program, and Parents as Teachers, share similar overall goals of enhancing child well-being and family health, they vary in their program structure, specific intended outcomes, content of services, and target populations. Program models also vary in the intensity of services delivered, with the duration and frequency of services varying based on the child's/family's needs and risks.

A growing body of research demonstrates that home visiting programs that serve infants and toddlers, can be an effective method of delivering family support and child development services, particularly when services are part of a comprehensive and coordinated system of high quality, affordable early care and education, health and mental health, and family support services for families prenatally through pre-kindergarten. Research has shown that high quality home visiting programs serving infants and toddlers can increase children's school readiness, improve child health and development, reduce child abuse and neglect, and enhance parents' abilities to support their children's overall development.[17] The benefits of home visiting, however, vary across families and programs. What works for some families and in some program models will not necessarily achieve the same success for other families and other program models.

Expanding access to evidence-based home visiting programs is one strategy in the prenatal to pre-kindergarten continuum which can help prevent long-term costs associated with remediating the effects of maltreatment while promoting healthy social and emotional development in later years. However, it is important to connect home visiting efforts with other child and family services, particularly those focused on children's well-being and healthy development, to help ensure that young children and their families have the supports they need to promote healthy outcomes.

2. Increasing access to preventive and treatment services for families affected by substance abuse, including screening of children for FASD. Millions of children and families are impacted by the growing epidemic of substance abuse. In fact, an estimated 11 percent of all children live in families where one or more parents abuse alcohol or other drugs.[18] This issue is even more pressing for families in the child welfare system where up to 80 percent of children are affected by substance abuse.[19] Families need access to a community-based, coordinated system of comprehensive family drug and alcohol treatment. Prevention and treatment services should include: prevention and early intervention services for parents at-risk of substance abuse; a range of comprehensive treatment options including home-based, outpatient, and family-oriented residential treatment options; aftercare support for families in recovery; and preventive and early intervention services for children that address their mental, emotional, and developmental needs.

In addition, given the heightened risk of FASD for children in the child welfare system, we must adopt useful screening strategies for children who come to the attention of child protective services staff. Many affected children will be born into families with severe dysfunction, substance abuse and long histories of parenting failure. Screening infants and children entering child protective services caseloads, and especially those in foster care, would link high risk children with appropriate treatment services. Currently, only children exposed to *illegal* substances are screened and referred for services despite the more devastating effects of *legal* substances such as alcohol.

It is also critical to recognize that many parents who maltreat their children do so as a result of the organic brain dysfunction caused by FASD. Behavioral deficits include: impulsive behavior, an inability to plan and remember commitments (e.g. the child's antibiotic regimen) from one day to the next, and emotional volatility. Some states recognize FASD as an adult disability and provide case management and disability payments. With this kind of support, FASD victims have a much greater likelihood of successfully carrying out the tasks of daily living, including their parenting responsibilities. The focus on screening we recommend for young children should include screening for their parents as well.

3. Increasing access to parent-child therapy by allowing reimbursement through Medicaid for dyadic/relational therapy for at-risk families and funding research into promising approaches. Currently, not all states allow reimbursement through Medicaid for therapy provided to parents and infants or toddlers together. Such therapy is often effective, because the mental health of parents and very young children are so closely interrelated. In a recent study among mother-child pairs where there was a history of domestic violence, not only was the therapy effective in improving the parent-child relationship and the child's behavioral symptoms, but the intervention had a positive effect on the mother's mental health.[20]

The proposed modification would allow infants and toddlers, who health practitioners find are at high risk for developing mental health disorders, to receive a referral for a full diagnostic evaluation. The referral would be made for both the young child and parents using a developmentally appropriate diagnostic tool such as the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised (DC:0-3R).* Current diagnostic tools such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) and the International Classification of Diseases (ICD-10) do not comprehensively cover the mental health issues of infants, toddlers, and their parents. A comprehensive classification tool such as *DC:0-3R* will allow professionals to identify, understand, and treat mental health problems, relational issues, and developmental disorders of very young children at an early stage and prevent problems from worsening.

In addition, while some approaches to parent-child therapy have been tested as noted above, more research and demonstrations are needed to advance our understanding of how best to improve parenting skills and repair damage to social and emotional development in infants and toddlers. The Subcommittee could play a critical role by financing such research. Too often, parents are simply sent to parenting classes that may not help them understand and experience how best to interact with their children and support their healthy development.

Improving Responses to Families Already Touched by Child Maltreatment

I have already noted the highly detrimental effects of maltreatment on the development of infants and toddlers. We know all too well that the circumstances that often surround a family where abuse or neglect has occurred do not bode well for the child's development, and we also know that the relationships that support this development, once gone awry, do not heal themselves. Much of the CAPTA statute focuses on the legal system for dealing with these cases and has indeed led to a great deal of progress in helping states ensure the physical safety of children. But we need to pay greater attention to the developmental needs of the children involved and the needs of their families – in other words, to the *treatment* part of the program.

Our Child Protective Services (CPS) system needs to recognize the critical nature of the early years for child development and have procedures in place to move quickly to address the damages of maltreatment and the needs of infants and toddlers and their families. Such procedures must start with training for all involved in the legal side of the system – CPS workers, *Guardians Ad Litem*, judges and other court personnel – about early childhood development. In their professional training, these key people are not taught about how young children develop and the importance of acting to keep that development on track.

ZERO TO THREE's experience with its Court Teams for Maltreated Infants and Toddlers project, which focuses on children in the foster care system and is discussed in more detail under Recommendation #1 below, has been instructive in learning how important such knowledge can be. It can literally change how staff and judges approach their decisions regarding young children.

The second need is services for children and families and quick linkage to them when a family comes into the child welfare system. We know that the levels of services such as mental health and special education among children in the child welfare system have historically been low. As with preventive services, workers at the treatment stage need the ability to connect children and families with a variety of services. Again, the Court Teams initiative creates a "team" of service providers in the community who ensure that the children and parents being supported by the local Court Team receive necessary services. Formation of the teams has brought together providers in communities, many of whom had not been involved with this population before. In some instances, forming the teams has revealed services of which child welfare workers were not aware. For example, the requirement in the 2003 CAPTA reauthorization that all infants and toddlers be referred for assessment under Part C of the Individuals with Disabilities Education Act was a huge step in seeking to meet the developmental needs of young children. However, states are still grappling with how to implement and fund this linkage and many child welfare workers, themselves, are unaware of the Part C early intervention requirements. I urge the Subcommittee to focus on how to ensure the connection between these two systems can be made more feasible.

Third, an increase in mental health services that address the needs of parents and children together, as discussed under prevention efforts, is extremely important in the context of treating child abuse and neglect. The whole area of infant/early childhood mental health is often overlooked, but addressing the mental health needs of both child and family is one of the keys to healing families and preventing future child maltreatment.

Clearly, there is a great deal of overlap in services for at-risk families to prevent child abuse and neglect and those where abuse and neglect are known to have occurred. I encourage the Subcommittee to explore approaches such as differentiated response that seek to connect families to services no matter what their CPS status.

Finally, the treatment of abuse and neglect continues after children are removed from home and placed in foster care, although this part of the child welfare system is generally addressed through the programs in Part IV of the Social Security Act. Additional policies must be implemented to ensure adequate services are in place for children once they enter foster care.

Infants and toddlers are removed from home at higher rates than older children precisely because they are so vulnerable to the effects of abuse and neglect. In fact, infants are the largest group of children entering foster care in the United States, accounting for 1 in 5 admissions.[21] Once they have been removed from their homes and placed in foster care, infants and toddlers are more likely than older children to be abused and neglected and to stay in care longer.[22] In addition, half of all babies who enter foster care before age 3 months spend 31 months or longer in placement.

Coupled with these alarming statistics is the fact that a young child's removal from his or her home adds additional layers of complexity to the initial trauma of maltreatment. Separation from a child's primary caregiver(s) can cause anxiety, distress, and additional trauma. For these reasons, we must pay particular attention to ensuring that developmentally appropriate services and family connections are available during this critical time in a child's life.

TREATMENT POLICY RECOMMENDATIONS

1. Requiring training for child protective services staff and other personnel involved with children in the child welfare system around the unique needs of infants and toddlers. There is a wealth of scientific knowledge available about very early child development which should be used to make informed decisions about babies in the child welfare system. However, child welfare workers are overburdened and do not have the time or means to seek the training that would provide them with this scientific knowledge base. Congress should provide grants to states to enable them to develop and provide training for child welfare workers and other staff (including *Guardians Ad Litem*, court personnel, mental health specialists, child care providers, Early Head Start teachers and early intervention specialists) around the developmental needs of infants and toddlers who have been abused or neglected and the steps that need to be taken to address these needs.

In addition, while training is important in providing the initial exposure to information, ongoing technical assistance is critical if the training information is to be applied in real life. Like any bureaucracy, child welfare agencies have developed protocols and guiding assumptions over the decades. Much of the knowledge of infant/toddler development is new and challenges prevailing practices in the field of child welfare (e.g., sibling relationships always trump the child's relationship with the foster parent, etc.). Changing long held opinion in bureaucratic settings is extremely difficult. Developing a mechanism to provide consultation to caseworkers on cases involving infants and toddlers will allow them to reflect on decisions that may otherwise be made without grounding in the child's best interests.

One example of innovation in this area is ZERO TO THREE's Court Teams project for children in foster care. Under the leadership of a juvenile or family court judge, the Court Team model works to increase awareness among court personnel and community providers about the negative impact of abuse and neglect on very young children and to change local systems to improve outcomes and prevent future court involvement in the lives of very young children in the child welfare system. Preliminary data and anecdotal evidence suggest that the Court Teams project is having a positive effect on children and families, including: reducing the number of times maltreated infants and toddlers move from one foster home to another, increasing visits between parents and their young children in foster care, providing critical health and developmental screenings, increasing placements with relatives, expediting and enhancing services to parents to facilitate reunification, and reducing the time to permanency.

2. Ensuring access to early intervention services (Part C of the Individuals with Disabilities Education Act) for children three and younger. Amendments to CAPTA in 2003 required states to develop procedures to ensure that all children 0-3 who are involved in a substantiated incident of abuse or neglect are referred to Part C early intervention services. The IDEA amendments of 2004 also required Part C services for all children who have been maltreated or exposed prenatally to illegal substances or domestic violence. Under Part C, all participating states and jurisdictions must provide early intervention services to any child below 3 who is experiencing developmental delays or has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. In addition, states may choose to provide services for babies and toddlers who are "at-risk" for serious developmental problems, defined as circumstances (including biological or environmental conditions or both) that will seriously affect the child's development unless interventions are provided.

Despite the promise it holds for the future, there is wide variation in the percentage of infants and toddlers enrolled in Part C programs across states. Currently, states carry a significant burden to fund Part C programs, in part, because of inadequate federal funding. The result is that many eligible infants and toddlers do not receive the early intervention services they desperately need in order to reach their full potential in school and in life. Congress should provide incentives and adequate funding for states to increase access to early intervention screening and Part C services for infants and toddlers in foster care.

Early intervention services under Part C may prevent or minimize the need for more costly services under Part B of IDEA or even later in a child's life.

3. Adding infants affected with FASD to the policies and procedures CAPTA requires states to have in place to identify and address the needs of infants born with and affected by illegal substance abuse. Infants and toddlers in the child welfare system have ongoing risk factors that predispose them to developmental delays. While developmental delays are often present in young children with FASD, currently, FASD is not included among the eligibility criteria for Part C services. It is critical to screen for FASD specifically because it is a lifelong chronic condition requiring management rather than a developmental delay that can be corrected. As mentioned earlier, when children are screened for FASD and determined in need of early intervention services, those services should be allowable under Part C.

4. Increasing access to parent-child therapy by allowing reimbursement through Medicaid for dyadic/relational therapy for at-risk families and funding research into promising approaches. This approach is discussed under the Prevention section above, but I want to reiterate its importance for families where maltreatment has occurred. CAPTA could be an important source of funding to develop and/or disseminate promising approaches for this type of therapy.

5. Requiring (under Title IV-B of the Social Security Act) that the Department of Health and Human Services promulgate guidelines for states for the care of infants and toddlers in the child welfare system, including:

a. **Visitation standards and developmentally appropriate visitation practices for infants and toddlers in out-of-home care.** One of the major challenges faced by young children in foster care is developing nurturing relationships with their parents. Standard visitation practice permits one visit each week. In practice, however, visits occur less than once a week. Parent-child contact consists of brief encounters at the child welfare agency. For very young children, infrequent visits are not enough to establish and maintain a healthy parent-child relationship. For parents, visits often become yet another forum where they feel judged and incompetent. Research indicates that visitation with parents and siblings is not only highly correlated with better child functioning at discharge from foster care, but also allows children to leave foster care in much higher numbers and more quickly.[23]

   Parental visitation can and should be looked at strategically. Visits can play an important role in concurrent planning (pursuing two permanency options simultaneously —reunification *and* adoption) and can be used to assess the parent-child relationship and how the family is progressing. The frequency and success of visits between children and parents can provide a caseworker with evidence for either movement to an alternative plan for the child or movement for early reunification. Visits should occur frequently, in a safe setting that is comfortable for both parent and child, and should last long enough for a positive relationship to develop and strengthen. CAPTA can provide a framework for enhancing the visitation experience by providing support and coaching to improve future visits for all involved. Standard practice must shift from a CPS worker sitting in the corner observing to an engaged and supportive visit coach who helps the parent plan the time with his/her child(ren), handle the actual visit, and reflect afterward on how well the visit went.

b. **Minimizing multiple placements while in out-of-home care.** In the first year of life, babies need to have the opportunity to develop a close, trusting relationship or attachment with one special person. The ability to attach to a significant caretaker is one of the most important emotional milestones a baby needs to achieve in order to become a child who is trusting, confident, and able to regulate his or her own stress and distress. For babies in foster care, forming this secure attachment is difficult. Multiple foster care placements present a host of

traumas for very young children. When a baby faces a change in placement, fragile new relationships with foster parents are severed, reinforcing feelings of abandonment and distrust. Even very young babies grieve when their relationships are disrupted and this sadness adversely effects their development. All placement decisions should focus on promoting security and continuity for infants and toddlers in out-of-home care.

Guidelines should be developed for states on how to minimize multiple placements for infants and toddlers in out-of-home care. For example, a state may decide to develop foster-adopt homes for infants who come into the child welfare system so that if the birth parents cannot successfully regain custody of the child, the child will not be moved again. States should have a system for tracking the number of moves an infant makes while in foster care. When a change in placement is necessary, child welfare workers and foster parents should receive training on how to handle transitions with infants and toddlers so the children have the opportunity to get to know their new caregivers before leaving the security they have gained in the care of their current caregiver.

c. Promoting timely permanent placements for infants and toddlers in foster care. During the earliest years of a child's life – a time when growth and development occur at a pace far exceeding that of any other period of life – time goes by quickly. Babies can drift for years in foster care. They need stable loving parents as soon as possible. Standard child welfare practice is to seek reunification over the course of months or years, and only when it is clear that the birth parents are not able to regain custody of their children, is an alternative permanency arrangement sought. In the meantime, the babies have grown up in a series of foster homes and have suffered developmental damage they will carry with them throughout their lives. All members of the family's team need to understand concurrent planning right from the start as the legal way to make sure that a child is in a permanent home as quickly as possible.

6. Requiring state child welfare agencies to include in their state plans a description of their approach to addressing the specific needs of infants and toddlers. Infants and toddlers in foster care have needs that are very different from older children. They also move through the child welfare system in ways that are very different from older children – they stay in care longer, they are less likely to be reunified with their parents and they are more likely to be abused and neglected while in foster care. State child welfare agencies should address the unique needs of infants and toddlers in their state plans, with a detailed description of their approach to dealing with issues for babies in foster care such as reducing multiple foster care placements, assuring regular visitation with biological parents, ensuring that all infants and toddlers have access to early childhood and family mental health services, addressing the effects of trauma and separation on infants and toddlers, and promoting interventions that support their healthy development across all domains.

Conclusion

We must ensure that infants and toddlers are healthy and safe. During the first years of life, children rapidly develop foundational capabilities – cognitive, social and emotional – on which subsequent development builds. The amazing growth that takes place in the first three years of life creates vulnerability and promise for all children. These years are even more important for maltreated infants and toddlers. We know from the science of early childhood development what infants and toddlers need for healthy social, emotional and cognitive development. We also know that maltreated infants and toddlers are at great risk for poor outcomes. We must continue to seek support for services and programs that ensure that our nation's youngest and most vulnerable children are safe, and that promote and improve their emotional, social, cognitive and physical health and development.

Policies and funding must be directed to preventing harm to all children and reducing further harm to maltreated children. I urge the Subcommittee to make the investment to support and protect our nation's most vulnerable children and their families.

Thank you for your time and for your commitment to our nation's at-risk infants and toddlers.

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