Rhode Island KIDS COUNT

December 2015

Issue Brief

Young Children in the Child Welfare System

Every child needs a family and a safe place to call home. Safe, stable, nurturing relationships in infancy and early childhood are fundamental for healthy brain development.[1]

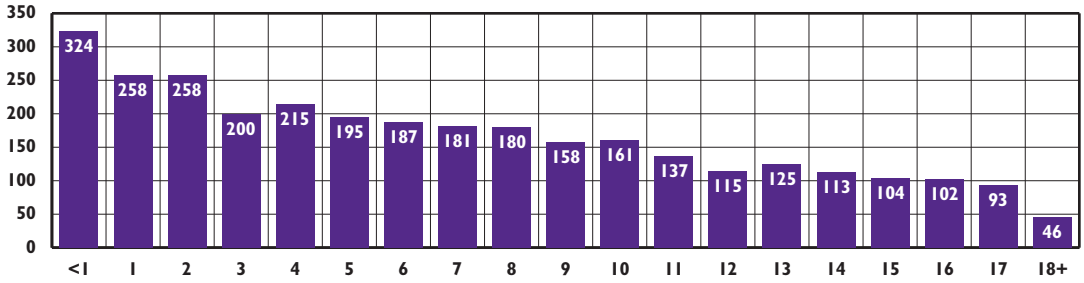
Safety: Child is free from fear and secure from physical or psychological harm

Stability: Child's social, emotional, and physical environment is predictable and consistent

Nurturing: Child's needs are consistently and sensitively met by parents and/or caregivers

In Rhode Island and nationally, young children under age six are more likely to experience abuse or neglect than older children. Infants under age one are the most likely age group to experience maltreatment.[2] Maltreatment at an early age can disrupt a child's ability to form positive attachments and relationships, which are essential for the development of emotional security and long-term success in life.[3]

Child Abuse and Neglect by Age of Victim, Rhode Island, FFY 2015



Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015.

Significant brain development occurs in the first few years of life.[4] Early experiences shape the developing brain, laying the foundation for future learning and life-long physical and emotional health.[5] Maltreatment - neglect or abuse - by parents or other caregivers during early childhood causes ***toxic stress***, which disrupts the development of the brain and biological systems, resulting in short-term harm and long-term negative outcomes such as depression, substance abuse, obesity, high-risk sexual behaviors, suicide, and certain chronic diseases.[5,6,7]

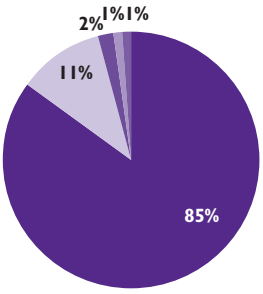
Child maltreatment often co-occurs with other key adverse childhood experiences such as poverty, domestic violence, neighborhood violence, parental mental illness, homelessness, and/or parental substance abuse. The cumulative effect of multiple adverse experiences in childhood can have devastating long-term consequences.[8,9,10,11]

Young Children who Experience Maltreatment

- During FFY 2015, there were 3,367 child maltreatment reports for children under age six that resulted in 3,270 completed investigations by the Rhode Island Department of Children, Youth and Families (DCYF), the state agency responsible for responding to child abuse and neglect. (The number of reports with completed investigations does not equal the number of reports received because multiple reports may be combined into a single investigation and due to the varied length of time to complete an investigation, some reports received at the end of one fiscal year may not be completed until the next fiscal year.)[12]

- Of the 3,270 child maltreatment investigations involving children under age six completed during FFY 2015, 40% (1,305) were substantiated. There were 1,450 victims of maltreatment under age six during FFY 2015 (more than one child can be involved in an investigation).[13]

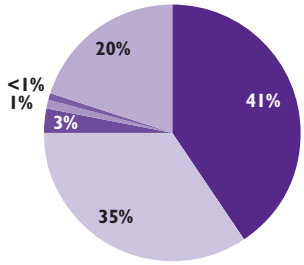
Indicated Allegations of Child Abuse/Neglect by Type, Children Under Age Six, Rhode Island, FFY 2015



85% (1,943) Neglect
11% (261) Physical Abuse
2% (51) Physical Neglect*
1% (20) Institutional Maltreatment
1% (20) Sexual Abuse

*n=2,295***

Indicated Allegations of Neglect by Type, Children Under Age Six, Rhode Island, FFY 2015



41% (795) Lack of Supervision
35% (675) Exposure to Domestic Violence
3% (62) Inadequate Shelter
1% (23) Medical Neglect
<1% (5) Specific Other Small Categories***
20% (383) Other Neglect

*n=1,943***

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015.

*Physical Neglect is neglect that results in a physical injury to the child.

**These numbers are greater than the unduplicated count of child victims because children often experience more than one maltreatment event and/or more than one type of abuse.

***The "specific other small categories" include: inadequate food (2), abandonment (1), failure to thrive (1), and inadequate clothing (1).

- The vast majority (85%) of indicated allegations (confirmed claims) of maltreatment of children under age six involve neglect.[14] There is a strong link between neglect and poverty, with children in low-income families experiencing significantly higher rates of neglect than their higher income peers. Nationally, children from low-socioeconomic status households are seven times more likely to experience neglect than their peers from households with higher socioeconomic status.[15]

- The importance of adequate capacity, affordability, and quality of child care, preschool, other early childhood programs and quality after-school opportunities is highlighted by the fact that 41% of indicated neglect cases for children under age six involved lack of supervision during FFY 2015 in Rhode Island.[16]

- The second largest category of neglect (35%) is "exposure to domestic violence." These are instances where the neglect is related to the child witnessing domestic violence in the home.[17] Witnessing domestic violence can result in immediate and long-term physical, emotional, and learning problems among children.

Child Abuse and Neglect Victims by Age, Rate per 1,000 Children, New England and U.S., FFY 2013

	<1	1	2	3	4	5
Connecticut	23.3	14.4	12.0	11.0	10.6	10.1
Maine	41.8	23.3	22.4	18.7	20.1	17.6
Massachusetts	37.1	20.2	17.2	18.3	18.0	18.0
New Hampshire	7.7	3.6	3.2	5.2	2.7	3.2
Rhode Island	**42.8**	**22.9**	**20.0**	**20.0**	**18.1**	**17.5**
Vermont	7.5	4.9	4.9	7.5	5.8	6.2
United States	*23.1*	*11.8*	*11.4*	*11.0*	*11.1*	*10.7*

Source: U.S. Department of Health and Human Services, Administration for Children and Families. (2015). *Child maltreatment 2013.* Retrieved on December 1, 2015, from www.acf.hhs.gov Note: States voluntarily provide data on child maltreatment to the National Child Abuse and Neglect System (NCANDS). States vary in their definitions of child abuse and neglect, their responses to maltreatment, and what they report to NCANDS.

- Nationally and in Rhode Island, young children are the most vulnerable to maltreatment. During FFY13, 27.3% of maltreatment victims in the U.S. were younger than three years and 19.7% were age three to five years. During the same year, 90% of children who died as a result of abuse and neglect in the United States were under age six.[18]

Emergency Department Visits, Hospitalizations, and Deaths Due to Child Abuse and/or Neglect, Children Under Age Six, Rhode Island, 2009-2013

YEAR	# OF EMERGENCY DEPARTMENT VISITS	# OF HOSPITALIZATIONS	# OF DEATHS
2009	62	19	2
2010	64	21	0
2011	52	29	0
2012	59	18	1
2013	54	19	0
TOTAL	*291*	*106*	*3*

- Between 2009 and 2013, there were 291 emergency department visits, 106 hospitalizations, and three deaths of Rhode Island children under age six due to child abuse and/or neglect.

Source: Rhode Island Department of Health, 2009-2013.

Maltreated Young Children are at High Risk for Developmental Challenges

- Infants and toddlers who have been maltreated are six times more likely to have a developmental delay than the general population. Recognizing this, the federal *Child Abuse and Prevention Treatment Act (CAPTA)* requires states to refer all maltreated children under age three to Early Intervention for an eligibility assessment.

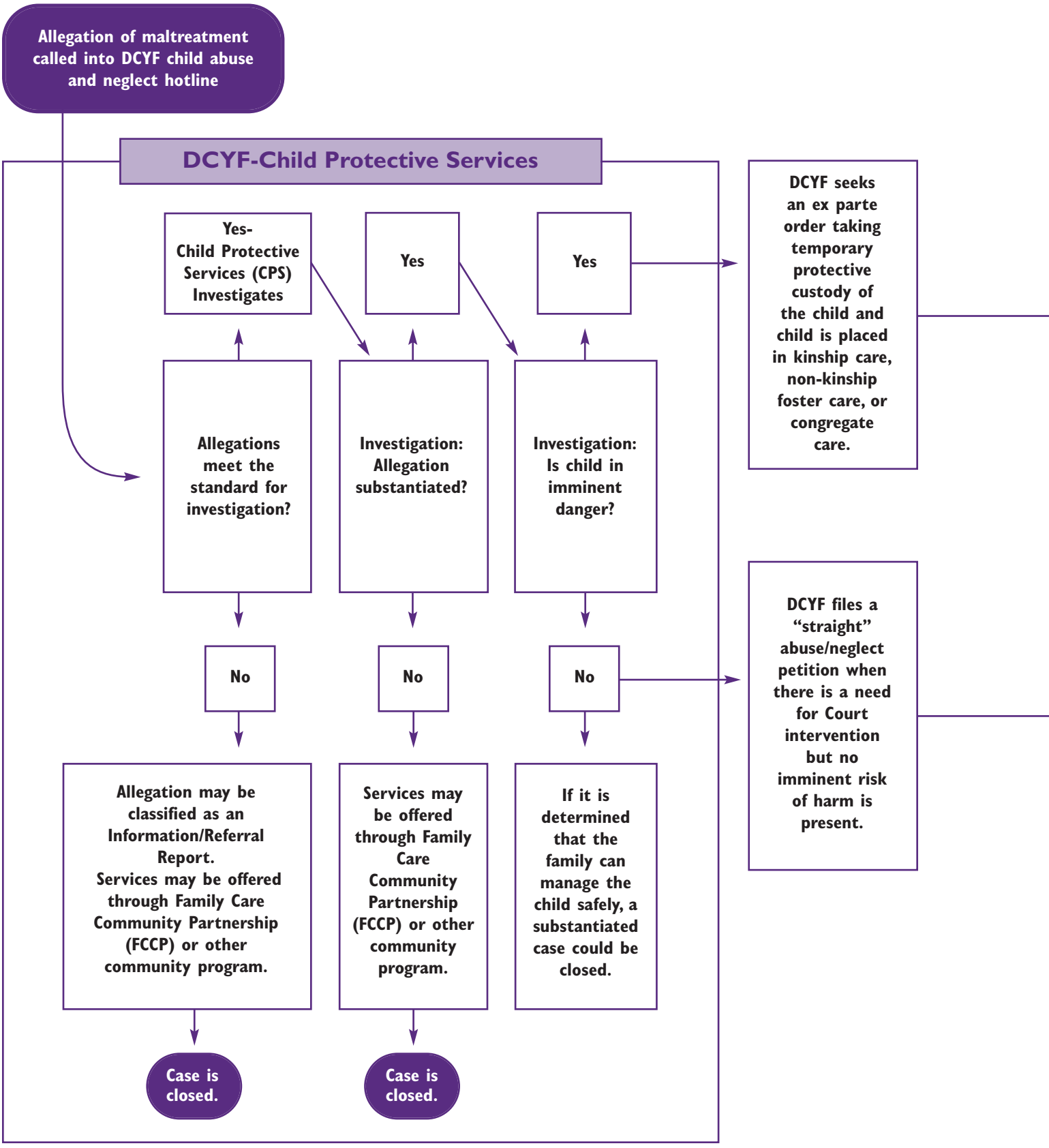
- Child maltreatment is often associated with other risk factors known to impair child development. More than half (55%) of maltreated infants and toddlers had at least five risk factors associated with developmental problems, and children with more than five risk factors have a 90% greater chance of delayed development. All children who have been subjects of child welfare investigations are at high developmental risk, not just those with a substantiated finding of child maltreatment.[19]

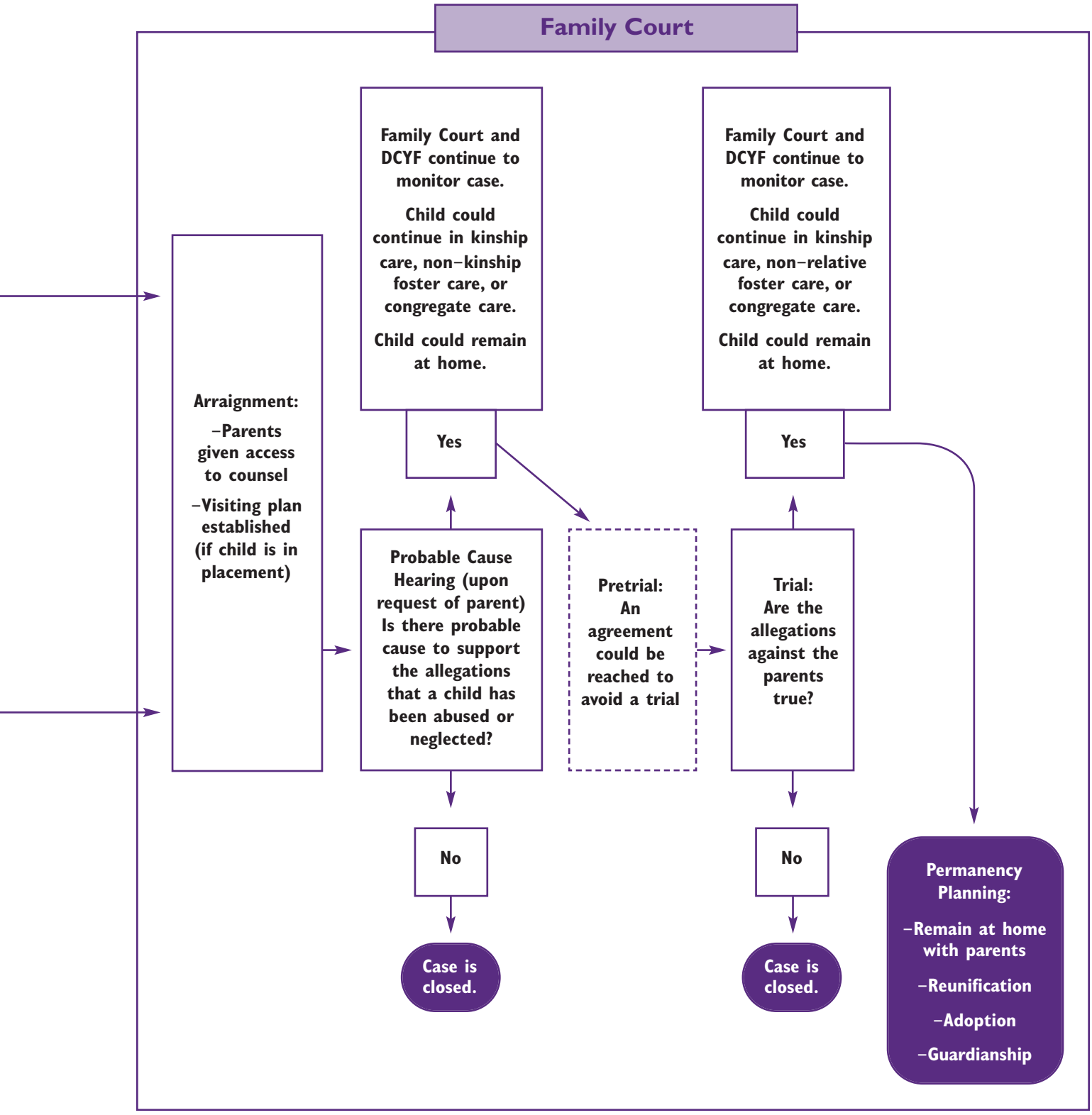
RISK FACTORS AMONG MALTREATED CHILDREN

Single Caregiver (48%)	Caregiver Substance Abuse (39%)	Biomedical Risk Condition (22%)
Poverty (46%)	Caregiver Mental Health Problems (30%)	Teenage Caregiver (19%)
Domestic Violence (40%)	Low Caregiver Education (29%)	Four or More Children in Home (14%)

How does the child welfare system respond to abuse and neglect?

This chart is intended to provide a general overview of how cases can proceed through Rhode Island's child welfare system and does not include all possible paths.





Source: Adapted by Rhode Island KIDS COUNT from Casey Family Programs. (2015). *How children move through the child welfare system.* Retrieved December 1, 2015, from www.georgiavoices.org

Young Children in Out-of-Home Placement

- **Most children who have been victims of abuse and neglect remain in their homes with their parents and are not in foster care.**[20] Children living at home under DCYF and Family Court supervision may be required to participate with home-based services to lower the risk of future child abuse or neglect, including parent education, counseling, and safety planning and/or material resources such as housing or food assistance.[21] Of the 1,773 children under age six open to DCYF on September 30, 2015, 1,058 (60%) were at home with their parents and receiving DCYF services and supervision.[22]

- **In cases where a child has been seriously harmed or is at risk for serious harm, removal from the home may be necessary.** In FFY 2013, 19% of victims of child maltreatment (all ages) in Rhode Island were placed in out-of-home settings, compared with 23% in the U.S.[23]

- **Young children are more likely to be removed from their home than older children.** Across the U.S., almost half (48%) of children who entered out-of-home placement in FFY 2014 were under the age of six and almost one in five (17%) were infants under age one.[24]

- **Most young children who are removed from their homes are placed in a foster home.** As of September 30, 2015, 707 of the 715 (99%) children under age six in out-of-home placement in Rhode Island were in a foster or pre-adoptive home.[25]

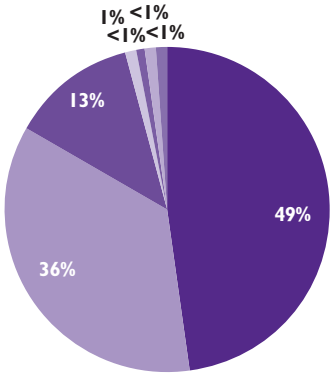
- **Many young children in foster care are in kinship care.** Kinship foster care is care that is provided by relatives and close family friends. In Rhode Island, 60% of children under age six placed in foster care are in kinship foster care (relative or non-relative) and 40% are in non-kinship care.[26] Kinship foster care helps children maintain familial and community connections. Children in kinship foster care are less likely to experience behavioral problems and psychiatric disorders than those in non-kinship foster care.[27] The federal *Fostering Connections to Success & Increasing Adoptions Act* requires states to notify relatives when a child is removed from the home and provides funding for states offering kinship guardianship assistance payments.[28,29]

- **If a child is removed and a kinship caregiver cannot be located, a non-kinship foster family is the best option for providing stable care in a family setting.** Placing young children in congregate or group care can deprive them of opportunities for attachment with a stable caregiver and individualized attention.[30]

Children Under Age Six in Out-of-Home Placement, Rhode Island, September 30, 2015

49% (352)	Relative Foster Care Home
36% (257)	Non-Relative Foster Home
13 % (93)	Private Agency Foster Care Home
1% (5)	Pre-Adoptive Home
<1% (3)	Shelter
<1% (4)	Medical/Psychiatric Hospital/Respite
<1% (1)	Unknown

n=715



Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015.

- Young children spend a greater length of time in foster care than older children. In Rhode Island, the median length of time in foster care for all ages of children is 14 months.[31]

Foster Families Caring for Young Children

Foster Families Caring for Children Under Age Six, Rhode Island, September 30, 2015

	# OF FOSTER HOMES	# OF CHILDREN UNDER AGE SIX
Relative Kinship	293	352
Non-Relative Kinship	55	69
Non-Kinship Foster Care	202	286
Total	*553**	*707*

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015. *The foster home type was unknown for three records.

- One third (34%) of foster homes caring for Rhode Island children are located in the four core cities.[32] In 2014 in Rhode Island, 52% of victims of child maltreatment (among children of all ages) lived in one of the four core cities.[33]
- Experts recommend that when reunification is a permanency option, young children be placed as near to their biological parent's home as possible to allow frequent visits.[34]

The basic **requirements for becoming a foster parent** in Rhode Island include being age 21 or older, physically and psychologically able to care for a child, able to pass a criminal and child abuse/neglect background check, economically stable without a monthly foster payment, having access to reliable transportation, and having a home that can pass fire inspection. DCYF has licensing requirements for foster homes and requires that foster families complete pre-service training.[35]

Foster families are required to ensure the safety and well-being of children placed in their care, including providing food, clothing, safe sleeping space, and personal hygiene. Foster parents are empowered to use the "reasonable and prudent parent standard" to allow their child's participation in age-appropriate activities.

In addition, foster parents are responsible for:

- Arranging for timely and competent medical, vision, and dental care.
- Supporting visitation with the child's family as outlined in the child's service plan.
- Ensuring school-age children attend school and younger children participate in appropriate activities to promote language, social, emotional, and intellectual growth and development, and protecting and nurturing the child in a safe, healthy environment with unconditional positive support.[36,37]

Licensed Foster Homes, Rhode Island, September 30, 2015

CITY/TOWN	# OF FOSTER HOMES
Barrington	3
Bristol	6
Burrillville	11
Central Falls	14
Charlestown	3
Coventry	23
Cranston	32
Cumberland	15
East Greenwich	3
East Providence	28
Exeter	4
Foster	3
Glocester	8
Hopkinton	4
Jamestown	3
Johnston	17
Lincoln	8
Little Compton	1
Middletown	8
Narragansett	10
Newport	7
North Kingstown	15
North Providence	13
North Smithfield	9
Pawtucket	31
Portsmouth	8
Providence	98
Richmond	3
Scituate	3
Smithfield	11
South Kingstown	9
Tiverton	8
Warren	7
Warwick	44
West Greenwich	1
West Warwick	18
Westerly	8
Woonsocket	43
Four Core Cities	*186*
Remainder of State	*354*
Out of State	*13*
Rhode Island	*540*

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015.

Foster Care That Meets the Needs of the Youngest Children

National experts recommend that states support foster parents of young children to provide love and attention "as if the child were their own" so the child can develop emotional security. A foster parent often becomes the child's primary attachment. This child-centered approach to foster care requires:

- Substantial emotional investment in the young child by the foster parent.
- Stable placements (with changes in placement happening only if continuing the placement is likely to be harmful to the child *and* the new placement is likely to be better for the child).
- Collaborative and supportive visits among biological parents, foster parents, and child-protection professionals when reunification is planned. The emotional needs of both the biological parents and the foster parents must be addressed to facilitate collaboration.
- Maintaining supportive contact with a child even after a transition to living with biological parents or new caregivers is complete.
- Ensuring that children have access to high-quality early care and learning experiences.[38,39]

Resources to Support Foster Families

Rhode Island provides financial support (monthly foster care payments and periodic clothing allowance payments) to foster families to offset the costs of caring for each foster child. However, like many other states, the financial support that Rhode Island provides ($5,552/year for children under age four) amounts to 52% of the estimated per child child-rearing costs of middle class families ($10,660/year for children under age three).[40] In addition to direct financial supports, foster parents in Rhode Island may also access the resources described below.

Resources for Young Children in Foster Care, Rhode Island

Health Insurance	Foster children are categorically eligible for RIte Care health insurance. Foster families are not responsible for any premiums or copayments.
Paid Family Leave	Employed foster parents who contribute to the state's Temporary Disability Insurance (TDI) program are eligible for four weeks of paid family leave through the Temporary Caregivers Insurance (TCI) Program upon placement of a foster child.
Nutrition	All foster children under age five are categorically eligible for the WIC nutrition program.
Child Care	Employed foster families are categorically eligible for child care subsidies through the Child Care Assistance Program for foster children, when authorized by DCYF. Foster families and DCYF professionals should use BrightStars ratings (available at www.exceed.ri.gov) to find high-quality child care options.
Head Start & Early Head Start	Foster children are categorically eligible for Early Head Start (up to age three) and Head Start (ages three to five), which are high-quality early learning and development programs.
Developmental Screening & Intervention	All young children in foster care should receive routine developmental screenings and Early Intervention/Preschool Special Education services when delays or disabilities are identified.
Family Home Visiting	Foster families caring for young children have access to First Connections, a rapid response home visiting program. In addition, foster families can participate in Parents as Teachers or Healthy Families America, two evidence-based programs that promote healthy early childhood development. Home visitors can work with children while they are in foster care and can follow the child upon reunification or future placement.

Parent-Child Visits to Support Healthy Relationships and Reunification

When reunification is the plan, parent-child visits are an opportunity to provide a **therapeutic intervention** to establish or re-build a healthy parent-child relationship. Parent-child visits can also be used as a diagnostic tool to observe parent capacity and determine if reunification is the best permanency option for the child.

- **Regular, frequent parent-child visits** increase the likelihood of successful reunification, reduce time in foster care, promote healthy attachment, and reduce the negative effects of separation for both the child and the parent. Experts recommend that infants in foster care **spend time with biological parent(s) every day** and toddlers should see parent(s) at least every two or three days. The first parent-child visit should occur **no later than 48 hours after a young child is removed from the home** unless a visit puts the child at risk.

- Parent-child visits for young children should occur **in the foster home, whenever possible,** with the foster parent(s) acting as a supportive role model to the biological parent. **Supervision of visits can be provided by a range of trained people** including a caseworker, therapist, foster parent, or relative. Supervisors of parent-child visits can evaluate interaction between the parent and child and model positive parenting behaviors.[41]

Permanency for Young Children

- Ensuring that young children develop secure, lasting relationships to permanent caregivers is critical to their healthy development.[42] Permanency planning is a shared responsibility between the courts and the child welfare agency, who work together to ensure that permanency is achieved as soon as possible.[43] For most young children under DCYF supervision, their permanency goal is to live with their birth parents at home.[44]

Permanency Goal for Children Under Age Six under DCYF Supervision, September 30, 2015

	#	%
Reunification	555	47%
Maintain at Home	288	24%
Adoption	100	8%
Guardianship	6	<1%
Other or Goal not Established	244	20%
Total	*1,193*	*100%*

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015.

- Nationally, infants are less likely to be reunified and more likely to achieve permanency through adoption than older children. For young children, concurrent planning should be used to pursue permanency through adoption or guardianship should efforts toward reunification fail.[45]

Adoption from Foster Care, New England & U.S.

	% OF WAITING CHILDREN UNDER AGE SIX, 2012	AVERAGE AGE AT ADOPTION, FY 2014	% OF ADOPTED CHILDREN UNDER AGE SIX, FY 2014
Connecticut	48%	5.9	61%
Maine	42%	5.1	67%
Massachusetts	48%	5.7	63%
New Hampshire	40%	6.1	54%
Rhode Island	**31%**	**5.7**	**65%**
Vermont	38%	6.2	57%
United States	*44%*	*6.2*	*57%*

Sources: The Annie E. Casey Foundation, KIDS COUNT Data Center, datacenter.kidscount.org and U.S. Department of Health and Human Services, Administration for Children and Families. (2015). *Age at adoption finalization.* Retrieved on December 1, 2015, from acf.hhs.gov

Health Care for Young Children in the Child Welfare System

- **Children who have been abused or neglected, especially those removed from their homes, have special health care needs.** They need consistent access to health coverage (all children in foster care in Rhode Island have RIte Care coverage) and a medical home with a provider who understands those needs. Children. Children in foster care experience chronic health conditions at a rate of one and a half times the prevalence in the general population. These include high rates of respiratory problems, neurological problems, dental caries, impaired vision and hearing, obesity, and growth failure.[46,47]

- **Health care providers often face multiple challenges in treating children in foster care**, including lack of information about the child's medical history and barriers to sharing and accessing health information. Gathering health information and obtaining the proper consents for treatment at the time a child is removed from the home can help mitigate these challenges.[48]

- **Hasbro Children's Hospital offers specialty services for children who may have been neglected and/or abused.** The Physical Abuse, Neglect Diagnostic Assessment (PANDA) Clinic, funded in conjunction with the State of Rhode Island, provides a child-friendly environment to complete medical evaluations for allegations of child maltreatment, with special emphasis on physical abuse or neglect. The Child Protection Program offers a child-friendly area where detailed and comprehensive medical evaluations are conducted by physicians who specialize in treating children who may have been maltreated or sexually abused.[48]

- **Children in foster care should receive an immediate medical screening followed by a comprehensive health assessment within 30 days by a medical provider with experience treating foster children.** Follow-up assessment and periodic preventive health care visits are critical in ensuring that children's health needs are addressed. The American Academy of Pediatrics recommends preventive health visits every month for foster children under six months, every three months for foster children age six months to age two, and every six months for children older than age two.[49]

- **Babies can also come to attention of the child welfare system and have special health care needs because of maternal alcohol or other drug use during pregnancy,** which can cause premature birth, low birth weight, and physical, emotional, behavioral, and cognitive problems. The impact of prenatal exposure to drugs and alcohol problems depends on the type of substance, frequency of exposure, and the level of prenatal care received.[50,51] *CAPTA* requires that health care providers notify CPS of all newborns identified as being affected by illegal substances, withdrawal symptoms resulting from prenatal exposure to alcohol and drugs.[52]

- DCYF works with health care providers by alerting area hospitals when they believe that there may be risk of harm to a baby born of a parent who has previously been found to have abused or neglected a child. In these instances, DCYF requests that the hospital contact the CPS Hotline at the time of the baby's birth.[53]

Getting to Kindergarten Initiative

- A new cross-departmental initiative of the Rhode Island Childern's Cabinet designed to support young children involved in the child welfare system is scheduled to launch in January 2016. The *Getting to Kindergarten* initiative will be a partnership among the Rhode Island Executive Office of Health and Human Services, Department of Children, Youth and Families, Department of Health, Department of Human Services, and Department of Administration to ensure that the infants, toddlers, and young children who touch the child welfare system remain healthy, develop appropriately, and become school-ready by kindergarten. This initiative will connect children ages birth to five to a continuum of early childhood services, including Early Intervention, Family Home Visiting, Early Head Start, and high-quality child care.[54]

Recommendations

- **Every Child Needs a Family:** Children do best in families. Child welfare agencies should maintain children with their birth parents whenever this can safely be accomplished. If removal is necessary, the child welfare system should find kinship caregivers and then to non-kinship foster homes until a family-based placement can be achieved. Young children should never be placed in institutional or group settings.

- **Workforce Development:** Provide all child welfare professionals, members of the judiciary, and foster parents with initial and ongoing training so they can better understand and support the developmental needs of infants, toddlers, and young children.

- **Primary Prevention:** Adopt programs that promote high-quality parent-child relationships and state policies that reduce or eliminate factors that lead to toxic stress for families with young children. State policies that reduce family stress are those that reduce unintended pregnancies; reduce poverty and increase economic security; establish more affordable, stable, healthy housing options; improve parent education levels; expand access to high-quality child care and early learning programs; and ensure streamlined access to mental health, substance abuse, and domestic violence prevention, screening, and treatment services for parents.

- **Secondary Prevention:** Provide evidence-based and intensive family support programs, including family home visiting (e.g., Nurse-Family Partnership) and parent-child therapy, to strengthen and stabilize at-risk families.

- **Maltreated Children:** Ensure maltreated children who remain at home with their families (supervised by DCYF or not) receive adequate support and services, including access to high-quality early learning and development programs. All maltreated young children should be screened for developmental delays and referred to appropriate intervention services.

- **Foster Care:** Recruit, license, and proved specialized support to foster families (both kinship and non-kinship) caring for young children. Ensure that all foster families have access to high-quality early learning and development programs and adequate resources to promote healthy child development and permanency. Adopt a child-centered approach to foster care, in which foster parents are encouraged and supported to become attached to young children and to maintain long-term relationships.

- **Health Care:** Ensure all children on the DCYF caseload have RIte Care coverage and receive timely medical assessments and needed treatment -- an initial assessment should be completed within 48 hours. Maintain stable relationships with pediatric health care providers whenever possible.

- **Visitation:** Young children in foster care whose permanency goal is reunification should have frequent, regular visits with their birth parent(s) beginning within 48 hours of a child's removal.

- **Permanency:** Expedite resolution of Rhode Island Family Court cases involving young children. Experts recommend monthly case reviews for young children with teams including attorneys, case workers, biological parents, foster parents, and others as needed. Concurrent plans should identify clear back-up options (adoption/permanent guardianship) if efforts at reunification are not successful within a reasonable timeframe. Consider adopting the Safe Baby Court model in the Rhode Island Family Court, which is a child welfare systems change model used in 12 states that is built on judicial leadership focusing on children under age three in foster care. It includes coordination of comprehensive developmental, medical, and mental health services and monthly family progress reviews to expedite permanency decisions.

- **Post-Permanency Services:** Provide regular contact with and ongoing support to biological families who have been reunified with their children and to families who have adopted children from foster care or assumed legal guardianship in order to identify and address issues that could result in re-entry to care or an adoption disruption.

References

[1,6] *Essentials for childhood: Steps to create safe, stable, nurturing relationships and environments.* (2014). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

[2,12,13,14,16,17,22,25,26,32,44] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2015.

[3,5] National Scientific Council on the Developing Child. (2004). *Young children develop in an environment of relationships: Working paper No. 1.* Cambridge, MA: Harvard University, Center on the Developing Child.

[4] *General brain development.* Retrieved December 10, 2015, from www.zerotothree.org

[7] National Scientific Council on the Developing Child. (2012). *The science of neglect: The persistent absence of responsive care disrupts the developing brain: Working paper No. 12.* Cambridge, MA: Harvard University, Center on the Developing Child.

[8] Golman, J., Salus, M. K., Wolcott, D., & Kennedy, K. Y. (2003). *A coordinated response to child abuse and neglect: The foundation for practice.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

[9,19] Barth, R. P., Scarborough, A., Lloyd, E. C., Losby, J., Cassanuea, C., & Mann, T. (2007). *Developmental status and early intervention service needs of maltreated children.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[10] Dworsky, A. (2014). *Families at the nexus of housing and child welfare.* Chicago, IL: Chapin Hall Center at the University of Chicago.

[11] Eckenrode, J., Smith, E., McCarthy, M. E., & Dineen, M. (2014). Income inequality and child maltreatment in the United States. *Pediatrics, 133*(3), 454-461.

[15] Sedlak, A. J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). *Fourth national incidence study of child abuse and neglect (NIS–4): Report to Congress.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

[18,23] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). *Child maltreatment 2013.* Retrieved on December 1, 2015, from www.acf.hhs.gov

[20] Beckman, K. A., Knitzer, J., Cooper, J., & Dicker, S. (2010). *Supporting parents of young children in the child welfare system.* New York, NY: Columbia University, Mailman School of Public Health, National Center for Children in Poverty.

[21] U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Welfare Information Gateway. (2013). *How the child welfare system works.* Retrieved December 1, 2015, from www.childwelfare.gov

[24] *The AFCARS Report: Preliminary FY 2014 Estimates as of July 2015.* (2015). Washington, DC: U.S. Department of Health and Human Services, Administration for Children, Youth and Families, Children's Bureau.

[27] *Stepping up for kids: What government and communities should do to support kinship families.* (2012). Baltimore, MD: The Annie E. Casey Foundation.

[28] The Fostering Connections Resource Center. (n.d.). *Description of the law.* Retrieved January 11, 2013, from www.fosteringconnections.org

[29] The Fostering Connections Resource Center. (n.d.). *Rhode Island's guardianship assistance program.* Retrieved January 11, 2013, from www.fosteringconnections.org

[30] Zero to Three and Child Trends. (2013). *Changing the course for infants and toddlers: A survey of state child welfare policies and initiatives.* Retrieved December 1, 2015, from www.zerotothree.org

[31] Rhode Island Department of Children, Youth and Families. (n.d.). *Questions about foster care.* Retrieved December 1, 2015, from www.dcyf.ri.gov

[33] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2014.

[34,41,45] Smariga, M. (2007). *Visitation with infants and toddlers in foster care: What judges and attorneys need to know.* Washington, DC: Zero to Three Policy Center and ABA Center on Children and the Law.

[35,36] *Foster care and adoption regulations for licensure.* (2013). Providence, RI: Rhode Island Department of Children, Youth and Families.

[37] *Promoting normalcy for children and youth in foster care: Executive summary.* (2015). Philadelphia, PA: Juvenile Law Center.

[38] Zeanah, C. H., Shauffer, C., & Dozier, M. (2011). Foster care for young children: Why it must be developmentally informed. *Journal of the American Academy of Child and Adolescent Psychiatry, 50*(12), 1199-1201.

[39] Dicker, S., Gordon, E., & Knitzer, J. (2002). *Improving the odds for the healthy development of young children in foster care.* New York, NY: National Center for Children in Poverty.

[40] Calculated by Rhode Island KIDS COUNT using the DCYF foster board rates and clothing allowance for children under age 4 and estimated annual expenditures on a child under age 3 by middle-income families in the urban Northeast from Lino, M. (2014). *Expenditures on children by families, 2013.* Alexandria, VA: U.S. Department of Agriculture, Center for Nutrition Policy and Promotion.

[42] Zero to Three and Child Trends. (2013). *Achieving prompt permanency for all maltreated infants and toddlers.* Retrieved December 1, 2015, from www.zerotothree.org

[43] Cohen, J. Cole, P., & Szrom, J. (2011). *A call to action on behalf of maltreated infants and toddlers.* Washington, DC: American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, Children's Defense Fund, and Zero to Three.

[46,48,49] Lewis, C., Beckwith, J., Fortin, K., & Goldberg, A. (2011). Fostering health: Health care for children and youth in foster care. *Medicine & Health/Rhode Island, 94*(7), 200-202.

[47] Stoltzfus, E., Baumrucker, E. P., Fernandes-Alcantara, A. L., & Fernandez, B. (2014). *Child welfare: Health care needs of children in foster care and related federal issues.* Washington, DC: Congressional Research Service.

[50] Behnke, M. & Smith, V. C. (2013). Prenatal substance abuse: Short- and long-term effects on the exposed fetus. *Pediatrics, 131*(3), e1009-e1024.

[51] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2014). *Parental substance abuse and the child welfare system.* Retrieved on December 1, 2015, from www.acf.hhs.gov

[52] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. (2015). *Child welfare policy manual.* Retrieved on December 1, 2015, from www.acf.hhs.gov

[53] Rhode Island Department of Children, Youth and Families. (2014). *Criteria for a child protective services investigation (Policy 500.0010).* Retrieved December 1, 2015, from www.sos.ri.gov

[54] *The Rhode Island Children's Cabinet Strategic Plan 2015-2020.* (2015). Rhode Island Children's Cabinet: Providence, RI.

Acknowledgements

Jamia McDonald, Kevin Aucoin, Denis Riel, Leon Saunders, Joseph Carr, Abby Swienton, DCYF; Chief Judge Haiganush Bedrosian, Sharon O'Keefe, Ronald Pagliarini, RI Family Court; Kristine Campagna, RI Department of Health; Susan Dickstein, RI Association of Infant Mental Health/Bradley Hospital/Brown University; Benedict Lessing, Darlene Magaw, Bridget Bennett, Ivy Medeiros, Community Care Alliance; Heidi Brinig, Providence Children's Museum; Kat Keenan, Lisa Guillette, Foster Forward; Darlene Allen, Adoption RI; Carol Lewis, Colleen Deems, Hasbro Children's Hospital.

Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action.

Primary funding for Rhode Island KIDS COUNT is provided by The Rhode Island Foundation, United Way of Rhode Island, The Annie E. Casey Foundation, Prince Charitable Trusts, Alliance for Early Success, Robert Wood Johnson Foundation, DentaQuest Foundation, The Pew Charitable Trusts, Nellie Mae Education Foundation, Hasbro Children's Fund, Neighborhood Health Plan of Rhode Island, Blue Cross & Blue Shield of Rhode Island, Delta Dental of Rhode Island, UnitedHealthcare Community Plan, and other corporate, foundation and individual sponsors.

Rhode Island **KIDS COUNT** *Staff*

Elizabeth Burke Bryant, Executive Director
Jill Beckwith, Deputy Director
Leanne Barrett, Senior Policy Analyst
Jim Beasley, Policy Analyst
Dorene Bloomer, Finance Director
Jennifer Capaldo, Program Assistant
Katy Chu, Communications Coordinator
W. Galarza, Executive Assistant/ Office Manager
Stephanie Geller, Policy Analyst
John Neubauer, Policy Analyst

Rhode Island **KIDS COUNT**

One Union Station
Providence, RI 02903
401-351-9400
401-351-1758 (fax)
rikids@rikidscount.org
www.rikidscount.org

Hasbro Children's Fund

We are very grateful to Hasbro Children's Fund for its support of this Issue Brief.