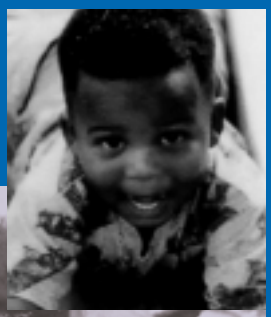
EARLY HEAD START NATIONAL RESOURCE CENTER

Technical Assistance Paper No. 9

Supporting Infants and Toddlers in the Child Welfare System:

# The Hope of Early Head Start



U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Head Start Bureau

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*Supporting Infants and Toddlers in the Child Welfare System:*

# The Hope of Early Head Start

## Technical Assistance Paper No. 9

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*Photo Disclaimer:*
*The children and families appearing in the photographs in this document are for publication purposes only and are not being portrayed as recipients of child welfare services.*

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## Supporting Infants and Toddlers in the Child Welfare System:

# The Hope of Early Head Start

Infants and toddlers in the child welfare system face numerous developmental risks and pose a complex challenge to the Early Head Start (EHS) programs that have the opportunity to nurture and support these vulnerable children and families. EHS programs are in a position to identify signs of potential abuse or neglect and are required to report their suspicion to authorities [1304.52(k)(3)(i)]. Along with this responsibility comes an opportunity to partner with vulnerable families in desperate need of support and intervention. In addition, as all EHS programs commit to serve the children who are most in need in their community, staff members in these programs, regardless of their formal collaboration with their local child welfare agencies, should be aware of the special needs of children in the child welfare system and should be prepared to provide support and resources to them should it become necessary.

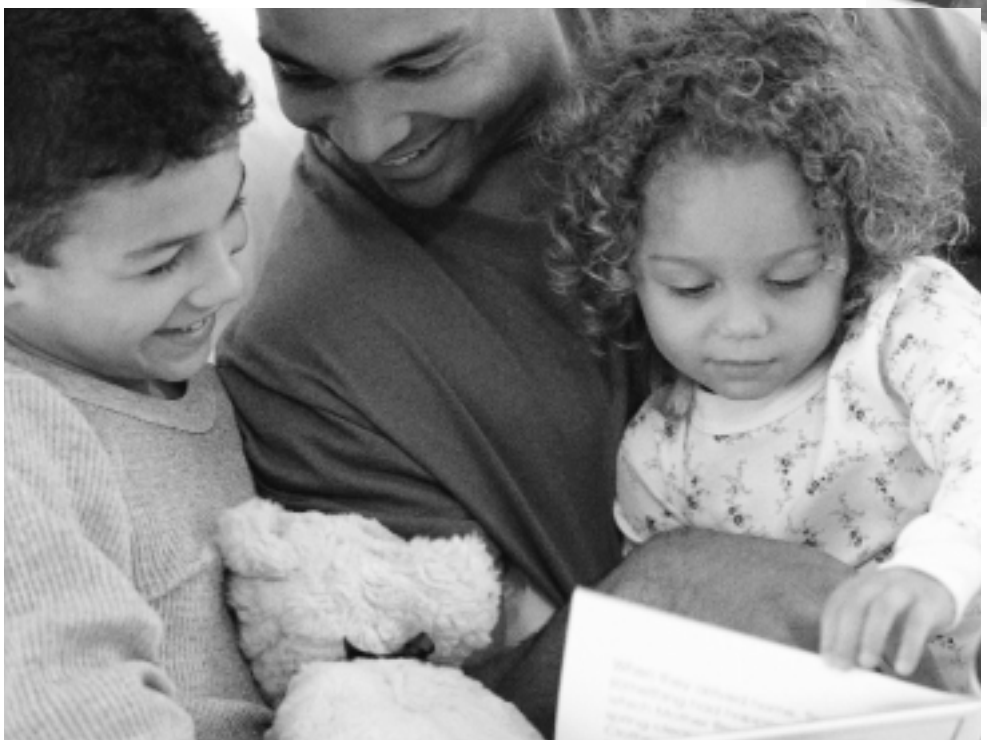
Child welfare is a term used to describe social services for children and their families, services that include foster care, adoption, family preservation, and family support. Children enter the child welfare system when they are victims of abuse or neglect or when they lack parents or other legal guardians who can provide adequate care. In some cases, their involvement is temporary and brief. In other cases, children are permanently removed from their homes. Often, children remain in the home while the children and families receive support, services, and monitoring by Child Welfare Services (CWS). Some children enter, leave, and reenter the child welfare system numerous times. Children in the following groups experience the kinds of circumstances that lead to their involvement in the child welfare system:



- **Newborn infants whose parents have exposed them to drugs or alcohol and who lack a suitable or willing caretaker—**Sometimes, these children are removed from their mother's care while she undergoes drug treatment; occasionally, these children are abandoned at the hospital.
- **Children whose parents have died, been incarcerated, or hospitalized—** When no suitable caretaker is available, these children become wards of the state and are put either in foster care or in a permanent adoptive home.

- **Children who have been physically, sexually, or emotionally abused—** Examples of abuse fall into three categories: (a) beating, shaking, hitting, burning, pulling hair, breaking bones, or not letting a child eat, drink, or use the bathroom; (b) inappropriate touching or exposure to sexual materials; and (c) abusive and threatening language.
- **Children who have been neglected—** Neglect may involve not meeting a child's need for food, clothing, shelter, or safety; leaving a young child unattended or in an unsafe environment; failing to provide necessary medical care; or preventing a child from attending school.

According to the latest statistics from the Child Welfare League of America (Child Welfare League of America, 2005), an estimated 895,569 children were victims of abuse and neglect in 2002, and children under the age of 3 years had the highest rate of maltreatment. Each year, about 150,000 children under the age of 5 are placed in foster care. Among those children, infants make up the group that is increasing fastest and that is the largest cohort of children in foster care; each year, 39,000 babies enter foster care each year, nearly a third of them directly from the hospital. Half of all children who were admitted into foster care before their first birthday remained in care for more than 2 years (ZERO TO THREE, 2003). This technical assistance paper will discuss the health, developmental, and mental health risks to infants and toddlers in the child welfare system and how EHS can have a positive effect. The second half of the paper will highlight some of the unique ways that EHS programs participating in a demonstration project have established formal partnerships with their local child welfare agencies to better meet the needs of the children and families who are involved in the child welfare system in their communities.



# Risks and Vulnerabilities of Infants and Toddlers in the Child Welfare System

Children who are involved in the child welfare system are likely to have a number of negative life experiences that put them at risk for problems related to physical health, mental health, and development. In this section, we discuss these three broad areas in detail and identify how EHS has the opportunity to buffer some of these challenges.

## HEALTH CARE

The health of children in the child welfare system is notoriously poor. A majority of the children have been exposed to prenatal risks such as exposure to drugs or other toxic substances, or they have suffered circumstances at birth (low birth weight, prematurity) that result in (a) health problems such as neurological or respiratory conditions or (b) developmental delays and disabilities.

To complicate matters, children in the child welfare system receive spotty medical care. They may receive medical care from different medical providers with each new placement, and their medical records may not follow them from one provider to another. Incomplete or delayed immunizations are common. Some of the barriers to receiving medical care include inadequate funding, poor planning and coordination among child welfare agencies and health-care providers, and lack of access to community health providers who will accept Medicaid or state funded health insurance.

To combat these issues, the American Academy of Pediatrics formed a Committee on Early Childhood Adoption and Dependent Care and issued guidelines for health care to young children in foster care (American Academy of Pediatrics, 2002). These guidelines include the following recommendations:

- All children entering foster care should receive an initial physical exam before or soon after placement in foster care to identify any immediate or urgent medical needs.
- All children in foster care should have a comprehensive physical as well as a mental health and developmental evaluation within 1 month of placement, which should be done by a pediatrician who is willing to provide the child's ongoing primary health services.
- The results and recommendations of all health assessments should be included in the individual court-approved social service case plans.

- The physical, developmental, and mental health status of children in foster care should be monitored more frequently than that of children living in stable homes.

## DEVELOPMENTAL DELAY

Over half of the children in the child welfare system have developmental delays or disabilities. Because of this high probability for developmental concerns, the American Academy of Pediatrics and the Child Welfare League of America recommend that every child in foster care receive a formal, comprehensive developmental evaluation within 1 month of his or her placement. The federal early intervention program for infants and toddlers with disabilities, known as Part C of the

Individuals with Disabilities Education Act, entitles children to a multidisciplinary evaluation and, if they meet eligibility criteria, to an Individualized Family Service Plan detailing family needs, resources, and goals.

Each state determines its own criteria for Part C program eligibility. Infants and toddlers who have either a developmental delay or a condition that has a high probability of resulting in a developmental delay (e.g., cerebral palsy, fetal alcohol syndrome, failure to thrive, or severe attachment disorders) are entitled to early intervention services. In some states, children can also qualify for services without meeting other criteria if the "informed clinical opinions" of qualified professionals determine that the child is at risk for developmental delay.



A majority of children in the child welfare system meet these eligibility requirements. The services that may be available include occupational, physical, or speech therapy; special instruction; mental health treatment; hearing and vision screening and treatment; assistive devices; and transportation to early intervention services. The early intervention program is required to provide service coordination to ensure that families (including foster families and other legal guardians) are informed of their rights and to help them navigate the system and meet their needs. All services must be provided in the child's natural environment, which may be the home, child care, or whatever setting is appropriate for that child and family.

## MENTAL HEALTH

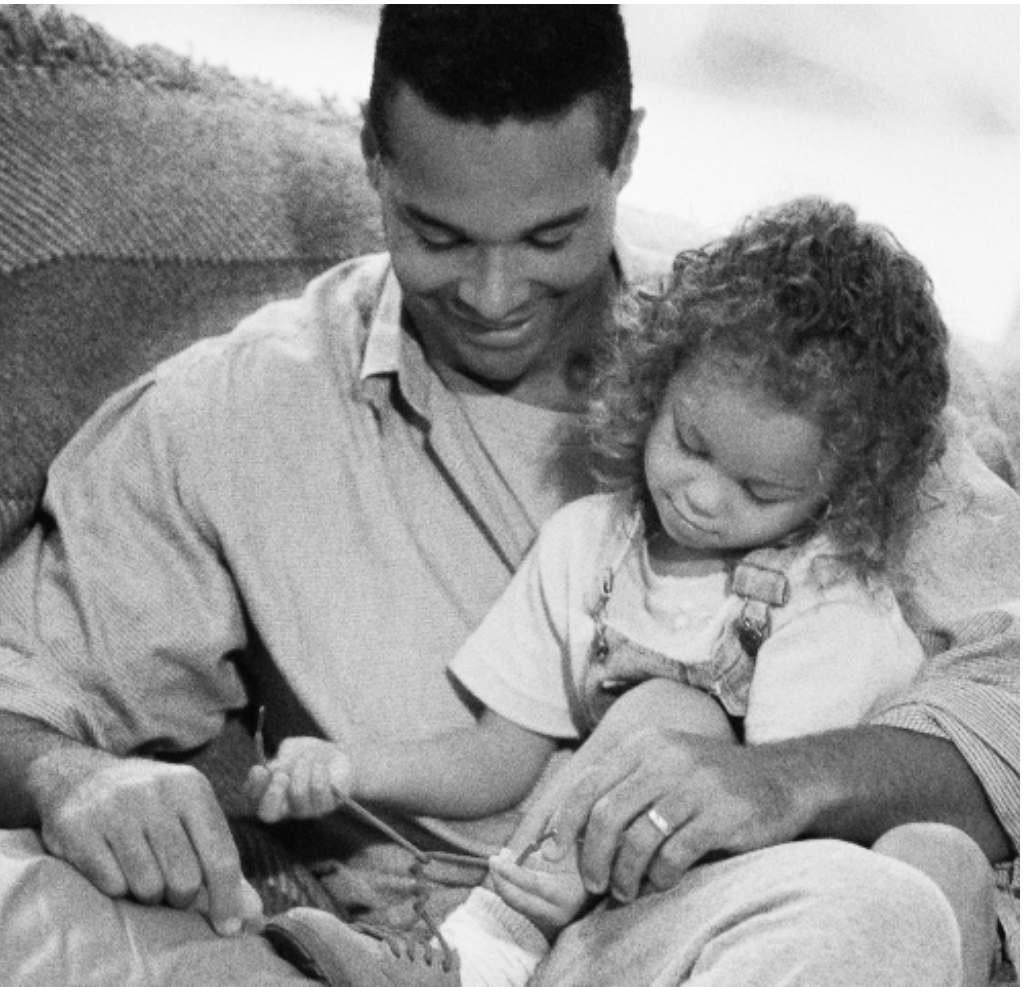
In addition to the health and developmental concerns listed above, children in the child welfare system are faced with a host of mental health challenges. The circumstances—abuse or neglect—that lead to their involvement with CWS are likely to leave emotional scars. The experience of being separated from their parents, even if for their own safety, is likely to cause emotional distress. And the child's current circumstances, such as his or her relationships with foster parents or visitation with family members, bring additional challenges.

The primary mental health need during infancy is to have at least one adult who provides unconditional love and who is devoted to the child's care and well-being. An infant develops attachment to significant caretakers over time as that care provider (or providers) consistently meets his or her physical and emotional needs. Healthy attachment during infancy is understood to be a precursor for healthy relationships throughout life. In circumstances where these important attachments are disrupted, children can experience an inability to relate to others,

deficits in language and other cognitive skills, and serious emotional disturbances. Some of the red flags for emotional health problems during infancy include excessive fussiness; chronic eating or sleeping problems; an inability to be consoled; and "failure to thrive," the unexplained lack of growth or weight gain.

One of the first developmental tasks of infancy is self-regulation. Self-regulation involves the ability to take in sensory information, attend to people and things in the environment, and ultimately, to control emotions and behavior. Self-regulation begins to develop in early infancy through sensitive and responsive caregiving during daily routines. For example, parents help their infant regulate emotions, or states of arousal, as they tend to the baby's need for food, sleep, activity, or physical comfort. The caregiver's appropriate response to an infant's need brings the baby to a calm, quiet state when the child is most open for social interaction and exploration. Familiar adults who learn how to "read" a baby's unique cues are better able to support the child's self-regulation; they are also forming the bonds that children need to develop loving and trusting relationships.

Perhaps, then, the biggest threat to emotional health for very young children in the child welfare system is disrupted relationships. Infants are developing their basic trust or mistrust of the world around them in the first months of life. Will I be fed when I am hungry? Does someone come when I cry? Am I held, tended to, and loved? Am I handled roughly, left alone to cry, or frequently hungry and unfed? Unfortunately, children who have been abused or neglected have too often experienced a lack of nurturing and responsive care and may not have access to healthy, available caregivers with whom to develop the bonds that are necessary for healthy attachment. Foster care is often characterized by multiple changes in caregivers. Although foster parents may be responsive and nurturing, these constant changes are harmful to children at any age and can be particularly problematic in the first 3 years of life.



# EHS Services for Children Involved With Child Welfare

A comprehensive child development and family support program such as EHS can play a pivotal role in the lives of children and families in the child welfare system. In addition to providing or linking families with needed services—medical, mental health, nutrition, and education—EHS can provide a place for children to experience consistent, nurturing relationships and stable, ongoing routines. This stability and consistency may buffer some of the upheaval in other areas of the children's lives. EHS can also be a safe, neutral place where people involved in a child's custody can meet for visitation, training, or observation. EHS staff members need training on the prevalent issues facing these children, and program policies and practices should reflect this knowledge.



## Transportation as a Barrier to Receiving Services

The issue of accessible and reliable transportation is an issue for many low-income families, but it seems to be an even greater barrier to services for children in the child welfare system. Specific issues to consider include the following:

- Children involved with the child welfare system are often involved in a number of intervention services and have an increased number of appointments outside the home.
- Foster families typically have additional children in the house, and it is burdensome to bring them all along for an appointment.
- Children with attachment issues may have particular difficulty if they must go with yet another unfamiliar adult to an appointment.
- Children may be placed in foster care outside of their home area, and the travel distance to access services is increased.
- Families involved in the child welfare system often lack social support and cannot rely on family members or friends to help with transportation.
- The funding for transportation services is unstable.

There are no easy answers to removing these barriers. Some EHS programs have been successful in developing community partnerships with groups such as faith-based organizations that can provide transportation resources. Other programs have provided gas vouchers or bus tokens, accessed Medicaid to pay for transportation to medical appointments, or partnered with local auto repair shops to help families find reliable used cars.

EHS programs are required by the Head Start Program Performance Standards to provide many of the services that address the risks and concerns with respect to children in the child welfare system, including the following:

- Finding a medical home—Grantees are required to ensure that each child has a continuous source of accessible, coordinated health care **[1304.20(a)(1)(i)].** Programs can address barriers such as lack of transportation, locating providers, financial resources, or language issues.
- Ensuring that well-child care, including immunizations and dental care, are up to date—Grantees are expected to collaborate with parents or other legal guardians to make arrangements for any necessary examinations and immunizations **[1304.20(a)(1)(ii)(A)].**
- Conducting health and developmental screenings—Within 45 days of entry into the program, grantees must screen children to identify concerns with respect to a child's developmental, visual, auditory, behavioral, motor, language, social, cognitive, perceptual, and emotional skills **[1304.20(b)(1)].**
- Tracking and record keeping—Procedures must be in place to ensure that appointments are kept and services are provided in a timely and quality manner **[1304.20(a)(1)(ii)(C)].**
- Identifying nutritional needs and providing healthy meals and snacks—Grantees are responsible for assessing children's nutritional status and working with parents to address concerns **[1304.23(a)].** Grantees must also design and implement a nutrition program that meets the nutritional and feeding requirements of each child **[1304.23(b)(1)].**
- Providing an environment that is safe, clean, and inviting as well as one that promotes learning—The physical environment, including toys, equipment, materials, and furniture, have a direct effect on the development of children's cognitive, social, emotional, and physical skills. EHS grantees are expected to provide a variety of toys and materials that promote active exploration and learning as well as emotional comfort and safety **[1304.53(b)(l-vii)].**
- Providing relationships that are consistent and secure—EHS programs help infants and toddlers develop secure relationships by limiting the number of caregivers and the group size in center-based settings to one teacher for a group of four children **[1304.52(g)(4)].** Staff members are expected to support the social and emotional development of infants and toddlers in an approach to education that is individualized for each child **[1304.20(f)]** and that includes a focus on self-awareness, autonomy, self-expression, and communication **[1304.21(b)(2)(i-ii)].**



- Providing parenting education and other family support services—Head Start programs are required to partner with families to help them meet their goals and nurture the development of their children. Parents or other legal guardians are invited to be involved in all aspects of the program **[1304.40].**
- Collaborating and coordinating with community agencies—Grantees must build on and support the goals of preexisting family plans such as those stipulated by child welfare agencies or through Part C early intervention programs. Grantees develop strategies with other community agencies to share information and ensure that the responsibility for delivering services to the family is properly shared **[1304.40(a)(3)].**

EHS programs can have a dramatic effect on the lives of children in the child welfare system if services are coordinated, timely, and responsive to individual child and family needs. Paramount for these children is the need for relationships that are warm, trusting, and available over time. All children who are involved in the child welfare system have experienced trauma and loss; thus, their needs are intensified, especially the need for love and security, the need for predictable routines, and the need to know that their needs will be met—that they will be fed when hungry, held when scared, and allowed to sleep when tired.

Many children in the child welfare system have experienced multiple losses, thus further increasing their vulnerability as well as their risk for attachment disorders and other social and emotional problems. Compounding this issue is an often seen "cyclical effect" wherein the parents of children in the child welfare system have also been involved with CWS in their own childhoods. In many cases, these parents have also suffered trauma and multiple losses that have affected their ability to develop healthy relationships with staff members, peers, their families, and their children.

EHS offers children and parents the opportunity to develop meaningful relationships with their EHS teachers or home visitors, and care should be taken to minimize further loss with unnecessary changes in the program. For example, consider policies such as primary caregiving and continuity of care. Primary caregiving is a term that refers to the practice of assigning one teacher to be primarily responsible for the care of a child during the course of the child's enrollment in the program. This person would be the key contact for the family and would be the person who provides most of the child's direct care during the day. Continuity of care is the practice of keeping young children in the same group

with the same caregiver for as long as possible. This practice honors the relationships in the lives of very young children and recognizes the negative consequences of repeatedly moving children from one group to another as they age. In work with parents, staff members should also be sensitive to issues such as building trust, looking for strengths, and being consistent.

A potential challenge for staff members is how to develop supportive relationships with both foster parents and biological parents. Staff members may see the foster parents on a daily basis and have little to no contact with biological parents. Staff members may also have strong feelings about the circumstances that led to the foster care placement, and those feelings can be a barrier to supporting the biological parents. Training and supervision provide opportunities to help staff members overcome these obstacles, dispel stereotypes, and recognize their critical importance in the long-term goal of family reunification.

**PROGRAM VOICES**

*Teachers in the center-based program keep journals of the children's activities and achievements to share with parents as children make the transition back to living with their biological families. Staff members also make regularly scheduled phone calls and intermittent home visits to help facilitate the transition.*

**San Diego, CA**

# Suspecting and Reporting Child Abuse and Neglect

One of the most difficult and sensitive issues confronting professionals who work with children and families is the suspicion of child abuse or neglect. Staff members may have fears or concerns that they are mistaken about the signs of abuse or neglect, or they may have concerns that parents will be come angry with the staff member or program or that parents will perhaps further injure the child.

Every program needs a crisis protocol to help staff members know when to report suspected child abuse and neglect. The crisis protocol should include the following:

- **Designated people to consult with and procedures to follow—** The decision to report should never be made alone.
- **Documentation procedures—** Documentation is critically important and should include a record of observations and interactions.
- **Reporting procedures—** Protocols should be established to decide (a) whether and when parents should be involved in the reporting process and (b) who should be involved in the reporting.
- **Follow-up—**Procedures should be identified for following up with the reporting agency to learn the outcome of the report.
- **Confidentiality procedures—** Protocols about protecting family privacy should detail the kind of records to keep, for how long, and who has access to the information.

If a child is removed from the care of his or her parents, the child benefits greatly if the EHS program can arrange with the CWS agency to keep the child in the EHS program to promote continuity and consistency. Programs need to consider how to ensure the child's and the staff's safety, how to support parents who have had their child removed, and how to work effectively with the foster family. Strong collaborative relationships with CWS are essential.

When a report leads to an open case in which the child and family is involved with CWS but the child is able to remain in the home, it is equally beneficial for EHS programs to work collaboratively with the CWS agency. Often, the family's involvement in EHS provides additional services that the child welfare agency may not be able to provide. And the relationships that have been established in the EHS program provide a foundation to strengthen family partnerships during a time of crisis and high level of need.

Staff members should know that laws are in place to protect those who report in good faith, and although it is true that parents may become very angry or leave the program, it is also true that some parents may be desperate for help and be relieved that someone has noticed and taken action.

Program leaders have the responsibility for ensuring that staff members have an appropriate outlet for the intense feelings they will likely experience after making a report of suspected abuse or neglect. Staff members may need extra emotional or practical support to continue to function well on the job. Program leaders set the tone for how this type of support is provided. Practices such as reflective supervision recognize and honor the importance of relationships in all aspects of the work.

**PROGRAM VOICES**

*We found that if the CWS worker accompanies the EHS home visitor on the first visit with the family, it helps the family realize how EHS can help meet the requirements of their CWS case plan and that increases their motivation to participate in EHS.*

**Marion, IN**

# Partnering With the Child Welfare Services System

EHS and CWS are two large systems, and each has its own history, philosophy, training, goals, and regulations. EHS programs can be successful providing services to children in the child welfare system only to the extent that they are able to work effectively with that system. Individuals working in each system need to understand the other and recognize the strengths that each can bring to working collaboratively for healthy child and family outcomes. Strategies for collaborating include the following:

- Planning and offering joint training sessions to learn more about each system and the specific roles of various staff members
- Inviting child welfare workers to EHS workshops on child development and other relevant topics
- Offering space for child welfare workers to meet or conduct trainings
- Inviting child welfare workers with children enrolled in EHS to use EHS facilities for parent–child visitation or other family meetings
- Establishing formal memoranda of understanding to coordinate referrals and other services
- Gaining familiarity with referral procedures
- Providing service coordination, when needed, and ensuring that staff members from each entity jointly participate in meetings about individual children
- Establishing communication systems with confidentiality guidelines to enhance information sharing
- Joining community groups or boards related to child welfare issues
- Forming relationships between the two agencies at both the management and direct service levels to ensure support for collaboration among agency leaders and to enable those working directly with the children and families to have working relationships

**PROGRAM VOICES**

*Our partnership with CWS has led to benefits for both systems. For EHS, we have more referrals, a greater awareness of our program, and better access to CWS as a resource. The benefits for the child welfare agency include access to the resources EHS has to offer, the continuity that EHS brings, and more services they can offer families.*

**Sedalia, MO**

# Supporting Staff Members

The maltreatment of a child, especially one so innocent and helpless as an infant, evokes strong emotional reactions from staff members. Some common reactions might include denial ("No one could do that on purpose."), anger ("If I ever see who did that to this baby, I'll …"), and depression and despair ("This world is a terrible place. How could this happen to a child?"). Teachers may have a strong desire to "rescue" the child, wanting to take him or her into their own home. Staff members may also feel frustration and anger toward "the system" if professionals appear to be not acting in the best interest of the child or when policies are counterproductive, for example, when barriers prevent information sharing that could benefit the child.

**PROGRAM VOICES**

*Our EHS program has a strong mental health component. The infant mental health specialist meets with EHS and CWS staff on a monthly basis to discuss the needs and progress of each family, and is available for phone consultation at any time. He is seen as a neutral person, so both EHS and CWS staff can bring up issues and can problem solve without feeling threatened.*

**Lake County, OH**

Supportive, or reflective, supervision provides staff members an opportunity to express and understand these normal reactions and work through them with a trusted supervisor in ways that enable them to continue working effectively with children and families. Reflective supervision occurs on a regular basis and involves a collaborative relationship between staff member and supervisor



to reflect on their work. Ideally, staff members have a regular, scheduled opportunity to speak candidly with their supervisor about their work, to develop self-awareness, and to get the support they need to do their job well.

The relationships that staff members build with children and families can, and do, make a tremendous difference. Staff members may not be aware of the power of their words, for example, how an offhand comment to a parent who is dropping off his or her child at the center in the morning can stay with that parent throughout the day. Similarly, helping a harried parent disengage from a clinging toddler with compassion, empathy, and respect helps the parent feel cared for and supported rather than judged as doing a poor job. These positive feelings can, in turn, help parents have more compassion and empathy for their child's struggle. Even brief encounters with parents provide opportunities for listening, sharing information, providing resources, and showing respect and concern for families and can combat the risk factors for troubled parent–child relationships such as isolation, lack of support, lack of information related to infant development and behavior, and limited strategies for positive discipline.

Perhaps nothing is as divisive and alienating as the mistreatment of a child, yet these instances are when children most need the adults in their lives to coalesce and strengthen the fragile bonds that will make healing possible—whether these bonds connect their troubled parents or connect children to others who have been entrusted with their care. The complex web of relationships that a child in the child welfare system encounters—foster parents, social workers, child protective services workers, and other legal representatives[1] as well as the existing relationships with biological parents, extended family, and child-care providers—offers the potential either to unravel and divide or to hold that child firmly in the center of a strong, collaborative system of support and care. The section that follows describes the efforts of three EHS programs and their partnerships with local CWS agencies to strengthen the support made available to vulnerable children in their communities.

**PROGRAM VOICES**

*EHS staff members play a critical role. And what they do is such a gift to children and families. The staff who are enthused and passionate about what they do make such a difference for these families.*

**Tulsa, OK**



[1] *Children in the child welfare system may be assigned a guardian ad litem, which is a legal representative appointed by the court to advocate for and protect the best interests of the child.*

# The Early Head Start–Child Welfare Services Initiative

In October 2002, the Head Start Bureau initiated a demonstration project to award grants to 24 EHS programs to promote and increase the collaborative partnerships between EHS programs and their local CWS agencies. See Appendix A for a list of participating programs.

Each EHS grantee, in collaboration with its local CWS agency, developed a program to meet the needs of children and families who are within the child welfare system in their community. Local and cross-site evaluation are part of the project. Each of the EHS–CWS grantees is expected to conduct its own local evaluation and is being provided with evaluation training and technical assistance, as necessary, through James Bell Associates, the evaluation contractor *(see Local Evaluations of Child Welfare Services Projects section in this paper)*.

Each program is unique and varied in their goals and services. The projects include, for example, services to pregnant women in the child welfare system; children who are at-risk for abuse or neglect; children whose parents have developmental delays; families whose children live with them but who are receiving services from a child welfare protection agency because of neglect, abuse, or both; and children whose parents are in substance abuse treatment. The following sections describe several examples of participating EHS programs and their CWS partnerships. After each program description is short vignette of an actual child and family who have benefited from the program.[2]

## FAMILY SERVICES OF GRANT COUNTY, MOSES LAKE, WA

This program is designed to help children in foster care by focusing on family reunification. Biological parents spend 3 days a week in a center-based program learning parenting skills, and they participate in monthly home visits with their child. Families have access to mental health services and other community resources.

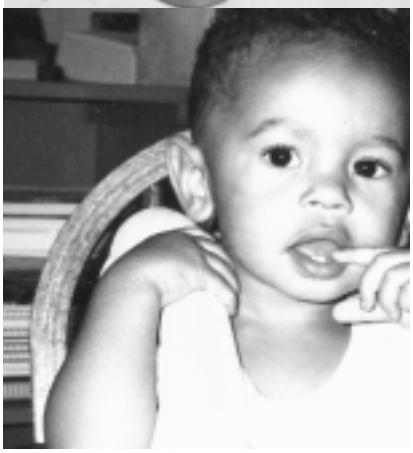
**Program Description**

Family Services of Grant County was formed in 1983 by a grass roots citizen's group to assist teen parents to nurture their children and remain in high school. Since that time, the agency has continued to meet community needs by expanding existing programs and developing new services. The agency became the grantee for the Family Planning program in 1993 and Head Start in 1996; in 1998, the agency began delivering EHS. Today, the program serves 169 Head Start children and 56 EHS children in five rural communities. Moses Lake, the largest community, has a population of approximately 16,000. The remaining communities,

including Quincy, Soap Lake, Ephrata, and Grand Coulee, all have populations of fewer than 7,000.

Grant County has a significant number of issues that place children at risk of child abuse, neglect, and subsequent placement into foster care:

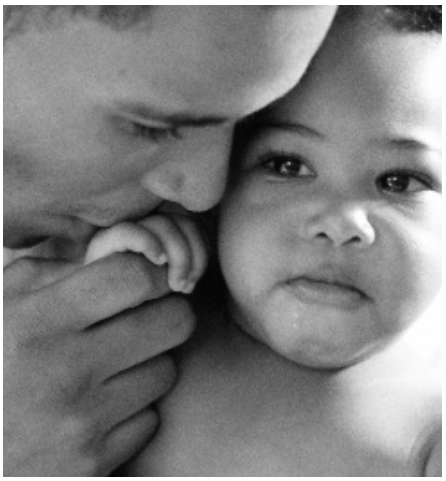
1. The birth rate in Grant County is high. At the time of writing the grant for the EHS-CWS initiative, Grant County's birth rate was 95.2 per 1,000 as compared with Washington State's birth rate of 62.7 per 1,000. Also, the number of births to mothers ages 10 to 17 years was more than double the state rate. Abortion and adoption rates are comparatively low, and proportionally more young mothers raise their babies.
2. Poverty in Grant County is high; 18.7% of all children in Grant County live in poverty. Over 30% of working families with children in Grant County qualify as low-income. Agriculture provides the largest source of employment in the county and draws to the area a significant number of undocumented laborers who do not qualify for needed services.
3. Domestic violence arrests have steadily increased over the past decade. In 1998, the state rate was 7.29 per 1,000, and Grant County's rate was 11.86 per 1,000.



4. Alcohol- and drug-related arrests for children ages 10–14 in Grant County are more than twice the state rate.
5. Violent crime arrests among the same age group are also twice the state rate.

In addition to the bleak economic picture and high birth rate, rural central Washington has extremely limited resources for families in crisis. With Grant County's high birth rate, poverty rate, and violent crime rate, more and more children are at risk each year, and no intervention services have previously been available.

In response to this situation, Family Services of Grant County and the local CWS program came together to develop the PACT (Parents and Children Together) collaboration project. This EHS–CWS collaboration is a partnership between Head Start's Pregnancy to Three program and Washington State's Child and Family Services (CFS) to provide specialized services for children in foster care. The project is able to serve eight children, their parents, and their foster parents in the Moses Lake area. Qualifying children and families are referred to the project through CFS.





[2] *The names and indentifying information of all parties have been changed to protect confidentiality.*

PACT's goal is to support the reunification of children with their biological families. The project staff members create a positive, secure, and educationally rich environment for children to meet their needs for nurturing, physical care, and learning. In this secure environment, staff members extend a partnership to the children's parents to increase their knowledge and skill in parenting. The project assists parents to improve their ability to understand their child's verbal and nonverbal cues and effectively meet their child's needs. To accomplish PACT's goal, Family Services PACT employees build relationships with the children's biological parents, foster parents, social workers, and child-care providers. The PACT class is structured to welcome biological parents, foster parents, and other providers at any time. In their efforts to ensure consistent care for each child, staff members also meet with or routinely contact these important people in the child's life. PACT offers a neutral place for those who love and care for the child to work together in the child's best interests.

The children participating in PACT meet 3 days per week—Tuesday, Wednesday, and Thursday—for 7 hours each day. Transportation and meals are offered to parents who desire to take part in the class. Parents are informed at the outset that regular written reports are made to CWS describing the quality of their participation and observations of their interaction with their child. Each parent has the opportunity to read these reports and provide input before the reports are sent to CWS. This initial intervention enables the parent to grasp a crucial concept—that PACT is a place to develop and demonstrate their skills. This intervention is the parent's opportunity to demonstrate that he or she wants to, and has the ability to, parent his or her child. At first, parents are sometimes angry because they do not have their children, and they blame PACT. But, eventually, they come to understand that PACT offers them not only daily opportunities to see their child but also a way to demonstrate to the state that they can improve the way they care for their child.

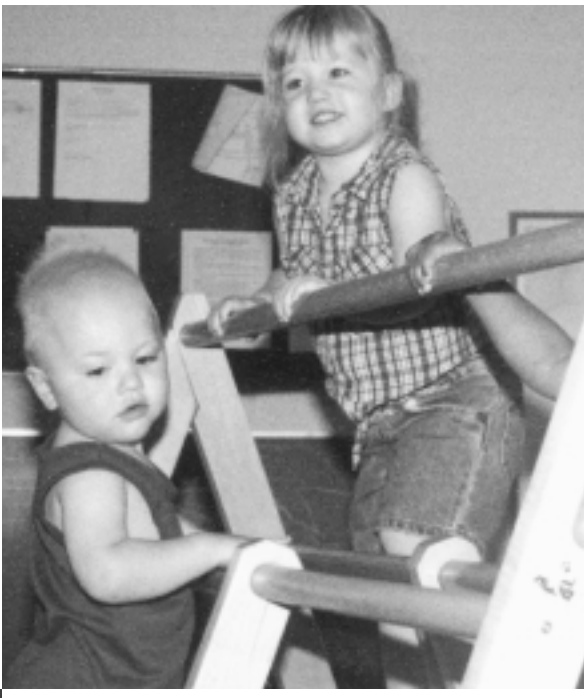
**PACT in Action**

Kaylee was 5 months old when she was referred to the PACT program in the summer of 2003. She displayed signs of developmental delay and some physical characteristics consistent with fetal alcohol syndrome (FAS). Her physician had scheduled a variety of diagnostic tests to discover more about the delay and the abnormalities of her appearance. Child and Family Services had, at her birth, removed Kaylee from the care of her parents, Will and Stacey, and had placed Kaylee in foster care because of concerns with respect to parenting skills and the lack of a safe and stable home environment. Stacey also had a developmental delay caused by in utero exposure to drugs and alcohol. In addition, Stacey had a history of abuse and neglect in childhood and was herself a recipient of CWS as a child. Kaylee's father had a history of alcohol abuse as well as numerous undiagnosed and untreated health complaints. Neither parent was employed, and they had no transportation because Will's license to drive had been suspended.

Kaylee's parents were very cooperative with their social worker and with PACT staff members on enrollment. They verbalized and demonstrated their willingness do whatever they could to be able to have their child returned home. PACT's individual support to the parents taught them how to observe Kaylee's cues and offer appropriate caregiving responses. Daily parent training provided information on safety, appropriate nutrition, child development, parenting, and other relevant topics. In addition, PACT's daily observations and weekly reports to CWS provided regular feedback that helped Will and Stacey improve their skills.

Stacey attended regularly, but Will had occasional difficulty participating because of his health problems. He was motivated to attend, in spite of the challenging PACT schedule (3 days a week for 7 hours each day), by the opportunity to spend time with his daughter. The chest pains and stomach problems that Will regularly experienced made participation more difficult; for example, when the group would go for a walk, he would often ask to be excused. It was obvious to the staff members that Will was suffering from some physical problem, so the staff members and the social worker worked with CFS to obtain a medical assessment. The doctor recommended that further diagnostic evaluation be done and provided medication to manage some of Will's symptoms.

Stacey's developmental delay caused difficulty for her with information processing. For example, if she was focused on a conversation happening within the group, she would not be able to notice and acknowledge Kaylee's cues. She also required very specific teaching about safety and appropriate routine care for Kaylee. Furthermore, once she learned best practice guidelines, she had difficulty in being flexible as Kaylee grew and developed more independent and challenging behavior. Staff members accommodated



these needs by individualizing their instruction and support for Stacey.

Will and Stacey were elected as Policy Council Representative and Alternate, respectively. In addition, they were very active as leaders on the Parent Center Committee. Last September, Family Services invited them to participate in a mental health conference panel to share with other programs how PACT has had an effect on their lives. Stacey described, "In spite of my disability I can feed her, I can change her, and I can give her a bath." Will described how he gets down on the floor with their daughter, in spite of his health problems, and how he sings silly songs and reads to her. "I read her cues, and she reads mine," Will said of his baby girl. "I don't think that would have happened without PACT." These successes and opportunities for leadership roles helped to encourage the parents, even in the face of setbacks and challenges.

Several days before the mental health conference, Stacey and Will were informed that the plan for unsupervised visitation was being eliminated because it was reported that Stacey had been seen purchasing alcohol. In addition, Will suddenly had criminal activity show up on his background check. In spite of these unforeseen problems, Will and Stacey, although disheartened, continued to make efforts to prove themselves as parents. Both continued their participation in PACT and displayed their commitment to their child.

Later, it was established that the criminal activity was a result of identity theft and that alcohol use was never substantiated. Eventually, unsupervised visitation was again planned and, then, reunification. After Kaylee's return home, Will began complaining less about his

physical symptoms, and his affect was brighter. He became highly motivated to regain his driver's license and find work. Although he had to pay a substantial fine and suffer some rejections for employment, eventually he regained his license and was able to obtain work as a cabulance driver for individuals who need medical care. He later commented that perhaps some depression had been exacerbating his symptoms.

Through this program, Will and Stacey were able to prove to the state, and ultimately to the courts, that they were capable of parenting. Will and Stacy believe they and their daughter have benefited from PACT. To be better parents, both Will and Stacey overcame the challenges that their disabilities presented. Will is the custodial parent and must be available to supervise Kaylee; when he is working, Kaylee goes to daycare. CWS staff members have expressed that they believe these parents would not have been able to be reunified with their child if it had not been for PACT. Although Kaylee qualified for special services because of a motor delay, it was eventually established that Kaylee's delays were not a result of drug or alcohol effects.

In its work with families, Family Services of Grant County has learned to define its program as a "proving ground," while still maintaining a family support and strengths-based perspective. Several keys to this organization's successes include intensive center-based services with an integrated mental health component; strong relationships with parents, foster parents, and social workers; and firm, clear boundaries. Parents are aware that the PACT program offers them an opportunity to prove themselves by showing their capability and by improving their parenting skills and their responsiveness to their child.



## CROSSROADS: LAKE COUNTY ADOLESCENT COUNSELING SERVICE, MENTOR, OH

An infant mental health perspective is infused throughout the Crossroads program. Home visits focus on helping parents read their child's cues and respond to their needs.

### Program Description

Crossroads is a private, nonprofit corporation in Lake County, Ohio, which provides a comprehensive continuum of mental health and chemical dependency services exclusively for children, adolescents, and their families. Crossroads Early Head Start (CEHS) program was developed

in 1998–1999 and is in its sixth year of program operation. The CEHS program is founded in a relationship-based infant mental health model of service, recognizing two important concepts: (a) everything that occurs for the child happens in the context of relationships and (b) the "parallel process" that occurs in the relationships between the parent and infant, between the child-care provider or other caregiver and infant, between the parent and child-care provider or other caregiver, between the home visitor and parent or other caregiver, and between the home visitor and supervisor hold special significance.

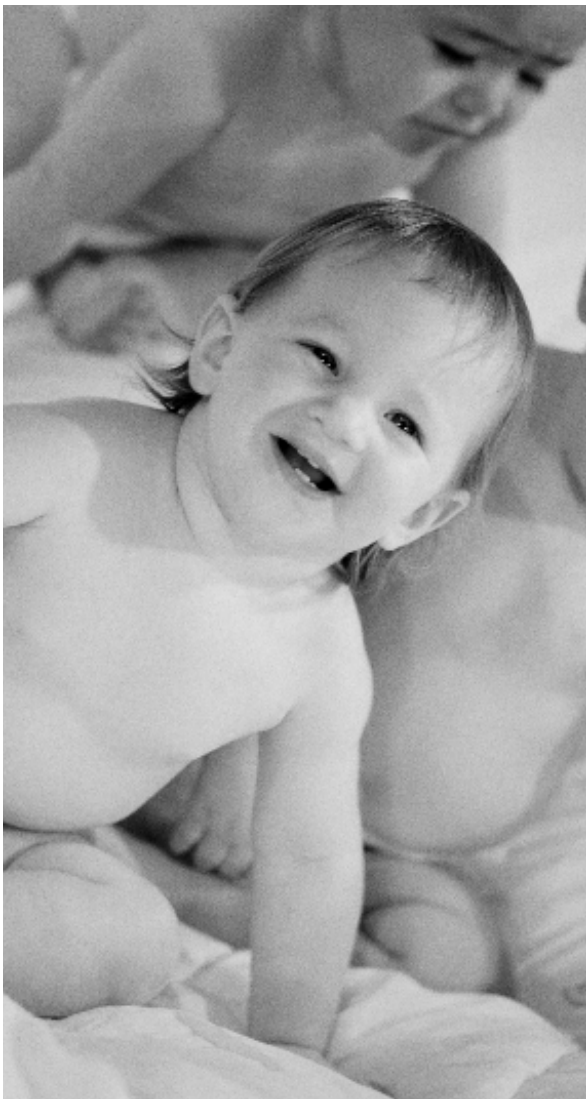
In January, 2003, CEHS and Lake County Department of Job and Family Services (LCDJFS) initiated a joint planning and training process to prepare for the CWS initiative. Staff members from LCDJFS met with CEHS staff members to orient them to the child welfare system, the variety of programs at LCDJFS, and the processes and procedures involving families in the child welfare system. Both programs participated in an orientation to CEHS and in a joint training with respect to infant mental health. The Crossroads infant mental health specialist provided the training for staff members from both agencies to ensure that both agencies would be equal partners in all aspects of the project. Involving an infant mental health expert was critical to promote an effective partnership between the agencies, provide reflective supervision with the service providers, and promote community training and development in the area of infant mental health. We began providing services to families in March 2003.

CEHS–CWS is funded to serve 10 children who are involved in the child welfare system in either foster care or protective supervision. Parent participation is voluntary. Parents are usually court ordered to participate in a parenting program but are not obligated to attend any specific program. Since the inception of the program, a total of 23 children have received services and all openings have been filled consistently. Families receive one or more home or supervised visits per week that last from 1 to 2.5 hours per visit. The number of visits is flexible to meet the changing needs of the family. Visits with parents have taken

place in the home, at a relative's home, during supervised visitation at LCDJFS, in the county jail, at a neutral site in the community such as a restaurant, at the daycare center, at the site of the Early Intervention service provider, and during supervised visitation at CEHS.

Maintaining a flexible approach to providing service is an important contributing factor to the success of the project because it enables project staff members to meet changing needs of the family and the case plan. Strong emphasis is placed on supporting the development of relationships between the children and their biological parents and other caregivers as well as on providing continuity for the child among all caregivers. Services are provided to biological parents, other relative caregivers, foster parents, and daycare providers as the project provides the comprehensive services of the EHS program and supports continuity of caregiving for the child. An initial infant mental health assessment includes an Indicators of Attachment screening, a Temperament Assessment, and administration of the Functional Emotional Assessment Scale for children 7 months–3 years. In addition to weekly home or supervised visits for the child and parent (or parents), families are able to participate in socialization opportunities, which include weekly playgroups, educational programs such as a Health and Safety series, and Family Celebrations, which are provided twice annually. The CWS initiative provides transportation through the public bus system as needed. Parents have the opportunity to participate in family partnership activities and receive a monthly calendar of family programs. They also receive a monthly family newsletter to which they can contribute recipes and through which they share parent pride with respect to their children's accomplishments, and they participate in parent surveys and elections. Parents can also participate in the EHS Policy Council and Parent Committee.

A strong partnership between CEHS and LCDJFS is critical to the success of the project and is based



on relationships that have developed over time between participating staff members from both agencies; frequent communication between the service providers from both agencies; joint meetings with the family initially and as needed to clarify roles and the communication process, review the CWS case plan, and to address family needs; and monthly 3-hour meetings for case review and reflective supervision that are attended by the service providers from both agencies, the supervisors, and the CEHS infant mental health specialist. The infant mental health specialists provide regular progress letters to LCDJFS and the court system with respect to the family's participation in the EHS program, progress on family goals, and recommendations. Participating staff members from both agencies worked together to develop a logic model and outcome measures for the evaluation of the project as well as to participate in semiannual focus groups to provide feedback and evaluate the progress of the project.

**CEHS–Child Welfare System in Action**

Marcy, a 42-year-old single mother with a long history of alcoholism and mental health issues, was referred to the program after the birth of her only child, Jessica, who was born after having been exposed to alcohol during the prenatal period and who tested positive for cocaine at birth. Jessica was diagnosed with failure to thrive and had significant delays in motor development and speech–language skills. She eventually needed a surgically inserted feeding tube to promote weight gain and to provide the nourishment necessary for brain growth and overall development. Jessica also had a tethered spinal cord, which is a closed type of spina bifida. She underwent surgery to correct this problem.

Marcy and Jessica were involved with the local CWS agency once they were discharged from the hospital. When Jessica was 3 months old, she was placed in emergency temporary custody after Marcy became intoxicated to the point of losing consciousness in the presence of the baby. Marcy worked intensively through an outpatient chemical dependency program and with an infant mental health specialist. She participated in regular visitation with Jessica over a 6-month period, after which Marcy and Jessica were reunited. Unfortunately, 6 months after reunification, Jessica was again placed in emergency temporary custody because of Marcy's alcohol use and her neglect of Jessica. Marcy, the



CWS social worker, and the infant mental health specialist met with Marcy's chemical dependency counselor together. Marcy was able to reconnect with her psychiatrist, continue to work with her chemical dependency counselor and with the infant mental health specialist, and again participate in regular visitation with Jessica for the next year. Marcy and Jessica, with much support, have recently attained the goal of reunification. Even with this success, it is clear that Marcy will need ongoing support to address the complex issue of chemical dependency and the demands of parenting.

The infant mental health specialist who was available through the EHS program was instrumental in the successful reunification of Marcy and Jessica. The intensity of services included 1.5 to 5 hours per week of supervised visits, home visits, and visits within the community, including medical appointments and hospital visits. During weekly home visits with Marcy and Jessica, the infant mental health specialist observed their interactions and helped Marcy read her daughter's cues and respond appropriately to her needs. The infant mental health specialist also helped Marcy to arrange for appointments with medical specialists and for hospital visits; to prepare herself emotionally for these appointments; and to explore her feelings—particularly guilt, fear, and anxiety—after these appointments to keep her feelings from interfering with her follow-through. Collaborative home visits were completed with the Early Intervention social worker, the CWS social worker, and developmental therapists as necessary to facilitate discussion of observations and concerns and to coordinate services.

The infant mental health specialist's participation in supervised visits, additional home visits, and coordination with the CWS social worker and other professionals allowed for more accurate assessment of Marcy and Jessica's concerns and needs as well as the opportunity to give honest feedback and maintain open communication with Marcy. The close collaboration with the CWS social worker, therapy professionals, and infant mental health specialist allowed for regular communication and opportunities to compare observations, share professional opinions, and develop a plan of action. The close communication with the foster mother, the CWS social worker, and infant mental health specialist facilitated not only the sharing of medical, developmental, and daily routines with the mother but also direct communication and coordination between the foster mother and the mother.

During the course of the infant mental health specialist's work with Marcy and Jessica, all involved learned a variety of lessons:

- Strong relationships with the family and all parties involved in the providing of services are essential to success.
- Services for high-risk families who experience frequent crisis periods should be delivered over time to provide ongoing support that helps the families stabilize and make new progress.
- Respecting, supporting, and collaborating with foster parents and relative caregivers, who develop a strong protective bond with the child, can be a resource or a barrier to reunification of the child and biological parent.
- Ongoing intensive involvement with high-risk families is necessary to make informed recommendations to the CWS and the legal system with respect to case planning, ongoing monitoring of concerns, and the reunification process.

## CHILDREN'S THERAPY CENTER, SEDALIA, MO

The EHS–CWS worker completes two or more home visits per week and monthly socialization groups to enhance parent–child interaction. EHS is helping to develop a protocol for CWS workers to use that will enhance continuity for the child when removing a child from the home.

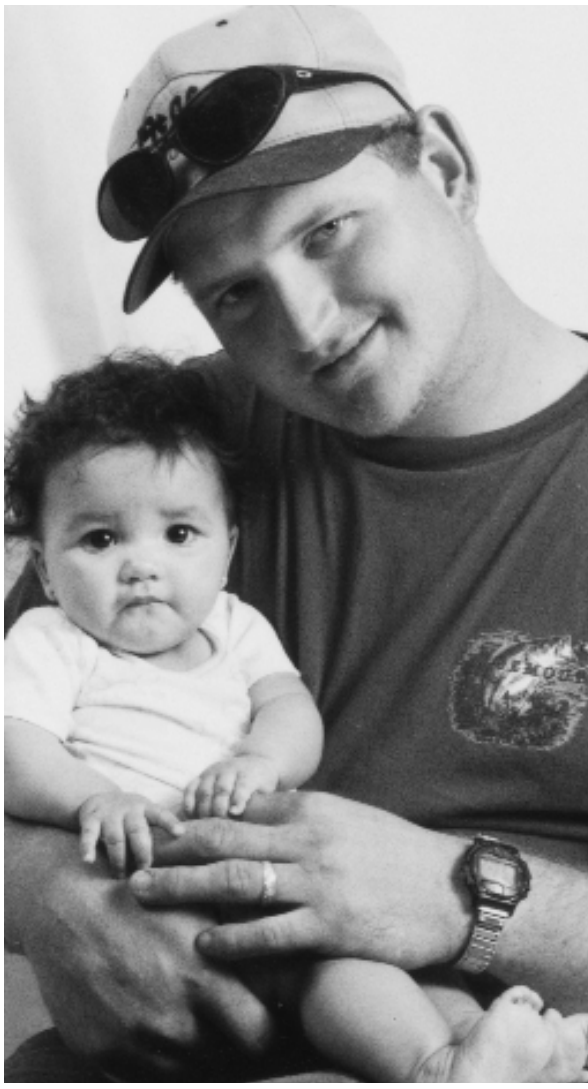
### Program Description

The Children's Therapy Center EHS–CWS project is located in a rural community in central Missouri. Located in a county with a population of fewer than 40,000, this EHS program is funded to serve a total of 131 infants, children, and pregnant women. The program has multiple options for enrolled families. Fifty of the families receive home visiting that focuses on pregnant women and

families who are not yet in the work force. Thirty-four children in families with parents who are working or in school receive full-day, full-year, center-based care at two sites that the program owns and operates, and an additional 42 children receive care through child-care partnerships. Finally, the program is funded to provide services for five infants and toddlers in its CWS project.

Before the Children's Therapy Center EHS had the opportunity to apply for EHS–CWS funding, its EHS program had learned from experience what the national EHS research (Mathmatica Policy Research, 2002) later revealed—that there was a population of EHS-eligible families who were not benefiting from EHS. The Children's Therapy Center EHS had experienced failure with some families who faced multiple challenges, and staff members were struggling to understand these failures. With the announcement of the opportunity for this project, staff members saw the chance to provide services that were extremely intensive and flexible and that might come closer to meeting the needs of the families who previously had not been reached.

The center began this project with strong collaboration between CWS and EHS. Joint planning meetings between the two offices led to an application that brought not only the strengths of both programs to the project but also a foundation of collaboration that continues to support their work. This planning led to two critical aspects of this EHS–CWS program. The first aspect, which staff members were hoping would lead to success, was a small caseload, which would allow great flexibility in meeting the needs of families with multiple challenges. Given what the program had learned from working with EHS families who faced multiple challenges and from the CWS knowledge base of families receiving their services, the EHS–CWS project chose a flexible, intensive home visiting model in which the EHS–CWS home visitor would have a caseload of five children.



The second critical aspect of the EHS–CWS project was the co-location of the EHS–CWS staff member, which was intended to support the intended system outcomes. This EHS–CWS home visitor is an EHS



employee, but her office is located at the CWS office. The decision for this physical arrangement was born out of the strong collaboration between the local CWS office and the center's EHS program as well as out of a desire to achieve systems outcomes along with the family outcomes that were intended through the project. This co-location of staff has led to many opportunities to take collaboration to even stronger levels in the implementation of the project.

#### Children's Therapy Center in Action

The following brief description of a child and family enrolled in this EHS–CWS project will highlight how the project's collaboration works.

Joey came to the attention of the CWS office because of the unsanitary conditions in his home. He had been removed from his home twice before involvement in this project and, at the age of almost 2 years, was in foster care at the time of enrollment in EHS–CWS. His father, Sam, had been his primary caregiver; an aunt and two teens made up the rest of the household.

Having the project's EHS–CWS home visitor located at the CWS office provides great convenience for the referral process. In ongoing meetings between EHS and the CWS county director and supervisor, staff members created an eligibility checklist for this project. This checklist and other project information is shared with CWS caseworkers. Therefore, when Joey entered the CWS system, those caseworkers knew to talk with the EHS–CWS home visitor about a referral. This time, the project had an opening, and Joey and his father were enrolled.

A great benefit that the flexibility of such a small caseload offers is that the project's EHS–CWS home visitor can provide very intensive services with a family. In this case, the home visitor provided frequent and intensive home visits with Sam. Early discussions with Sam centered on his meeting the criteria for reunification set by CWS and his understanding of what would be needed to provide Joey with a safe and healthy environment. Sam made a decision and set a goal to move out of his current living situation, which he understood was chaotic and was interfering with Joey's safety, and move in to a new location with his girlfriend. He also got a job and has maintained employment for more than 5 months. Currently, the family is not dependent on food stamps, cash assistance, or community assistance.

A second early focus of the home visitor's work with Joey was to supervise visits between Joey and Sam. Through a collaborative agreement with CWS, she has been able to supervise significantly more father–son visits than the CWS system alone can support. This relationship-building work between home visitor and father as well as between father and son led to smooth preparation for Joey's transition back into his home. The home visitor and Sam discussed Joey's possible responses not only to moving back with his father but also to moving into a new household.

A regular aspect of the project's collaboration is that the EHS–CWS home visitor attends all family support team meetings. She takes an active role in the case, bringing her perspective of the situation to the group and keeping lines of communication clear. In this case, the home visitor's level of support for Sam and Joey changed the predicted outcomes of the case and affected the Juvenile Office's opinion of Sam's success. The resulting trial placement of Joey back into his father's new home has been monitored and facilitated by the EHS–CWS home visitor.

In her ongoing work with Joey and Sam, the home visitor has learned that Sam himself was a product of the CWS system during his own childhood. Her awareness of the potential effect of this history has helped focus her work to support

Sam's determination to be his child's father in both fact and practice. They have focused on child development and appropriate expectations as a means of further support for Sam and Joey's relationship. Additionally, she has encouraged Sam's communication with CWS and other monitoring agencies to strengthen his skills in being his child's primary advocate. The family continues to set goals and have now initiated consultation with the home visitor on more mundane topics—potty training and discipline.

In the process of transformation led by the family, it is heartening to see the focus of their work shift from meeting criteria for reunification to topics that typically consume all parents of toddlers. Through flexible, intensive, collaborative services—and a relationship built on trust—the EHS–CWS project has supported a change in the predicted trajectory of Sam and Joey. Where history and expectations predicted failure, we now see a path leading to success.

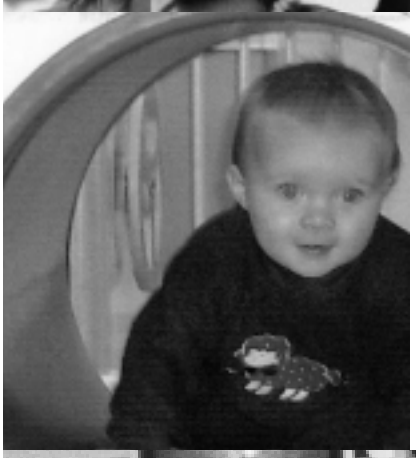
## LOCAL EVALUATIONS OF CHILD WELFARE SERVICES PROJECTS

An important component of the EHS–CWS initiative is the local evaluations. The 24 EHS programs participating in the initiative designed local evaluations to assess how they are implementing their EHS services for children and families involved in child welfare. Agencies were able to design a program that would meet the specific needs of their families and communities and, at the same time, assess a variety of ways to work with families as a strategy to learn about what is most effective. Agencies developed their own "theory of change," or how they believe their services can have an effect, which guided their program models and their local evaluations.

James Bell Associates (JBA) provides technical assistance to support the programs in their evaluation efforts. The role of JBA is to help build the capacity of agencies to conduct a local process-and-outcome evaluation. For the most part, agencies do not have the resources to contract with a third-party evaluator; thus, the grantee agency staff members are performing a self-evaluation of their programs. JBA provides assistance to grantees through the following:

- Providing site visits
- Conducting workshops at conferences
- Offering individual consultation during conferences or through telephone calls
- Reviewing evaluation plans and data collection instruments
- Collecting progress reports
- Providing written comments and feedback

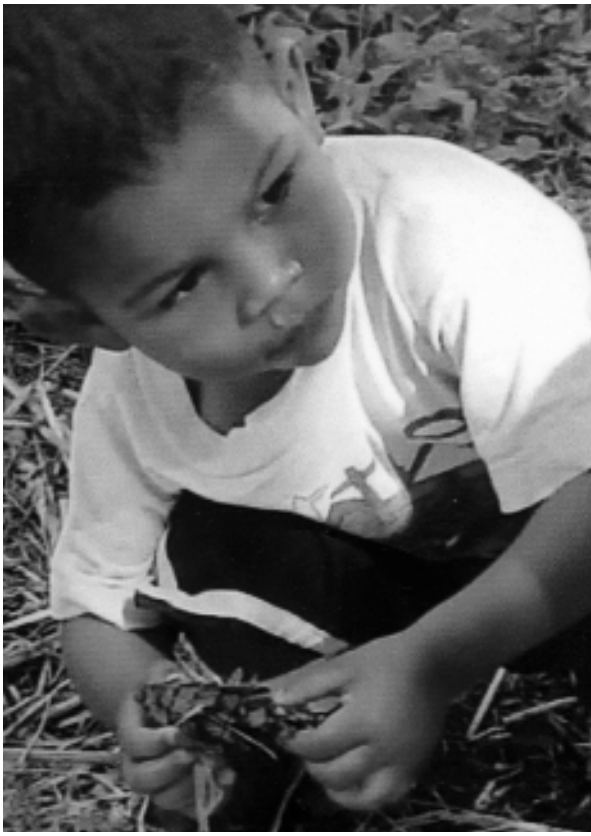
JBA also helps grantees to structure the type of ongoing data they submit by preparing semiannual reports that include suggested topics and formats for reporting outcome data and by synthesizing the findings from the grantees' progress reports. The primary emphasis on the local evaluations has been (a) to implement a strong "process evaluation," which provides information the programs



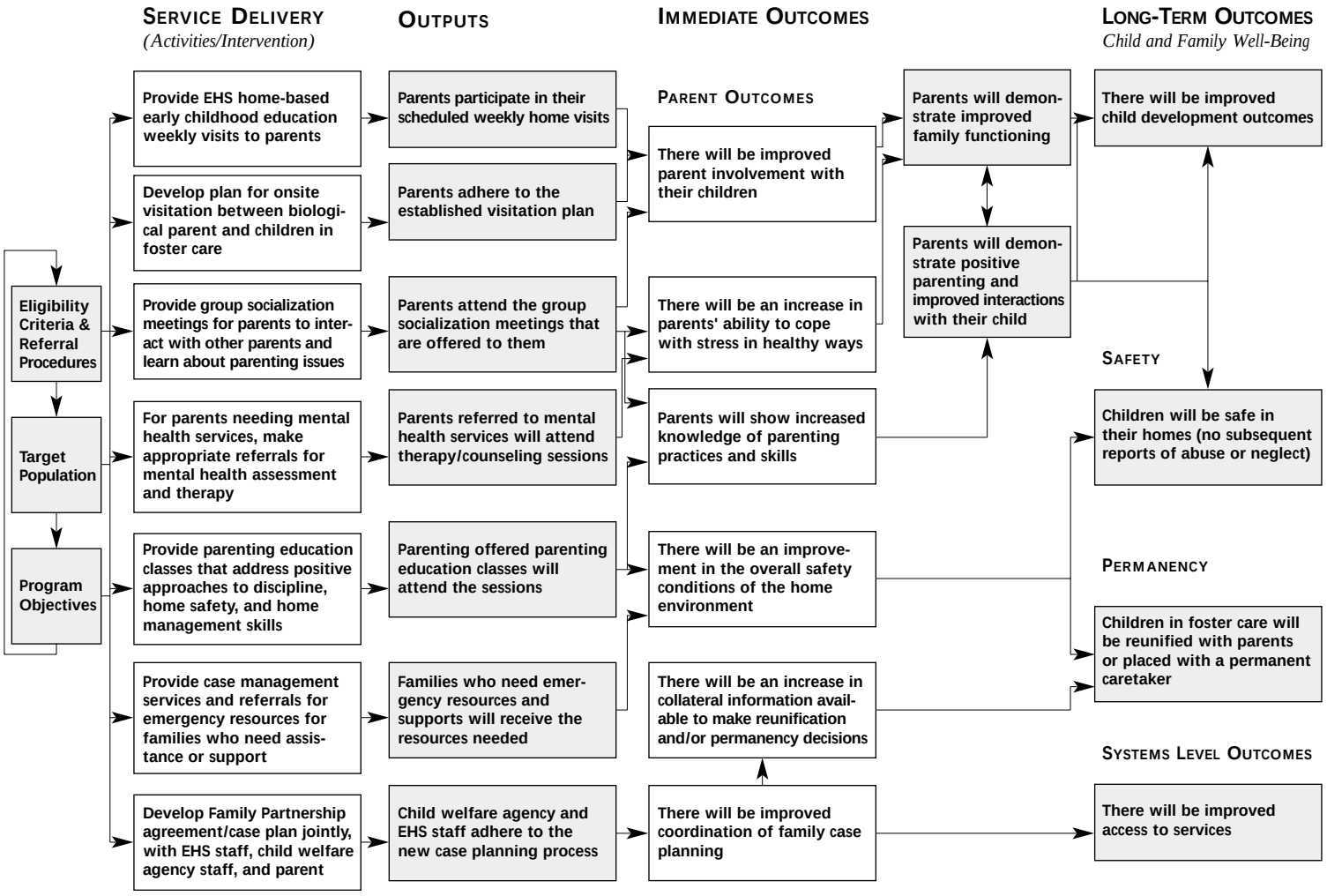


can use to help improve program services; and (b) to increase knowledge about not only the factors that contribute to successful EHS–CWS partnerships but also the challenges that exist in bringing the two systems together. A number of the local evaluations are also exploring child outcomes in the areas of safety, permanency, and well-being.

Each agency has a site-specific evaluation plan that identifies its theory of change. A number of agencies are addressing the same outcomes using similar measures. JBA's initial work was focused on ensuring that all agencies had developed a "logic model" to guide their evaluation activities. In addition, JBA developed a cross-site evaluation framework (see box "Early Head Start Child Welfare Services Evaluation Framework") that identified the program's theories of change, or how different agencies were attempting to have a positive effect on the children and families. This framework helped promote discussion among grantees with respect to the goals that they shared in common and similar change theories they were following in their local evaluations. Through the use of this framework, several agencies gained an increased understanding of the plausible changes to expect as a result of the services provided. These agencies also recognized that they could collect data to address a number of outcomes that other grantees also were addressing, which were appropriate for their own local, theory-driven evaluations.



# Early Head Start Child Welfare Services Evaluation Framework




The agencies implementing a CWS project have made considerable progress in expanding their knowledge about evaluation concepts and in building their capacity to undertake a program evaluation at the local level. This progress is particularly evident with respect to their process evaluations. Several agencies have also examined outcome goals such as improvements in parenting practices, parenting skills and involvement, parenting attitudes, and safety as well as decreased parenting stress.

Through the 24 local evaluations that currently are under way, some important lessons are already emerging with respect to the capacity of agencies to take on evaluation tasks without additional resources or the assistance of a third-party evaluator.

- First, several agencies learned that data collection was a far more labor-intensive and challenging process than they had anticipated. Difficulties were attributed to factors such as parents' reluctance to give informed consent to participate in the evaluation or parents' dropping out of the program and no longer being available to complete data collection instruments. Other programs learned that it was not as

easy as they originally expected to establish a data-sharing agreement with their CWS partners or other community partners, which created delays in their access to necessary evaluation data.

- Second, agencies learned (a) that it takes significant time to train staff members to use data collection instruments that are unfamiliar to them and (b) that there are challenges in getting staff members to use the instruments in a consistent manner. When agencies attempted to recruit volunteers such as graduate students to help them in collecting data, they experienced delays in trying to locate someone with the right "fit" to help with the evaluation. Also, when the academic semester ends, the students often leave school and, consequently, agencies found it was necessary to retrain someone else to assume the data collection tasks.

- Third, a number of agencies that were conducting a self-evaluation found that, even though their knowledge about evaluation and how to implement a local evaluation had been enhanced, their capacity to do so was hindered by the amount of time needed to focus on the evaluation when they also were responsible for overseeing implementation of the program. Being able to focus exclusively on the evaluation was not possible, and often, the evaluation did not receive as much attention because of other pressing issues related to program implementation.

The agencies participating in the EHS–CWS initiative have discovered a number of important factors that contribute to a successful evaluation. These include needing good relationships with families to obtain reliable data; drawing on professional help such as a consultant to help with the local evaluation, when resources permit it; encouraging EHS staff members to develop a receptive and enthusiastic attitude about data collection; limiting the number of data collection instruments to avoid overburdening participating families and staff members; updating children's case files frequently if these are to be used as a data source for the evaluation; and developing evaluation tools, including logic models, early during the project startup period so existing data sources can be identified and decisions can be made sooner with respect to what new data needs to be gathered.



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# Appendix A

## EARLY HEAD START/CHILD WELFARE SERVICES (EHS–CWS) INITIATIVE

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