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Critical Connections for Children Who are Abused and Neglected

Harnessing the New Federal Referral Provisions for Early Intervention

[AQ1]

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This article highlights strategies that link the child welfare, court, and Early Intervention systems to enhance the healthy development of young children in foster care. It spotlights the need for infants and young children in foster care to be referred to the Early Intervention Program (EIP) and outlines the importance of implementing the new Child Abuse Prevention and Treatment Act Part C referral provisions. It outlines the barriers to the EIP for maltreated children and identifies strategies to ensure referral and successful navigation of the EIP. The authors will describe several innovative, collaborative programs that link child protective services, health, mental health, and developmental services and provide cross-system training and funding to facilitate early intervention diagnosis and treatment for young children in foster care. **Key words:** [AQ2]

THE KEEPING CHILDREN AND FAMILIES SAFE ACT of 2003 amended the Child Abuse Prevention and Treatment Act (CAPTA) to require states to refer children younger than 3 who are involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA) (Pub. L. No. 108-36 § 106(2) (A) (xxi)). Parallel language also appears in the 2004 IDEA application requirements (20 U.S.C. § 1400) (December 3, 2004). The referral provisions remove a significant barrier to Part C early intervention services for young children who are abused and neglected. These provisions—which will place many more eligible children within the Part C program—have sounded an unnecessary alarm among some policymakers and providers of the Early Intervention Program (EIP). Yet, strengthening the EIP to effectively screen, evaluate, and serve abused and neglected children is a vital and doable task. It requires EIP professionals to understand the unique experiences and needs of these children; develop new skills to engage and support their parents who may struggle with substance abuse, serious mental illness, and limited cognitive abilities; and forge new partnerships with systems—the courts and child welfare—not traditionally linked to the EIP. Most important, it requires new strategies to harness an array of funding resources for at-risk children to ensure a strengthened and more inclusive system for EIP screening, evaluation, and services.

This article spotlights child welfare trends nationwide, finding that the vast majority of abused and neglected young children are entitled to Part C services. It identifies what new knowledge and strategies EIP policymakers and providers need to identify, assess, and serve these children and describes models that exemplify this doable task.

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EIP ELIGIBILITY FOR ABUSED AND NEGLECTED CHILDREN

Child maltreatment is a leading cause of disability and developmental delay in young children (Jaudes & Shapiro, 1999). Children age birth to 3 are the largest cohort of victims of substantiated abuse and neglect. Among these young children, babies younger than 1 year are at the greatest risk for maltreatment—involved in more than one third of all substantiated neglect reports and more than half of all substantiated medical neglect reports (Administration for Children & Families, 2002). Research confirms that in addition to the trauma of abuse and neglect, 80% of these children face serious risks to their healthy development, resulting from prenatal exposure to substance abuse, and 40% have premature birth and/or low birth weight (Halfon, Mendonca, & Berkowitz, 1995; Silver et al., 1999). These risks are often compounded by parental substance abuse addiction, serious mental illness, and family instability, resulting in disruptions to caregiver relationships and foster care placement (Administration for Children & Families, 2002).

Not surprisingly, abused and neglected young children are far more likely than all other children to have fragile health, developmental delays, and disabilities (Blatt, Saletsky, & Meguid, 1997; Chernoff et al., 1994; Hochstadt, Jaudes, Zimo, & Schacter, 1987; Spiker & Silver, 1999; U.S. General Accounting Office, 1995). Studies find that at least half of all young children in foster care placement exhibit developmental delays—approximately 4 to 5 times the rate found among children in the general population (Juades & Shapiro, 1999; Takayama, 1994). They have growth problems twice that found in the general population (Blatt & Simms, 1997; Halfon et al., 1995). Several programs evaluating young children in foster care have identified significant rates of motor development problems and delays (25%) and language delays and disorders (50%) (Halfon et al., 1995; Hochstadt et al., 1987; Silver et al., 1999). Given these risks, many children who are abused and neglected will be found eligible for Part C evaluation and services under the federally mandated eligibility criteria based on the presence of developmental delay or a diagnosed mental or physical condition that has a high probability of resulting in developmental delay. For the states adopting Part C at-risk eligibility definitions, these children will also be eligible for Part C evaluation because they are at grave risk of having substantial developmental delays if services are not provided. This can be attributed to biological and medical risks, such as failure to thrive and low birth weight, and environmental risks associated with parental developmental disability and parental substance abuse.

Despite their vulnerability, many abused and neglected children are not identified and referred to the EIP. While the slightest sniffle or monthly well-child visit bring other young children to the pediatrician, a primary referral source for Part C, a significant number of abused and neglected children do not receive even basic healthcare such as immunizations, dental services, hearing and vision screening, and testing for exposure to lead and communicable diseases (U.S. General Accounting Office, 1995). And while other young children may be referred to Part C by their parents, many abused and neglected children lack a stable relationship with an adult who can observe their development over time, advocate on their behalf, and consent to services. All too often, the courts and child welfare systems responsible for their well-being have limited knowledge of child development and the EIP. Although child welfare caseworkers are primary referral sources under EI law, research has found that reliance on their assessments of a child's developmental needs is often inadequate—only one third of the problems identified by EIP professionals were reported by caseworkers and caregivers (Silver et al., 1999). Even after these children have been referred to the EIP, they face barriers to evaluation and service provision, resulting

from confidentiality and consent issues. EIP professionals also may be unfamiliar with child welfare procedures and lack experience assessing and engaging parents challenged by substance abuse, serious mental illness, and cognitive limitation.

The federal referral provisions respond to the national indicators confirming the serious risk of developmental delay and disability among maltreated children and findings that these children were not referred to Part C. They require states to develop formal mechanisms that link maltreated children to the EIP. To implement the referral provisions and provide eligible children and their families with their entitlements under Part C, EIP professionals must acquire new knowledge and skills and collaborate with the child welfare and court systems to understand the unique experiences of these children and families.

IMPLICATIONS FOR PRACTICE

Assessing and serving the children

Active parental involvement is the premise of the EIP. Yet, this expectation does not fit the reality of life for most maltreated children. Many do not reside with a biological parent and may be subject to frequent moves in foster care. Thus, they often lack a consistent adult in their lives who can observe their development over time, consent to necessary evaluations and services, or participate actively in treatment plans. Fortunately, Part C permits the appointment of a surrogate parent if an eligible child has no "parent" as broadly defined under the EIP to act on the child's behalf. While the law specifically excludes state officials from acting as a parent, it defines parent to include a legal parent (biological or adoptive), legal guardian, and a person acting in the place of parent such as a grandparent or other relative with whom the child lives and foster parent if permissible under state law (34 C.F.R. § 303.19). Where the child has no identifiable parent, the whereabouts of the parent are unknown, or the child is a ward of the state, the EIP lead agency can assign a surrogate parent for the limited purpose of representing the child in all matters related to the EIP. Under the 2004 IDEA, courts also have the authority to designate the education decision maker (20 U.S.C. § 1415(a) (2) (A) (i)). Although the law bars the state from acting in this role, nothing in the law precludes the foster parent from serving as a surrogate parent (34 C.F.R. § 406).

Abused and neglected young children also differ from other children in their elevated risk for physical, developmental, and mental health problems and inadequate access to health services. Many lack a medical home—a place where their primary health needs are identified and treated by a practitioner who knows them and their caregivers and who can make information available to the EIP and other providers. Given their complicated lives, maltreated young children have more serious mental health and behavioral problems than do other young children. While between 5% and 10% of the general pediatric population has a measurable behavioral or mental health problem, 60% of children involved with the child protection system have mental health conditions that warrant intervention (Jaudes & Shapiro, 1999). Maltreated children often exhibit attachment, mood, and behavioral disorders (Morrison, Frank, Holland, & Kates, 1999). This is not surprising for children in foster care since removal from home can be traumatic, disrupting attachments to caregivers, daily routines, and familiar environments. Maltreated children may also develop maladaptive regulatory patterns in response to abuse and/or neglect that impact their daily living activities, emotions, and relationships with caregivers (Morrison et al., 1999). When abused and neglected children are referred to the EIP, professionals should ensure particular attention to the mental health assessment part of their comprehensive, multidisciplinary evaluation. Practitioners may need targeted training and familiarity with specialized assessment tools (Morrison et al., 1999; Zero to Three, National

Center for Infants and Toddlers, 1994). For example, awareness of the relationship between child maltreatment and disability can lead to better psychosocial assessment, as well as more meaningful intervention on the child's behalf and more targeted training for caregivers (Jaudes & Shapiro, 1999). The lack of consistent primary healthcare, multiple placement changes, and turnover in caregivers and child welfare caseworkers can complicate information sharing and assessment by making it more difficult to obtain reliable, objective reports about the child's medical and developmental history and needs. EIP and child welfare professionals will need formal mechanisms to gather and share information about the children and changes in placement to ensure the provision and continuity of EIP services.

Engaging families

The unique needs and configurations of families of abused and neglected children also present new challenges for EIP professionals. Because of the investigatory nature of child protection services (CPS), biological parents may be wary of overtures by the EIP. They may have concerns about labeling their child or the child's involvement in the EIP being used as evidence of maltreatment. They may perceive the EIP process as further intrusion by the child welfare and court system. Often, biological parents' ability to participate in the EIP process is further compromised by addiction to drugs and alcohol, serious mental illness, cognitive limitation, domestic violence, or extreme poverty (Andrews & Bishop, 1999). It is essential that the EIP embrace strategies to help these parents understand and feel comfortable with the benefits of Part C as a voluntary program separate from the child protection system. Because child welfare caseworkers may be viewed as investigators for the involuntary foster care system, EIP professionals should seek other allies to engage biological parents, including staff from substance abuse treatment and mental health programs working closely with the parent. For parents under court supervision (under court order with children at home or in foster care), judges, attorneys for parents and children, and Court Appointed Special Advocates (CASA) can help explain the benefits of the EIP and secure consents at the earliest possible juncture and facilitate, where necessary, the appointment of a surrogate parent.

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When biological parents are willing to participate in the EIP process, professionals will need to develop enhanced service coordination strategies. Parents of abused and neglected children may benefit from more frequent support, respite care, situation-specific training with concrete practices to accommodate cognitive limitations and mentoring for ongoing teaching.

Working with abused and neglected children—particularly those placed in foster or kinship care—also requires EIP professionals to broaden their view of family to include foster and relative caregivers and develop strategies to manage multiple caregivers. It is critical to engage substitute caregivers to share information about a child's needs and to participate in the EIP. Like biological parents, foster and relative caregivers may vary in the education and skills they bring to parenting. Many face barriers to EIP participation, such as lack of transportation and complicated schedules resulting from the care of several children in their home (Kronstadt, 2000). They too can benefit from respite care, support, and training, and recognition as essential, contributing members of the EI team. In addition, prospective adoptive parents should receive information about the developmental needs, services, and future progress of the children whom they plan to adopt and a continuation of services once the adoption is finalized.

Identifying new partners

EIP professionals must forge new partnerships with systems not traditionally linked to the EIP—the courts and child welfare. They must understand the roles of these systems in the lives of abused and neglected children and their families. Child protection services investigate complaints of abuse and neglect

and make a finding based on the investigation. If a case is substantiated, CPS may provide home-based services to the family or recommend removal of the child from the home. The court is the central decision maker in all child abuse and neglect cases, determining whether a child is placed in foster care or returned home with supports and periodically reviews the placement and case plans for services (Dicker & Gordon, 2000). Court orders can help facilitate connections to the EIP through orders for referral, for sharing of medical and other confidential information, and for parental cooperation. Other new partners might include drug treatment, domestic violence, criminal justice, adult developmental disability, adult mental health, and public assistance programs. Training should highlight the decision-making procedures, timelines, confidentiality requirements, and data collection activities in each system. EIP professionals can benefit from training that offers specific strategies to engage reluctant caregivers, parents who have limited cognitive capacity, and families who struggle with poverty, substance abuse, domestic violence, and/or mental illness. The training curriculum for EIP professionals should include the CPS system and the role of judges, attorneys, and other court players in ensuring the healthy development of abused and neglected children as required by law. At the same time, EIP professionals need to share their knowledge about child development and the EIP with the child welfare systems, the court, and service providers to promote a steady focus on the developmental needs of abused and neglected children.

Formal mechanisms are critical to exchange information about children and families and coordinate services. Examples include written guidelines and standardized forms to refer, screen, and evaluate children, obtain parental consent, appoint a surrogate parent, release information relevant to EI evaluation and service provision, and secure needed court orders. It may also require interagency memoranda of understanding, liaisons, or colocating EIP and child welfare staff to facilitate service coordination. EIP professionals can also partner with other systems such as interagency stakeholder groups and conferences to create informal opportunities for communication and relationship-building.

Identifying funding sources

The Part C and child welfare systems also must work collaboratively to identify funding to serve abused and neglected children and their families within the present EIP. While in an ideal world, Part C funds would cover the administrative and service costs for all potentially eligible children, most states receive inadequate federal and state funds. Some states tap insurance and require sliding scale fees. To avoid creating a 2-tiered EI system—one for abused and neglected children and one for all other children—it is critical that EIP professionals, in collaboration with child welfare systems, harness an array of federal programs and dollars creatively to ensure Part C entitlement for every eligible child. It may require tapping a range of resources to ensure that EIP professionals—not child welfare caseworkers—screen and evaluate all maltreated children to comply with the CAPTA requirement.

In addition to Part C funds, Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program reimbursement can be used to maximize state resources for EI services. Many abused and neglected children not placed in foster care will meet income eligibility for Medicaid or state child health insurance programs. And, nearly all children in out-of-home placement are eligible for Medicaid. All Medicaid-eligible children are entitled to receive EPSDT, a comprehensive benefit that includes screening, diagnosis and treatment services, and outreach. EPSDT permits states to use Medicaid to finance an array of required services that might otherwise be ineligible for Medicaid reimbursement, including early intervention services and developmental screening. At least 27 states have developed EPSDT screening forms for participating providers that target early intervention services such as developmental, nutritional,

vision, hearing, and dental assessment (Perkins, 2002). The U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services has issued specific statements approving EPSDT coverage of many EIP services, including assessment of the child and the child's home life; physical, occupational, and speech therapy; vision and hearing testing, diagnosis and treatment such as eyeglasses and hearing aids; nutritional assessment and intervention; basic living and social skills development; parent skills training; case management; home visiting programs; and transportation costs for the child to services as well as the costs of an attendant to accompany the child where the attendant is not a family member (Perkins, 2002). Courts have found that EPSDT can be a source of funding early intervention services and is required if a developmental condition is discovered by a screen (*Pediatric Specialty Care v. Arkansas Dep't of Social Services*, 2002).

Other federal funds and programs that might be harnessed for early intervention to abused and neglected children and training for professionals are as follows:

- *Maternal and Child Health Program* (Title V of the Social Security Act)—This program provides health services safety net for women and children to assure basic healthcare and can be used for screening, assessments, and follow-up medical care. States also can use Title V funds for special projects of regional and national significance, including training for professional staff.
- *Head Start/Early Head Start*—This program requires grantees to perform or obtain developmental screens and arrange or obtain further diagnostic testing, examination, and treatment for children with suspected disability or developmental delay. It also requires grantees to establish partnerships with Part C and the CPS.
- *Temporary Assistance for Needy Families* (TANF)—If reauthorized, TANF could be a source to promote family well-being. Many states have used TANF to fund preventive programs that reduce out-of-home placement, including assessment, case management, and family instruction (Dicker, Gordon, & Knitzer, 2001).
- *CAPTA*—The newly reauthorized provision contains an increase in funding for state CPS. CAPTA funds can be used for community-based prevention-focused services designed to strengthen families, including interdisciplinary training, building interagency partnerships, identification, screening, evaluation, and respite care.

Additional funding streams that might be explored include Title IV-B child welfare services program and training grants and IV-B Subpart Two discretionary funds under the Promoting Safe and Stable Families Program, Abandoned Infant Assistance Act funds, Title IV-E Foster Care Program funds, Adoption Opportunity grants, and funding programs that support substance abuse treatment and jail diversion program.

REPLICABLE STRATEGIES

National models that link abused and neglected children and their families to the EIP exist throughout the country. These models have developed targeted strategies and training that reflect the new knowledge and skills needed to identify, evaluate, and serve these children and build collaborative partnerships among Part C, child welfare systems, and the courts. Many models have established formal partnerships with written protocols, memoranda of understanding, and out-stationing of EIP and child welfare. All of the models have harnessed Medicaid/EPSDT and other funding resources in creative ways to ensure that eligible abused and neglected children, like all other eligible children, receive their entitled services under Part C.

State strategies

Several states have begun to address the implementation of the new Part C referral provisions for abused and neglected children (see the National Early Childhood Technical

Assistance Center Web site, www.nectas.unc.edu):

- *Massachusetts:* Established in 2001 under the leadership of the Brandeis University Heller School for Social Policy and Management, the Massachusetts Early Childhood Linkage Initiative (MECLI) was the first project in the nation to require that all children younger than 3 be referred from the CPS to the EI system. Funded by federal grants and private foundations, MECLI creates a formal link between the Department of Social Services (DSS) and the Department of Public Health that is mandated to implement the state's EIP. At 3 pilot DSS sites, MECLI coordinators encourage the state's child protection agency to regularize the referral of children younger than 3 to EI and collect data on the referrals. A majority of the children referred have been found eligible for the EIP. As DSS EIP referrals are implemented statewide, MECLI is exploring ways to overcome funding restraints, develop protocols to share DSS service plans and EI eligibility evaluation and service plans, and facilitate interagency data collection and monitoring (John Lippitt, MECLI Project Manager, Lippitt@brandeis.edu).
- *Vermont:* Vermont's Success by Six Initiative is a comprehensive strategy to cut across traditional organizational boundaries to enhance outcomes for children and their families. As part of this initiative, every child born in Vermont receives a home visit, including children involved with the CPS. Children age birth to 3 receive a developmental screening and families at-risk receive extra support. The child protection agency makes computerized, automatic referrals to the EIP, and interagency training is provided for both social services and EI staff. The program is funded through Medicaid and grants from local organizations (Agency of Human Services and the Department of Education, 2004).

Court-based strategies

- *New York State Permanent Judicial Commission on Justice for Children*: The commission has developed several initiatives and extensive training material to raise awareness about the health, developmental, and emotional needs of young children in foster care and ensure that these needs are identified and addressed by those involved in the court process. As a result of these efforts, many Family Court judges now routinely order that every foster child younger than 3 be referred to Part C. The commission has worked closely with the State Court Appointed Special Advocates program to assign CASA volunteers to cases of children younger than 5 to facilitate Part C and other healthcare referrals. In addition, its Babies Can't Wait Initiative identifies and convenes local courts, child welfare and EIP staff, and other early childhood providers in the community to facilitate collaboration, provide training on infant health and development, and host case consultation clinics. Using foundation grant money and federal court improvement funds, the commission has placed an early childhood specialist in several New York Family Courts to provide training to court staff and facilitate EIP referrals and evaluations (Permanent Judicial Commission on Justice for Children). **[AQ8]**
- *The Dependency Court Intervention Program for Family Violence:* In Miami, Judge Cindy Lederman, as the administrative judge of the Juvenile Court, spearheaded a court-based collaborative effort to develop and evaluate an intervention program for women and children from homes with domestic violence and child maltreatment. Children aged 1–5 referred from the court received a comprehensive developmental evaluation and referrals to Part C. Written evaluations were provided to the court, the child's child welfare caseworker, and the EI

service coordinator (Hon. Cindy Lederman, www.miamisafestart.org).

Provider strategies

- *The Starting Young Program:* The Starting Young Program is a pediatric, multidisciplinary developmental diagnostic and referral service that is designed exclusively for infants and toddlers who receive foster care or in-home child welfare services from the Philadelphia Department of Human Services. The multidisciplinary assessment team includes an intake worker from the county agency that coordinates the EIP. The assessment team collaborates with the child welfare social worker to develop recommendations for the child's service plan. Biological parents are encouraged to attend sessions, and all caregivers receive training and support to enhance the child's development. Typed reports are sent to the child welfare worker and all caregivers. The child's attorney receives the report when the Starting Young team determines additional advocacy is needed (Judy Silver, PhD, The Children's Hospital of Philadelphia, silverj@email.chop.edu).
- *The Foster Care Project:* In Suffolk County, NY, the Departments of Health Services and Social Services provide home visits by public health nurses twice a year to children age birth to 13 years in foster care. For children younger than 6, the nurse conducts a developmental screening and refers eligible children to Part C. Reports of the visit are sent to the foster care division of the DSS. The visits are billed to Medicaid (The Suffolk County Foster Care Project, Suffolk County Department of Health Services, 225 Rabro Dr East, Hauppauge, NY 11788, (561)853-3068).

In passing the referral provisions, Congress sought to eliminate a major hurdle in bringing abused and neglected children to the door of the EIP. These provisions also reflect the need for a strengthened, more inclusive EIP to identify, screen, evaluate, and serve all eligible children. Ushering eligible abused and neglected children and their families through that door, and helping them navigate once inside, is a challenging, but doable task. The knowledge, program models, and financing exist—child welfare and EIP professionals must now collaborate to harness them on behalf of these most vulnerable young children.

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