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Transforming Early Intervention Screening, Evaluation, Assessment, and Collaboration Practices: Increasing Eligibility for Children Impacted by Trauma

Stephanie A. Adrihan, BS[1], Brooke N. Winchell, PhD[2], and Sarah J. Greene BSW, IMH-E(1)[1]

Abstract

In this program description, the authors describe outcomes of a 2-year project influencing programmatic changes to screening/assessment practices and increased collaboration with Child Welfare (CW) in an early intervention (EI) program. The EI professionals reviewed how they assessed children who have been abused/neglected. Based on their findings, they revised the eligibility process and assessment tools utilized. Objectives of the programmatic changes were to increase the number of children substantiated as abused/neglected to become eligible for EI services and improve identification of social emotional delays. A summary of overall outcomes is presented aling with implications for policy and practice.

Keywords

assessment, CAPTA, early intervention, maltreatment, screening, social emotional development

A growing body of research connects child maltreatment and early trauma exposure to mental health and developmental concerns in infants, toddlers, and preschool children (Grasso, Ford, & Briggs-Gowan, 2013; Johnson-Motoyama, Moses, Conrad-Hiebner, & Mariscal, 2016; Harden, Buhler, & Parra, 2016; Milot, St-Laurent, Ethier, & Provost, 2010; Mongillo, Briggs-Gowan, Ford, & Carter, 2009; Scarborough & McCrae, 2010). A 2009 study shows one in four toddlers between the ages of 18 months and 36 months experience potentially traumatic events (PTE; Mongillo et al., 2009). PTEs refer to specific events during which a person experiences or sees physically violent acts inflicted on an individual within the home or neighborhood. Mongillo et al. (2009) found "exposure to potentially traumatic events is associated with a range of socioemotional and behavioral problems that may compromise healthy development and place them at risk for persistent serious psychological problems later in life" (p. 464). A study of toddlers who experienced or witnessed PTEs finds these children are 7 times more likely to demonstrate symptoms of posttraumatic stress disorder (PTSD) compared with children without traumatic experience exposure (Grasso et al., 2013). PTSD symptoms include internalizing, externalizing, dysregulation, and maladaptive behaviors. Grasso et al. report that boys are more likely to show externalizing behaviors as a response to traumatic experiences than girls who are more likely to have internalizing stress responses.

Children learn through early experiences with their most trusted caregivers. When children experience consistent nurturing, they learn that the world is a safe place and they can trust those around them to help meet their needs (Center on the Developing Child at Harvard University, 2016). Few empirical studies to date explore the connection between neglect and PTSD symptomologies. In one study, Milot et al. (2010) found children with histories of neglect were more likely to demonstrate symptoms of PTSD when compared with children who did not experience neglect. Using a variety of assessment measures including mother–child observations and parent and teacher completed behavior checklists, Milot et al. (2010) found that preschoolers who experience neglect have increased rates of PTSD symptoms and delayed communication skills.

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[1] Walworth County Wisconsin, Elkhorn, USA
[2] University of Wisconsin–Whitewater, USA

Corresponding Author:
Stephanie A. Adrihan, Birth to Three, Department of Health & Human Services, Walworth County Wisconsin, P.O. Box 1005, Elkhorn, WI 53121, USA.
Email: adrihansa19@uww.edu

An estimated 27% of substantiated cases of child maltreatment involve children under the age of 3 years (Rosenberg & Smith, 2008; Scarborough & McCrae, 2010). Scarborough and McCrae (2010) found that in the U.S. population, children under 3 years of age experience the highest substantiated rates of PTEs including physical abuse, severe injury, and longer out of home placements. Multiple studies report that over 45% of infants and toddlers experiencing child maltreatment have significant developmental delays before the age of 3 years (Johnson-Motoyama et al., 2016; Rosenberg & Smith, 2008) and display high rates of poor adaptive and social emotional skills when they enter school (Scarborough & McCrae, 2010). Child welfare (CW) and public instruction entities keep independent data systems, placing significant challenges on gathering data. Based on information collected from the National Study of Child and Adolescent Well-Being, 21% of maltreated infants and toddlers required Individual Education Programs (IEPs) when they reached school-age (Scarborough & McCrae, 2010). Based on research showing the long-term effects of early childhood maltreatment, better-targeted policies have been enacted to support the developmental needs of children who have experienced maltreatment.

Two federal laws include provisions to support the developmental needs of infants and toddlers who experience child maltreatment. The Individuals With Disabilities Education Act (IDEA) Part C mandates states to provide early intervention (EI) evaluations and services for children with qualifying diagnoses, developmental delays, or atypical development (IDEA, 2004). Amendments made to IDEA in 2004 require Part C EI providers to establish a process for evaluating children referred by CW (IDEA, 2004; Johnson-Motoyama et al., 2016; Rosenberg & Smith, 2008; Stahmer, Thorp Sutton, Fox, & Leslie, 2008). The Child Abuse Prevention and Treatment Act (CAPTA) requires CW to refer all children under 3 years of age involved in substantiated cases of child maltreatment to Part C to determine if they meet eligibility requirements to receive EI services (Herman-Smith, 2009; Johnson-Motoyama et al., 2016; Scarborough & McCrae, 2010; Stahmer et al., 2008). Authors of multiple studies found that approximately 45% of children under the age of 3 years receiving CW services are likely eligible for EI services. However, significantly fewer infants and toddlers receive EI services (Johnson-Motoyama et al., 2016; Rosenberg & Smith, 2008; Scarborough & McCrae, 2010). These findings suggest the need for further investigation into the low rates of CAPTA referrals leading to EI participation.

State Part C coordinators and local EI providers name two challenges that may be affecting low Part C enrollment from CAPTA referrals. These challenges include (a) cultural differences between CW and EI programs, which may hinder the sharing of information critical to the evaluation process and (b) a lack of effective tools for evaluating social emotional development in infants and toddlers (Allen, Hyde, & Leslie, 2012; Corr & Santos, 2016; Stahmer et al., 2008). Recommended assessment practices for EI include choosing assessment tools designed to evaluate all areas of development; designing an evaluation team including parents, caregivers, and other professionals with knowledge of the child; and assessing the child's performance in a variety of settings (Division for Early Childhood [DEC], 2014; Grasso et al., 2013; Milot et al., 2010; Mongillo et al., 2009; Stover & Berkowitz, 2005).

Implementing recommended evaluation practices for children involved with CW can be complicated by multiple factors. Parents involved with CW are not always available during evaluations or they may give inaccurate information in the evaluation process (Milot et al., 2010; Stahmer et al., 2008). Milot et al. (2010) found parents significantly underreported behaviors associated with PTSD compared with early childhood teachers who completed the same assessments. Foster parents and social workers often lack enough experience with the child to provide accurate information at the time of evaluation (Stahmer et al., 2008). Furthermore, CW case managers may withhold information critical to the evaluation process due to concerns about violating privacy rights (Allen et al., 2012; Corr & Santos, 2016; Stahmer et al., 2008).

The purpose of this article is to present a program description of one Part C EI program that sought to improve outcomes for infants and toddlers who experience child maltreatment. Moreover, the authors describe the EI program and the work group, outline the programmatic changes, and describe the outcomes, successes, and barriers to the implementation of programmatic changes.

Program Overview

The EI program discussed in this program description article is the sole EI provider in one Southeastern county in Wisconsin, with an approximate population of 100,000 people. This county is rural, over 90% Caucasian and approximately 11% of county residents are Hispanic or Latino. The median household income is US$55,500; 11% of the residents live in poverty. This EI program is administered through the local department of health and human services. This program consisted of a program manager, two service coordinators, an early childhood special education teacher/service coordinator, two speech therapists, one physical therapist, and one occupational therapist. They were a cohesive team who had worked together for over a decade without staff turnover. The EI program implemented a family-centered approach focusing on building parent capacity for supporting the child's individual needs through coaching (Trivette & Banerjee, 2015).

During the time of this program change, EI and CW were both within the children's division and shared a program manager. All children under the age of 3 years who experience a substantiated case of child maltreatment receive a CAPTA referral to EI. After completing a 2-year data review, this program determined that the rate of CAPTA referrals resulting in EI eligibility was approximately 40%, falling below the 45% suggested by Scarborough & McCrae (2010) and Rosenberg and Smith (2008). Sixteen percent of families referred to EI because of CAPTA did not respond to EI practitioners attempts to contact or they declined EI offers of screens or evaluations. Ongoing communication with the CW department revealed that multiple children who were referred but not determined eligible for EI services went on to be determined eligible for IEPs when they reached school age. When children were determined eligible for EI services, social emotional delays were rarely showing up on the standard assessment tools used by the program. To address concerns related to the screening and evaluation methods impacting eligibility and the identification of social emotional concerns, this EI program developed a work group to look at changes that could be made to support improved outcomes for infants and toddlers who had experienced child abuse and neglect.

Work Group

The work group consisted of a cross-section of professionals with a variety of expertise. The work group was comprised of the following: (a) local Division of Children and Families program manager; (b) EI service coordinator with infant mental health credential; (c) EI service coordinator/early childhood special education teacher; (d) speech, occupational, and physical therapists; (e) child psychologist; (f) child protective services case manager; and (g) higher education faculty member. The goals for the work group were (a) to increase the numbers of CAPTA referrals who become eligible for EI programming due to social emotional delays; (b) to determine what services seem to be the most effective in improving social and emotional development; (c) to determine impact of the program change on children and families; and (d) to provide agency-wide training on trauma and brain development and program initiatives.

While reviewing the program's screening and evaluation process, it was clear that the group needed to identify tools focused on social emotional development. The work group examined the literature and reviewed various tools. They identified mulitple tools that evaluated children—incluing social emotional development—and assessed family characteristics.

The DEC (2014) Recommended Practices for assessment states, "Practitioners use assessment materials and strategies that are appropriate for the child's age and level of development and accommodate the child's sensory, physical, communication, cultural, linguistic, social, and emotional characteristics." Early childhood professionals identify knowledge of, training in, and access to effective assessment tools for infants and toddlers as a significant challenge (Banerjee & Luckner, 2013). Banerjee and Luckner (2013) found teachers specifically report a lack of knowledge of tools for infants and toddlers with sensory and behavioral needs. Curriculum-based assessments, such as the Assessment and Evaluation Programming Systems (AEPS; Bricker et al., 2002), are commonly used and provide evaluators with the opportunity to complete authentic strengths-based evaluations consistent with DEC recommended practices (Bagnato, 2005). One weakness of curriculum-based assessments is that they might fail to identify atypical development and challenging behaviors (Gomez & Baird, 2005). Therefore, the work group decided to implement additional assessments that showed potential for data that are more sensitive.

Programmatic Changes

The EI program determines program eligibility based on the following state guidelines: (a) a child has a diagnosed condition known to have a high probability of leading to developmental delay; (b) a child demonstrates a delay greater than 25% in gross motor, fine motor, adaptive, cognitive, communication, or social emotional development; or (c) a child is evaluated and determined to demonstrate atypical development likely to result in developmental delay ("Early Intervention Services for Children From Birth Through Age 3 With Developmental Needs," 2017). To assure data that were more accurately collected, the work group planned for and implemented significant programmatic changes.

There were three major changes in the process. The primary change made in the process focused on rescreening procedures. The new procedure required offering rescreening to all ineligible children every 6 months until the age of 30 months (see Figure 1). The secondary change was the identification of new screening tools and new assessment tools. In addition, the EI program worked diligently to improve interdivision communication and coordination between EI and CW case managers, and when appropriate, behavioral health counselors/therapist.

Upon receipt of a CAPTA referral, EI and CW team members would briefly discuss what was known about the child and family and decide if EI would proceed with an offer for a developmental screen or a developmental evaluation. If CW case managers identified developmental or health concerns, the team would proceed with an offer of an evaluation. When developmental or health concerns were not presented by the case worker, EI reached out to families and offered developmental screening.

Screening and Rescreening

Two specific changes were made to the screening process: (a) the decision was made to use the Greenspan

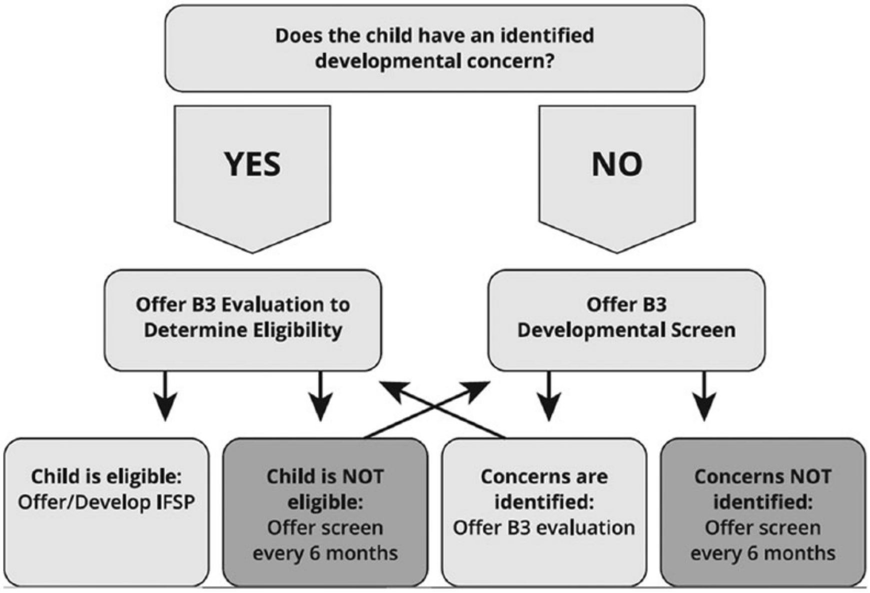

Figure 1. CAPTA referral process.
Note. CAPTA = Child Abuse Prevention and Treatment Act; IFSP = Individualized Family Service Plan.

Social-Emotional Growth Chart (Greenspan, 2004) and (b) children/families were offered rescreens every 6 months up to 30 months of age if they were found to fall within normal limits throughout the screening or evaluation process.

The decision to include the Greenspan Social-Emotional Growth Chart was made to increase the sensitivity for social emotional concerns by using a tool with a 6-point rating scale as opposed to the Ages and Stages Social Emotional (J. Squires, Bricker, & Twombly, 2002) with a 3-point rating scale. A Likert-type scale allows for a wider range of responses, which can provide additional levels of sensitivity more so than a simple yes or no, 3-point scale. Prior to this change, concerns arose that children may be passing the screening stage because of inaccurate reporting from parents or caregivers (i.e., in cases where caregivers other than the parents were participating in the developmental screen) who were not appropriately familiar with child development or the specific child. Prior to the programmatic changes, practitioners questioned if the 3-point rating scale of the Ages and Stages Social Emotional screener was sensitive enough to identify social emotional concerns in children who experienced maltreatment. EI practitioners decided to implement the Greenspan Social-Emotional Growth Chart to address this question. The *Environmental Rating Scale* (J. Squires & Bricker, 2007) was added to the screening protocol to assess family and environmental risk factors known to impact child development. EI also used the Ages and Stages Questionnaire, Third Edition (J. Squires & Bricker, 2009) and state hearing and vision checklists to screen global development.

The second change to screening consisted of offering rescreens every 6 months up to 30 months. CAPTA referrals are submitted when an initial determination of substantiated child maltreatment is made. Children, specifically those who are placed in out of home placements with family members or foster parents, are often going through significant transition at the time of the EI screening or evaluation. This leads to challenges in accurate screening and evaluations because some of the individuals contributing information are unfamiliar with the child and/or child development (Allen et al., 2012; Stamer et al., 2008). EI practitioners implemented the rescreening program change to provide children time to adjust to these significant transitions and offer foster parents and other professionals working with the children and families more time to get to know the children.

Rescreens were also offered to screen for developmental concerns that may show up over time. The standard practice was that when children passed a screen, families were informed of their right to request another screen at any time. Concerns were that children involved with CW might look typical at the point of CAPTA referral, especially if they were young, and that parents, caregivers, or CW case managers may not recognize and refer if delays developed over time. With the new changes, EI maintained a list of all CAPTA referrals that did not result in eligibility and contacted each family 6 months later to offer a rescreen.

Social Emotional Assessment Tools

To assure the thorough evaluation of social emotional development, the *Temperament and Atypical Behavior Scale* (TABS; Neisworth, Bagnato, Salvia, & Hunt, 1999) and the *Social-Emotional Assessment/Evaluation Measure* (SEAM) Experimental Edition (J. Squires & Bricker, 2007) were added to the evaluation protocol for CAPTA referrals. The TABS (Neisworth et al., 1999) is a norm-referenced assessment tool designed to evaluate atypical temperament in children between the ages of 11 and 72 months. The TABS includes 55 questions to evaluate four factors and determine if an infant or toddler is detached, hyper-sensitive/active, underactive, or dysregulated. Parents or caregivers use a "yes" or "no" rating to report the presence of specific atypical behaviors. Scoring produces a raw score for each factor and an overall *Temperament and Regulatory Index* (TRI). The TRI is a standardized score and is categorized as "typical," "at-risk," and "atypical" (Neisworth et al., 1999). The TABS is useful because it identifies atypical temperament traits and it provides a standardized score with cutoffs.

The SEAM (J. Squires & Bricker, 2007) is a curriculum-based assessment tool designed to assess social competencies in infants, toddlers, and preschoolers. The SEAM is a functional assessment tool completed by caregivers to assess social competencies. While completing this assessment, caregivers report if the child engages in specific social competencies "most of the time," "sometimes," or "rarely" and they can say if a behavior is a concern for them (J. Squires & Bricker, 2007; J. Squires et al., 2012). The SEAM is a strengths-based assessment and includes age ranges for specific social emotional competencies making it useful for finding delays in social emotional functioning and planning for intervention.

Improved Collaboration Between EI and CW

A key component to the program change involved increasing collaboration between EI and CW. Although these two programs shared management, cultural differences created barriers to collaboration between the two programs. Some of these differences were that EI is voluntary, requiring parent consent, and children need to qualify based on set state guidelines related to child development. CW services are court ordered, and in some cases, conditions of return are imposed if a child is placed out of the home. Staff turnover in CW also affected relationship building and consistency. CW case managers regularly made CAPTA referrals; however, they did not frequently follow up on EI status unless they had significant concerns related to the child's development or they sought a second set of "eyes and ears" in the home to help monitor progress.

The work group recommended focusing on building relationships between EI and CW case managers. Prior to the implementation of the program changes, EI provided interagency training on the effects that trauma has on the developing brain. The agency's child psychologist supported this training. EI also attended CW staff meetings to explain the importance of developmental screening and share information on the new programmatic procedures and processes related to screenings and assessments. Together, EI and CW developed an interoffice referral form specifically for CAPTA referrals. All team members focused on EI requirements of family involvement and the necessity of obtaining the consent of biological parents, regardless of their involvement with their children, unless parental rights had been revoked.

Beginning in 2016, EI and CW worked closer together when CAPTA referrals were made. For example, EI kept CW updated on the status of referrals. When EI was unable to reach biological parents by phone after two attempts, they would reach out to the CW case worker for assistance. CW would support EI through providing alternate contact information, arranging EI visit during supervised visitations, or assisting in obtaining consent for developmental screens or evaluations. While EI participation is voluntary, CW case managers could express expectations that families follow up with EI developmental screens or evaluations. In cases where parents' rights were revoked, the department identified a CW worker who could sign the legal documents pertaining to EI services.

EI received 12 more CAPTA referrals after implementing the programmatic changes compared to 2 years prior (see Figure 2). EI conducted one additional evaluation and four additional screens. When families declined the initial offer of a screen or evaluation, EI closed the referral while also informing the CW worker assigned to the family. In some cases, the CW worker spoke with the family and then made a second CAPTA referral to EI with the expectation that the family would follow through. The most significant difference was that 10 rescreens took place following the programmatic changes compared to 0 in the 2 years prior. One of the rescreens resulted in a child being determined eligible for EI services. These data suggest that rescreening may be effective in identifying developmental delays that appear over time.

With consent of parents, EI began inviting CW case managers to the evaluations and Individualized Family Service Plan (IFSP) meetings, and shared copies of IFSP documents. CW and EI began having more case specific conversations to support collaboration. EI also invited CW case managers to attend quarterly team coaching meetings to provide updates. While both programs were working to support improved child outcomes, EI generally focused on supporting each caregivers' confidence and competence in caring for their child's developmental needs while CW focused their attention on health/safety and permanency planning. Quarterly meetings allowed for EI and CW to

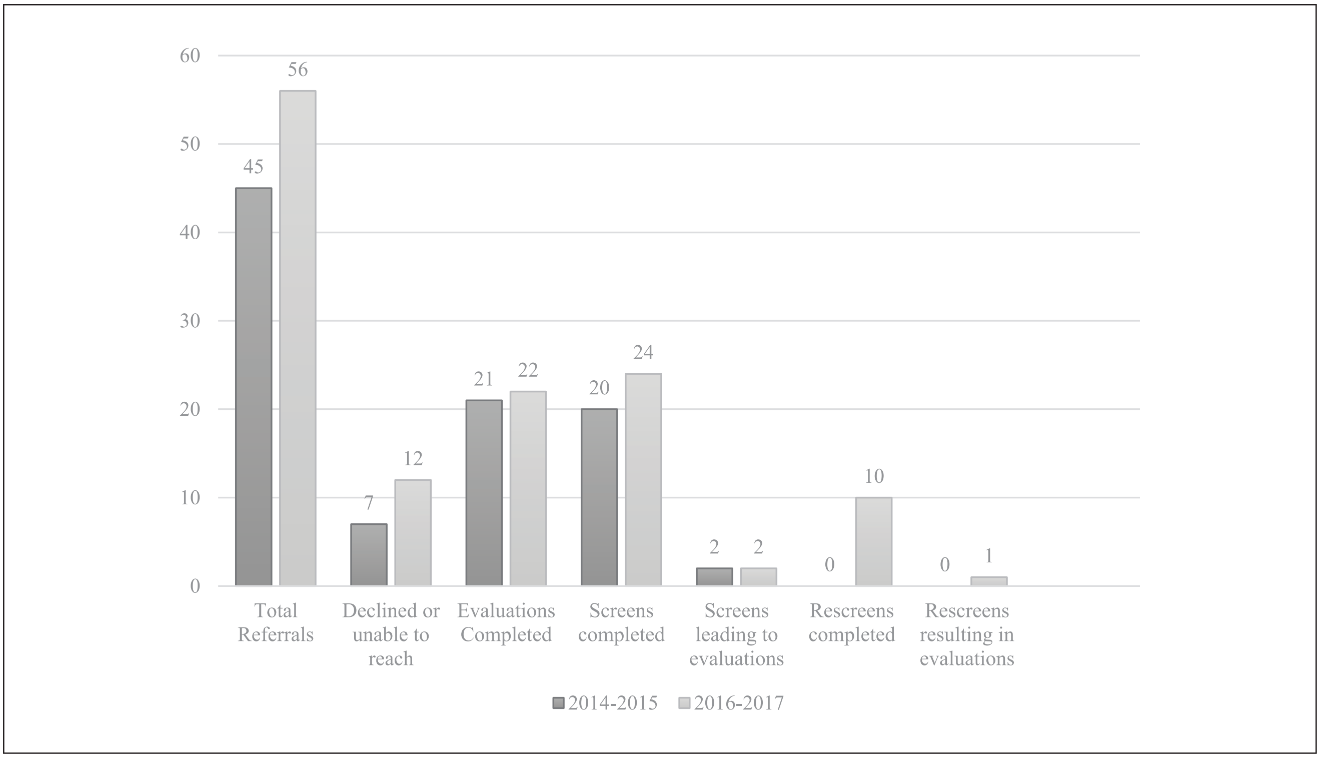

Figure 2. CAPTA referral participant data.
Note. CAPTA = Child Abuse Prevention and Treatment Act.

collaborate on shared outcomes, discuss information on the status of IFSP outcomes, parent engagement, and additional services implemented in the home to support the reunification of family members and CW case closure.

Lessons Learned: Outcomes, Successes, and Challenges

Screening and Evaluation Successes

EI rescreens offered at 6-month intervals were successful with increasing opportunities to provide family coaching, developmental resources, and, in some cases, referrals for evaluations. Findings indicate that the rescreening process was successful in identifying developmental concerns, with one rescreen resulting in an evaluation and determination of eligibility (see Figure 2). In some cases, families or CW case managers reached out for rescreening prior to the 6-month rescreen.

Prior to the program change, service coordinators were hesitant to base eligibility solely on social emotional development. EI was not fully confident determining a child eligible based on social emotional development because they did not have assessment tools that offered a comprehensive assessment of social emotional development, therefore the decision would have to be based on clinical judgment without assessment data to support that decision. The TABS and the SEAM yielded results that supported EI eligibility. The TABS identified seven children between 11 and 36 months of age as demonstrating atypical social emotional development (see Table 1). While the TABS identified the largest number of children as “atypical,” it could not be used on children under the age of 11 months; children under 11 months of age accounted for 45% of the CAPTA referrals received. The SEAM was successful in identifying five infants and toddlers with social emotional concerns using the age ranges or concerns identified by parents or caregivers. The AEPS was scored using the cutoff scores suggested by the publishers (Waddell, Pretti-Frontczak, Johnson, & Bricker, 2007) and identified social emotional concerns in only two children. These data suggest that tools designed to assess only social emotional development are more sensitive to identifying social emotional concerns compared with global developmental assessment tools.

EI practitioners became confident determining eligibility on social emotional development because they could justify the decisions using the results of the TABS or the SEAM. EI practitioners placed increased focus on the social emotional development of all children, even when assessments did not identify significant concerns. Conducting and reviewing the results of the assessment tools helped to guide conversation

Table 1. Number of Atypical Social Emotional Scores by Evaluation Tool.

Children age	Total children	Children identified as atypical on AEPS	Children identified as atypical on TABS	Children identified with concerns on the SEAM
0–10 months	10	0	NA[a]	1
11–36 months	12	2	7	4
Total	22	2	7	5

Note. AEPS = Assessment and Evaluation Programming Systems; TABS = *Temperament and Atypical Behavior Scale*; SEAM = *Social-Emotional Assessment/Evaluation Measure*.

[a]The TABS is normed for children over 11 months of age.

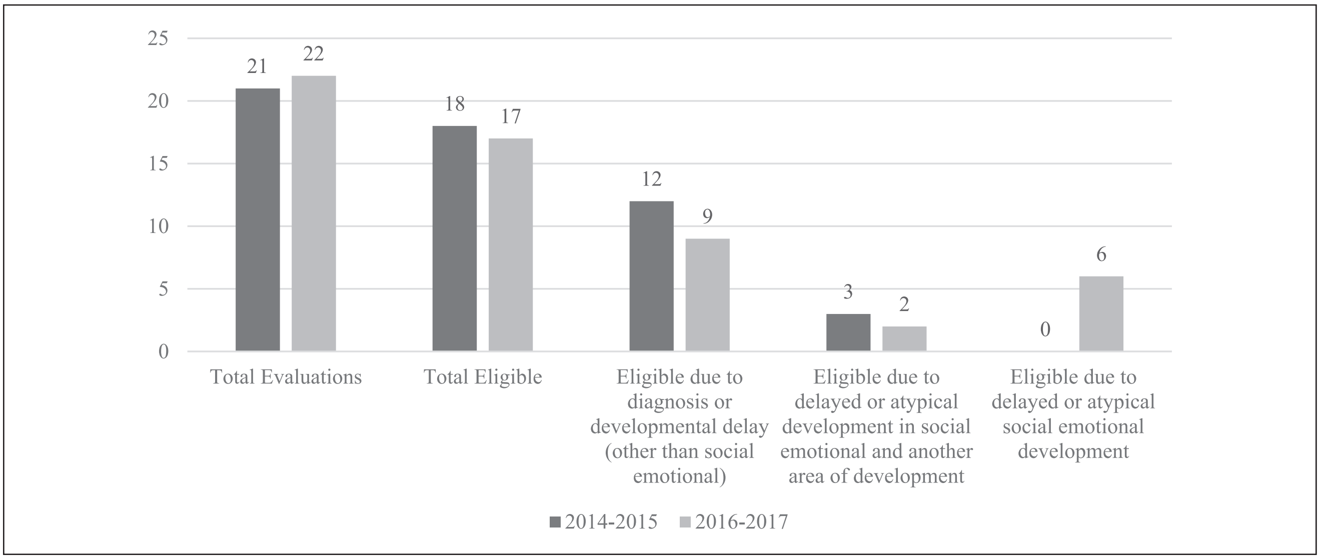

Figure 3. CAPTA evaluation results.
Note. CAPTA = Child Abuse Prevention and Treatment Act.

between practitioners and families about social emotional development. Six children were determined eligible based solely on social emotional development after the addition of these tools compared to 0 in the 2 years leading up to the change (see Figure 3). While the results showed an increase in social emotional factors contributing to the determination of EI eligibility, the overall eligibility rate decreased. This suggests the need to continue to study assessment practices and the discrepancies between evaluation results and the related literature.

Increased Time Commitment From EI Team

Under the new process, service coordinators began to see that CAPTA referrals were more time consuming between point of referral and determination of eligibility/development of the IFSP. This could be attributed to a few causes. First, access to biological parents was sometimes limited. IDEA requires the participation of one parent, even when children are placed in out of home care. In some situations, the whereabouts of biological parents were unknown, making it difficult to obtain consent. For example, parents affected by addiction to drugs or alcohol were often difficult to track down and unreliably attended scheduled appointments; other parents were incarcerated out of county or out of state. In these cases, EI sought the assistance of CW managers, in some cases a surrogate parent or CW worker was appointed to sign consent for screens, evaluations, and IFSP services.

Second, EI practitioners were increasing their efforts to reach families to offer screens and/or evaluations. Prior to the programmatic change, referrals would have been closed after three unsuccessful attempts to contact a family. Under the new process, practitioners were informing CW case managers after two unsuccessful attempts to contact families. At that point, CW case managers began reaching out to biological parents to encourage their follow-through with an offer of a screen/evaluation. The collaboration with CW resulted in the screening of children who may not have been seen by EI otherwise; however, the process often extended beyond the 45-day timeline required under IDEA.

Third, to assure that accurate screening and evaluation information was being collected, EI practitioners included more people in the screen/evaluation process. After obtaining consent from parents, EI team members were diligent in collecting assessment information from multiple sources including parents, foster parents, case managers, and child care providers. The increased number of sources resulted in screenings or evaluations occurring in multiple locations with significantly different scheduling needs.

Once evaluations were complete, arrangements needed to be made to share information with noncustodial parents and, when appropriate, offer IFSP services. IFSP teams sought to develop outcomes based on priorities and concerns of all participating caregivers. With a focus on building caregiver capacity, services were frequently provided in multiple locations and strategies were individualized to support the unique characteristics of the different caregiver–child dyads.

Relationships Between EI and CW

The organizational structure of this county agency offered opportunities to implement recommended collaboration practices (DEC, 2014, 2016). The EI work group anticipated and planned for challenges including cultural differences between EI and CW, understanding of program requirements and expectations, and hesitation to share information between agencies (Allen et al., 2012; Corr & Santos, 2016; Stahmer et al., 2008). Interagency training and joint planning prior to the implementation of the programmatic changes supported collaboration and relationships between programs.

As relationships built, teamwork and collaboration increased between workers. In some cases, EI was able to provide an extra set of “eyes and ears” to share information to CW. EI was also able to form different types of relationships with parents and supported them in their reunification plan if children were placed out of home. Collaborations between varieties of professionals started emerging. CW informed EI when changes in status were made, specifically in change of placements and additional services family members were receiving including supports such as drug court, Functional Family Therapy, and Trauma Informed Parenting. CW case managers began asking more questions regarding child development, when screens should be conducted, and sought input from EI when considering other services to introduce into the home. As EI and CW workers would have conversations regarding which service the family seemed most committed to, the primary services model began to expand beyond typical EI services (Trauma Informed Parenting, Functional Family Therapy, Early Head Start, early care, and education programs). These conversations informed how EI practitioners could support those providers using a coaching model to reduce appointment for the family.

Challenges related to voluntary EI services and required components of CW protection plans remain. For example, parent consent is a cornerstone of EI participation. Questions persisted as to whether or not EI services should be court ordered. A coaching model relies on family participation and court ordered families might not be fully invested in the IFSP, and because of this, lack follow-through and attendance. Should parents’ decision to not enroll in EI services be held against them in court if every other parent has the right to deny EI services?

Implications: A Call to the Field

Local, State, and National Leadership Needs

Programmatic changes described in this article succeeded because of unified leadership within both programs. Interagency buy-in was important because changes were made within the normal operating budget of the EI program without the assistance of additional grants. This was successful because of dedicated staff at all levels who understood that doing this well took more work initially but had the potential for significant long-term benefits. CW supervisors had begun to understand the importance of assuring staff was available for quarterly team meetings and willingness to share information to support the referral process.

Moreover, there should be consideration for making complex trauma a criterion for automatic eligibility/diagnosed condition, at a state/policy level. There is significant research for the inevitable effects of trauma, yet we maintain a wait and see approach rather than a prevention/intervention mind-set. We know early trauma significantly impacts young children across all developmental domains (Harden et al., 2016). Like many states, Wisconsin EI allows EI practitioners to determine automatic eligibility if there is evidence and documentation of a diagnosis resulting in a high probability (50% or higher) of developmental delay (Wisconsin Department of Health Services, 2018). The challenge is that substantiation of abuse and neglect is not a medical diagnosis. The evidence for the adverse outcomes of exposure to early trauma supports that best practice needs to include prevention and interaction with programs which can impact the developmental trajectory of those children impacted by trauma (Harden et al., 2016). A clear analogy is that of a child diagnosed with Down syndrome. A young infant with Down syndrome may not present with a developmental delay, yet the diagnosis is an automatic eligibility criterion for EI services. This is because the research shows the child has a high likelihood of having developmental delays. As professionals in early childhood development, we know the same truth of the trajectory for complex trauma, yet the services provided to children do not match our knowledge base.

Training and Resources

IDEA and DEC recommended practices state that assessment tools should be selected to accurately evaluate and assess all areas of development. Administrators and practitioners need to use assessments that were designed to assess social emotional development and have a high level of sensitivity to detect issues related to trauma at a very young age. There is also a need to revise existing assessments and develop new tools to better capture social emotional concerns, specifically for infants.

The effects of complex trauma may look different at various stages/times, thus the items on the assessment need to include aspects of trauma as well as specificity to detect progress monitoring in these areas. Curriculum-based assessments may not identify atypical or challenging behaviors associated with trauma. Further study on the effective and accurate assessment tools and methods is needed.

The majority of social emotional tools rely on parent/caregiver report. This can be problematic for several reasons: (a) parents working with CW might be scared or angry at the time CAPTA referrals are made. Primary caregivers might be hesitant to divulge sensitive information out of fear about how it may affect the ongoing CW case, (b) biological and foster parents may not understand what is developmentally appropriate and what is not, and (c) foster parents may not have enough experience with the child to be able to answer important questions related to social emotional needs. Social emotional tools and data need to be gathered across people, settings, and materials to gain an accurate understanding of a child's needs with respect and sensitivity to the unique situations of families. Moreover, data should not only be collected from a parent/caregiver because maltreating parents may not recognize the behavioral effects of abuse and neglect (Milot et al., 2010).

As more social emotional screening and assessment tools become available, it is critical that all professionals working with infants, toddlers, and preschoolers are informed of these tools and provided the necessary training required to reliably use them. CW is required to make CAPTA referrals for all children below 3 years who are substantiated for child abuse and neglect. However, professionals encounter many other children who are not found to be substantiated and may never be referred to EI even though they may be experiencing developmental delays (Johnson-Motoyama et al., 2016; Rosenberg & Smith, 2008). Moreover, case managers are not experts in child development and most times have had limited contact with the child to provide an accurate assessment. Therefore, specified training needs to be provided to professionals with various backgrounds outside of early childhood development. Improved screening and assessment tools in conjunction with better training will ensure that more children receive appropriate evaluations that support both eligibility and program planning that they are entitled to under IDEA.

Once a child is determined eligible for EI services, challenges arise in identifying appropriate services to support the social emotional needs of infants and toddlers within their family system. Because learning takes place in the context of relationships, improving outcomes often requires connecting families to the appropriate resources to make meaningful, long-term changes in their lives. We need to train preservice personnel on the importance of family-centered practices and confronting personal biases (DEC, 2014). It is especially important for EI practitioners working with families who have instances of trauma and maltreatment to engage in reflective practices exploring their personal bias when working with families involved with the CW system. Incoming professionals need better tools and different strategies for understanding families' perspectives, meeting families where they are, matching strategies and services with families' priorities, and involving families in interventions and supplemental services. EI practitioners in the field also need access to training and curriculum resources that target supporting the parent–child dyad.

Funding and Policy

Infant and early childhood outcomes improve when families, specifically mothers, receive the support they need prior to conception through infancy (Verbiest, Tully, & Stuebe, 2017). Funding prenatal and early childhood family education, infant mental health, and prevention programs is critical. The goal should be to prevent complex trauma, which starts through parent education, social safety nets, and access to health care before a child is conceived. Increased funding for evidence-based prenatal and evidenced-based early childhood programs and support for paid parental leaves are critical in preparing parents to minimize their infant's or toddlers' exposure to maltreatment (Zero to Three, 2017).

Policy changes are needed that require cross agency collaboration (DEC, 2014), specifically when children are involved with CW to coordinate services that support struggling families without overwhelming them. Many times, families are receiving multiple services with differing expectations. The lack of coordination may result in redundancy, inconsistent or conflicting expectations, or gap in services.

Finally, quality collaboration between agencies requires additional time and fiscal resource at a time when CW and EI receive limited state and federal funding (Allen et al., 2012; Corr & Santos, 2016). Fully funding the IDEA as authorized by Congress is one funding source to support EI programs facing increased referrals because of CAPTA. There remains a lack of funding sources that support mental health services for children enrolled in EI services. In many states, special education is not a reimbursable service. Specific therapies such as speech, physical, and occupational therapy may be covered by insurance companies provided they relate to a covered diagnosed condition. We currently lack medical providers trained and willing to make infant mental health diagnosis. With the availability of the DC: 0-5 Manual (Zero to Three, 2016), the opportunity exists among the medical field to be more equipped to properly recognize and diagnose young children. Without a reliable funding source, EI programs will continue to lack the resources needed to conduct thorough screening, evaluation, and service delivery for CAPTA referrals (Derrington & Lippitt, 2008). Eligible children will continue to go undetected and denied their right to EI services.

Conclusion

The CAPTA of 2003 placed the requirement that all children below the age of 3 years who experienced substantiated cases of child abuse and neglect receive a referral to EI. Over a decade later, children who have experienced abuse and neglect continue to slip through the EI cracks. Regardless of policy, effective procedures for conducting screening and evaluations continue to lag. The EI program described in this article demonstrates how individual programs can make grassroots changes to increase EI participation. Local EI programs should be relentless in their attempts to include social emotional screening and assessment procedures and build interagency relationships to improve outcomes for children who have experienced trauma.

Authors' Note

Author Stephanie A. Adrihan's affiliation has changed since the time this research was done; she is now affiliated with the School District of Brown Deer.

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References

Allen, A. D., Hyde, J., & Leslie, L. K. (2012). "I don't know what they know": Knowledge transfer in mandated referral from child welfare to early intervention. *Children and Youth Services Review*, *34*, 1050–1059. doi:10.1016/j.childyouth.2012.02.008

Bagnato, S. J. (2005). The authentic alternative for assessment in early intervention: An emerging evidence-based practice. *Journal of Early Intervention*, *28*, 17–22. doi:10.1177/105381510502800102

Bagnato, S. J., Neisworth, J. T., Salvia, J., & Hunt, F. M. (1999). *Temperament and Atypical Behavior Scale (TABS): Early childhood indicators of developmental dysfunction*. Baltimore, MD: Paul H. Brookes.

Banerjee, R., & Luckner, J. L. (2013). Assessment practices and training needs of early childhood professionals. *Journal of Early Childhood Teacher Education*, *34*, 231–248. doi:10.1080/10901027.2013.816808

Bricker, D., Capt, B., Pretti-Frontczak, K., Johnson, J., Slentz, K., Straka, E., & Waddell, M. (2002). *Assessment, evaluation, and programming system for infants and children (AEPS): AEPS items for birth to three years and three to six years (Vol. 2)*. Baltimore, MD: Paul H. Brookes.

Center on the Developing Child at Harvard University. (2016). *Applying the science of child development in child welfare systems*. Available from http://www.developingchild.harvard.edu

Corr, C., & Santos, R. M. (2016). "Not in the same sandbox": Cross-systems collaborations between early intervention and child welfare systems. *Child and Adolescent Social Work Journal*, *34*, 9–22. doi:10.1007/s10560-016-0470-4

Derrington, T. M., & Lippitt, J. A. (2008). State-level impact of mandated referrals from child Welfare to part C early intervention. *Topics in Early Childhood Special Education*, *28*, 90–98.

Division for Early Childhood. (2014). *DEC recommended practices in early intervention/early childhood special education 2014*. Retrieved from http://www.dec-sped.org/recommendedpractices

Division for Early Childhood. (2016). *Child maltreatment: A position statement of the Division for Early Childhood (DEC)*. Washington, DC.

Early intervention services for children from birth through age 3 with developmental needs. (2017). Wisconsin, Department of Health Services, Chapter 90 § 90.04.

Gomez, C. R., & Baird, S. (2005). Identifying early indicators for autism in self-regulation difficulties. *Focus on Autism and Other Developmental Disabilities*, *20*, 106–116. doi:10.1177/10883576050200020101

Grasso, D. J., Ford, J. D., & Briggs-Gowan, M. J. (2013). Early life trauma exposure and stress sensitivity in young children. *Journal of Pediatric Psychology*, *38*, 94–103.

Greenspan, S. I. (2004). *Greenspan social-emotional growth chart: A screening questionnaire for infants and young children*. San Antonio, TX: Harcourt Assessment.

Harden, B. J., Buhler, A., & Parra, L. J. (2016). Maltreatment in infancy: A developmental perspective on prevention and intervention. *Trauma, Violence, & Abuse*, *17*, 366–386.

Herman-Smith, R. L. (2009). CAPTA referrals for infants and toddlers: Measuring early interventionists' perceptions. *Topics in Early Childhood Special Education*, *29*, 181–191. doi:10.1177/0271121408331259

Individuals With Disabilities Education Act. (2004). 20 U.S.C. § 1400.

Johnson-Motoyama, M., Moses, M., Conrad-Hiebner, A., & Mariscal, E. S. (2016). Development, CAPTA Part C referral and services among young children in the U.S. child welfare system: Implications for Latino children. *Child Maltreatment*, *21*, 186–197. doi:10.1177/1077559516630831

Milot, T., St-Laurent, D., Ethier, L. S., & Provost, M. A. (2010). Trauma-related symptoms in neglected preschoolers and affective quality of mother-child communication. *Child Maltreatment*, *15*, 293–304. doi:10.1177/1077559510379153

Mongillo, E. A., Briggs-Gowan, M., Ford, J. D., & Carter, A. S. (2009). Impact of traumatic life events in a community sample of toddlers. *Journal of Abnormal Child Psychology*, *37*, 455–468. doi:10.1007/s10802-008-9283-z

Rosenberg, S. A., & Smith, E. G. (2008). Rates of Part C eligibility for young children investigated by child welfare. *Topics in Early Childhood Special Education*, *28*, 68–74. doi:10.1177/0271121408320348

Scarborough, A. A., & McCrae, J. S. (2010). School-age special education outcomes of infants and toddlers investigated for maltreatment. *Children and Youth Services Review*, *32*, 80–88. doi:10.1016/j.childyouth.2009.07.015

Squires, J., & Bricker, D. (2007). *An activity-based approach to developing young children's social emotional competence*. Baltimore, MD: Paul H. Brookes.

Squires, J., & Bricker, D. (2009). *Ages & Stages Questionnaires®, Third Edition (ASQ®-3)*. Baltimore, MD: Paul H. Brookes.

Squires, J., Bricker, D., & Twombly, E. (2002). *Ages & Stages Questionnaires®: Social-Emotional (ASQ®:SE): A parent-completed child monitoring system for social-emotional behaviors*. Baltimore, MD: Paul H. Brookes.

Squires, J. K., Waddell, M. L., Clifford, J. R., Funk, K., Hoselton, R. M., & Chen, C.-I. (2012). A psychometric study of the infant and toddler intervals of the social emotional assessment measure. *Topics in Early Childhood Special Education*, *33*, 78–90. doi:10.1177/0271121412463445

Stahmer, A. C., Thorp Sutton, D., Fox, L., & Leslie, L. K. (2008). State Part C agency practices and the Child Abuse Prevention and Treatment Act (CAPTA). *Topics in Early Childhood Special Education*, *28*, 99–108.

Stover, C. S., & Berkowitz, S. (2005). Assessing violence exposure and trauma symptoms in young children: A critical review of measures. *Journal of Traumatic Stress*, *18*, 707–717. doi:10.1002/jts.20079

Trivette, C., & Banerjee, R. (2015). Using the recommended practices to build parent competence and confidence. In *DEC recommended practices: Enhancing services for young children with disabilities and their families*. (DEC Recommended Practices Monograph Series No. 1) (pp. 65–75). Los Angeles, CA: Author.

Verbiest, S., Tully, K., & Stuebe, A. (2017). *Promoting maternal and infant health in the 4th trimester*. Zero to Three. Washington, DC. Retrieved from: http://4thtrimester.web.unc.edu/files/2017/06/ZERO-TO-THREE-Journal.pdf

Waddell, M., Pretti-Frontczak, K., Johnson, J., & Bricker, D. (2007). *Using AEPS® to determine eligibility for IDEA services*. Baltimore, MD: Paul H. Brookes.

Wisconsin Department of Health Services. (2018). *Diagnosed conditions and atypical development guidance for Wisconsin's birth to 3 program*. Retrieved from https://www.dhs.wisconsin.gov/birthto3/forms.htm

Zero to Three. (2016). *DC:0–5™: Diagnostic classification of mental health and developmental disorders of infancy and early childhood*. Washington, DC: Author.

Zero to Three. (2017). *The child development case for a national paid family and medical leave program*. Retrieved from http://www.nationalpartnership.org/research-library/work-family/paid-leave/the-child-development-case-for-a-national-paid-family-and-medical-leave-insurance-program.pdf