



IS PART C READY FOR SUBSTANTIATED CHILD ABUSE AND NEGLECT?

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The Keeping Children Safe Act of 2003 amended CAPTA, the Child Abuse Prevention and Treatment Act (PL 108-36), and was signed into law on June 25, 2003 (<http://thomas.loc.gov/cgi-bin/query/z?c108:S.342.enr>). This law includes the requirement that each state develop “provisions and procedures for referral of a child under the age of 3 who is 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 (section 106(b)(2)(A)(xxi)).” Part C is a component of PL 105-17, IDEA (Individuals with Disabilities Education Act). Agencies providing Part C services are required to provide comprehensive, coordinated, multidisciplinary, early intervention for infants and toddlers with disabilities or developmental delays and their families.

At this point it is possible to make a rough estimate of the increase in Part C’s service load that will result when Child Protective Services (CPS) agencies refer all children under 3 who are victims of maltreatment to Part C. Currently, Part C serves about 2% of the population under 3 years of age, which is 226,982 children, based on counts from the 50

states (IDEA Part C Child Count, 2000). About 1.64% of all children under 3 years of age (183,476 based on 48 states) were substantiated as victims of abuse or neglect in 2000 (U.S. Department of Health and Human Services, 2002). If we assume that 10% of these children have already been referred to Part C, then we can expect an increase of about 70% (167,000) in the number of children referred to determine Part C eligibility. A similar calculation can be done to estimate the increase in enrollment that may occur as a result of this legislation. Assuming that 35% of these maltreated children are Part C eligible, and that 25% of these children are already enrolled in Part C, refuse services, or cannot be contacted, we project an increase in Part C enrollment of about 20% (44,000). These estimates are based on limited information and can be expected to vary from state to state depending on current levels of Part C—child welfare collaboration, state criteria for enrollment in Part C, and the extent to which these families feel they can refuse Part C services.

Nevertheless these estimates suggest that substantial increases in workload for providers of Part C evaluation and intervention services are

likely as a result of this legislation. Accordingly child welfare and Part C as well as other agencies involved in the financing and delivery of services that promote the health, welfare, and education of young children need to begin planning to ensure that the capacity to provide the evaluations and necessary follow-up is in place.

CPS and Part C databases in each state should provide planners with the information they need to determine the numbers of children who may be expected to be referred and the current amount of overlap between Part C and CPS for each county in the state. Having estimates of potential increases in referrals for eligibility determination and Part C enrollment will help in determining the resources communities will need in order to manage projected increases in referrals. To the extent that Part C is already at capacity in some communities, Part C and child welfare agencies will need to develop strategies to provide timely evaluations for the additional children referred. Increased CPS referrals are likely to exacerbate insufficient capacity to deliver Part C services in those communities with the highest rates of child maltreatment—most often urban settings with high rates of poverty.

THE MASSACHUSETTS EARLY CHILDHOOD LINKAGE INITIATIVE (MECLI)

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The Heller School at Brandeis University initiated the Massachusetts Early Childhood Linkage Initiative (MECLI) in November 2002. MECLI encourages the Department of Social Services (DSS), the state's child protection agency, to regularize the referral of children under 3 years of age to Early Intervention (EI). EI, the implementation of Part C of IDEA in Massachusetts, evaluates the child's developmental status, including risks for impaired development, to determine whether the child and family are eligible for EI services. If they are eligible, EI works with the family to develop and implement an Individualized Family Service Plan (IFSP). MECLI seeks to capture data on the implementation of these referrals and identify what is required for them to occur consistently. It identifies barriers and means for overcoming them, with the goal of providing information that will support replication of these referrals throughout Massachusetts and in other states.

MECLI is being implemented at 3 pilot sites, which are 3 of DSS's 29 Area Offices. These DSS offices are working to refer all young children involved in newly opened abuse or neglect cases to EI. Because EI is a voluntary service, DSS personnel offer the referral to the child's parent(s). Data are gathered on whether the referral was accepted, declined, or whether the child was already involved with EI.

Similarly, data are gathered at the six EI Programs that serve the catchment areas of these DSS Area Offices. The results of EI's efforts to engage the child's family and the child's eligibility for EI are captured.

As part of MECLI, the Heller project team has obtained access to the EI Information System, a statewide database maintained by the Department of Public Health, the lead agency for EI in Massachusetts. These electronic data provide information on EI's eligibility assessment of each child, the services that are indicated on the IFSP, and the actual delivery of services. By combining and analyzing all of the data captured, MECLI plans to project the impact of statewide implementation of these DSS referrals.

Highlights of the data gathered and analyzed through August 2003 include the following:

- DSS has reported the results of 128 referrals to EI that have been offered to parents.
- Of these referrals, 88 were accepted by parents, 23 were declined, 11 children were already involved with EI, and 6 had unknown outcomes.

- EI reported the results of 90 referrals received from DSS.
- Of 45 children with completed EI assessments, 32 were eligible for EI services under Massachusetts' criteria, which require roughly a 25% delay in any domain, 4 out of a list of 20 risk factors, a diagnosed condition, or a clinical judgment that a child should be enrolled. Thirteen children were not eligible for EI, and 31 were still in the process of having assessments completed.
- Of the eligible children, 25 had an established delay and 9 met the risk factor criterion, including 3 who had both an established delay and met the "at-risk" criterion. One child was deemed eligible based on clinical judgment.
- Ten families either refused the EI assessment when contacted by EI or were not able to be contacted by EI.
- Four children were already involved with EI.

Preliminary findings from MECLI indicate that regularizing the referral of young children from child protection agencies to Part C systems will not be easy. Given the high workload of many child protection workers, training them to effectively offer the referrals, getting them to consistently do so, and collecting data on the referrals requires sustained attention and reinforcement from busy managers. Preliminary findings suggest that a high proportion of parents in newly opened child protection cases will agree to a referral to Part C. They also suggest that a high proportion of the children referred will be eligible for Part C based on the presence of a developmental delay, a federally mandated eligibility criterion. States that serve children at risk for a developmental delay, a state option, can expect to find an additional but relatively small proportion of children eligible.

In addition to the increased numbers of children that Part C will assess and serve if referrals from child protection are regularized, the types of Part C services required may change. Specifically, it seems likely that children involved with child protection will have social-emotional and behavioral issues more frequently than other children served by Part C. Therefore, Part C may need to enhance its ability to meet early childhood mental health needs. As a component of this, Part C may also need to enhance its ability to address parental issues that affect children's mental health, such as parental substance abuse, domestic violence, and parental mental health problems, especially maternal depression.

Additionally, the Part C early intervention system needs to begin to prepare to serve families and children who are referred to Part C by CPS agencies as a consequence of child maltreatment. Although some children who are referred as a consequence of maltreatment will live with foster parents or in kinship care, most of these children will reside with their biological parents. Families in which abuse and neglect has occurred can be quite different in their motivation to participate in early intervention and in their ability to care for their children than most families currently receiving Part C early intervention. Many parents who maltreat their children will have considerable difficulty focusing on issues of child development. In addition, maltreating parents are likely to be less effective in their day-to-day caretaking than other parents. Consequently, the interventions required to improve their

caregiving skills may be more complex and may require different sets of interventionist skills and knowledge than those required for work with most families who currently receive Part C services. Moreover, these families may need far greater levels of supports than those required by most families now served by Part C.

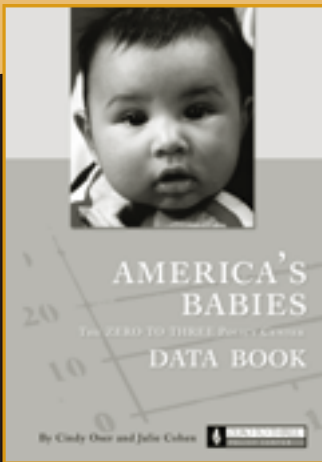
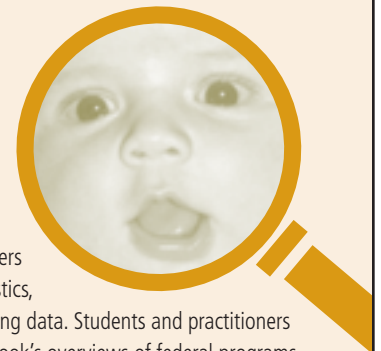
Clearly, representatives of child welfare and Part C need to work together to design referral, evaluation, and intervention systems that meet the needs of these vulnerable children and their caregivers. At the national, state, and community levels, representatives of Part C and social services will need to meet and develop relationships that will allow them to build upon existing links between their systems. Representatives of Medicaid, an important source of funding for many Part C services, should be involved in this effort. Representatives of the

courts and guardians *ad litem* may also be able to play useful roles. The Part C Interagency Coordinating Committee (ICC) in each state could serve as a forum for discussion. These committees already meet regularly to address issues related to the coordination of Part C services across agencies and programs at all levels of government and in the community. Perhaps most important, ICCs include parent representatives. Their contributions will be essential in this major expansion of Part C services. §

REFERENCES

- IDEA Part C Child Count (2000). Table AH1- Number of infants and toddlers receiving early intervention services, December 1, 2000. Retrieved October 1, 2003, from www.ideadata.org/tables24th/ar_ah1.htm
- U.S. Department of Health and Human Services. (2002) *Child maltreatment 2000*. Table 3-8 Victims by single-year age, 2000. Retrieved October 1, 2003, from www.acf.hhs.gov/programs/cb/publications/cm00/table3_8.htm

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