Policies to Implement Developmental Screening in Pennsylvania Child Welfare Services: Reports from Agency Perspectives

Child Welfare Education and Research Programs
University of Pittsburgh, School of Social Work

August 2010

Faculty Investigators:

Helen Cahalane, PhD

Rachel Fusco, PhD

Julie S. McCrae, PhD

Mary Beth Rauktis, PhD

Project team:

Rachel Winters, Evaluation Coordinator

Wendy Flynn, Research Assistant

Matt Kerr, Michael Suhina, and Nicole Tipton
Information Technology, Pennsylvania Child Welfare Training Program

Elizabeth Boulware Bair, Jennifer Caruso, and Shauna Reinhart
Program Development Specialists, Pennsylvania Child Welfare Training Program

Jill Kachmar, Office of Children, Youth and Families, Department of Public Welfare

Lovie Jackson, Postdoctoral Scholar, Western Psychiatric Institute and Clinic

National Advisory Board:

Jil Hawk, Clinical Advisor; Michelle Myers- Cepicka, Executive Director,
The Alliance for Infants and Toddlers, Allegheny County
Laurel Leslie, MD, MPH, Associate Professor, Director, Program for Aligning Researchers and
Communities for Health, Tufts University School of Medicine
Nancy Seibel, M.S, Director, Center for Training Services, Zero to Three
Carol Spigner, MSW, DSW, Associate Professor and Clinician Educator,
University of Pennsylvania, School of Social Policy and Practice

This project was funded by the Office of Children, Youth and Families, Pennsylvania Department of Public Welfare.

Citation for this report:

Child Welfare Education and Research Programs (2010). *Policies to Implement Developmental Screening in Pennsylvania Child Welfare Services: Reports from Agency Perspectives.* University of Pittsburgh, School of Social Work, Pittsburgh, Pennsylvania.

Executive Summary

In 2008, Pennsylvania's Office of Children, Youth and Families implemented developmental and social-emotional screening for very young children who are referred to child welfare services. Screening, using a standardized instrument, is required among all children ages 0 to 3 who are substantiated for maltreatment, and is strongly encouraged among children up to age 5 who are receiving child welfare (CW) agency services. The state-issued policy follows federal amendments to the Child Abuse Prevention and Treatment Act (U.S. DHHS, 2003) and the Individuals with Disabilities in Education Act (IDEA, 2004) that require better referral mechanisms between CW and early intervention services (EI), the care and service coordination system for children with developmental delays or disabilities, or who are at high risk for such concerns. Children involved with CW services have high rates of mental health and developmental problems, but too few receive EI services.

The University of Pittsburgh, School of Social Work conducted a study of how counties in Pennsylvania have implemented standardized screening in CW services. Goals of the study were to describe policies and procedures put into place to conduct screening, levels of collaboration between CW and EI agencies, service gaps and availability, and methods to engage families in screening and services. Phone survey interviews were conducted with CW and EI representatives in each PA county June through September, 2009.

Results show that in 67% of counties, CW workers complete the screenings and in 33% EI workers do so. About one-half of counties (43%) screen children that fall under the CAPTA and state-required policy only; that is, children under age 3 who are substantiated for maltreatment. Another 40% screen children up to age 5 who are receiving agency services. Remaining counties screen children that are mandated by the policy, along with some other group, such as children under age 1 who are receiving CW services.

Most respondents report that screening is successful (completed) with families "all" or "most of the time". Early intervention providers report somewhat lower rates of success (72%) completing screens compared with CW (94%). In-home caregivers are rated as the most challenging to engage in screening. Engaging families typically includes educating families about the purpose (37%) or benefits of screening (19%) and emphasizing their participation as valued team members (20%).

Agencies have inconsistent policies concerning whether consent is obtained from caregivers to conduct screening. Most EI providers report obtaining consent (83%), while just 46% of CW agencies report obtaining consent. When consent is obtained for children in foster care, agencies vary according to who provides that consent, including the CW agency, a parent surrogate, or a biological caregiver. Respondents are clear that attempts are made to contact biological parents of the results of screening in the event a child is in foster care. Fathers rarely participate in screening.

Services that are rated as the most available in PA are developmental, including services to address concerns in speech and language, sensory integration, and autism spectrum disorders. Services that are reported as least available are services focused on parent-child attachment and trauma-informed services. The most common reasons for service gaps are having too few providers, wait lists for services, or difficulty for families to access services due to distance.

Children's screening results are reported back to CW in 97% of counties, according to EI respondents, and counties have clear policies about which agency is responsible for ensuring that children receive preventive medical care, such as well-child check-ups (41% indicate that CW is responsible, 18% report that EI is responsible, and 17% report shared responsibility). However, CW and EI agencies rarely collaborate on Individualized Family Service Plans (IFSP), and inconsistently share information about risks that children have been exposed to that may increase the likelihood of developmental and mental health problems, including positive toxicity at birth, a history of multiple placement moves, and severity of maltreatment.

Recommendations

Research clearly and consistently shows that whether or not a young child referred to CW has substantiated maltreatment does not predict whether that child has developmental or mental health concerns (Casanueva, Cross, & Ringeisen, 2008; Leslie, Gordon, Ganger, & Gist, 2002; Rosenberg & Smith, 2008). That is, children with unsubstantiated maltreatment have similar levels of concerns and ought not to be disqualified from screening. For some very small counties in PA, just one or maybe no children are substantiated for maltreatment in a year, indicating that the current screening policy may not make much of an impact in these counties. Current state and federal policies that limit screening or distribute services to children with substantiated maltreatment likely miss many children that may benefit from early developmental care and intervention.

Early interventionists clearly feel more qualified to coordinate and provide children's developmental services, rather than services that address children's social and emotional needs. Availability of parent-child, trauma-informed, and evidence-based services are moderate in PA. There is arguably no other group of children who needs strong parent-child interventions more so than children involved with CW services. A major initiative is needed to implement preventive, social-behavioral, parent-child interventions during children's most critical period of development. Programs with proven ability to reduce children's risk of poor academic performance and behavior problems, such as Nurse-Family Partnership (Olds, 2006) or aimed to address early childhood trauma (Lieberman & Van Horn, 2009) are needed.

Because CW workers are not highly trained or educated developmental specialists, and results from another portion of this study show that detection rates of developmental problems are significantly higher when screening is conducted by EI rather than CW workers (McCrae, Cahalane, & Fusco, under review), greater support or structural changes are needed to ensure that screening in PA is conducted effectively. This should include strengthening the CW workforce through social work education (BSW and MSW), training, and on-the-job mentoring and supervision. Regional screening

centers in CW staffed by workers specifically employed to conduct screening, assessment, and collaborative planning with EI is one model that is used in Illinois (Bruhn, Duval, & Louderman, 2008) that may help improve the quality of screening, and streamline service planning for families in Pennsylvania. Consultative models, such as Early Childhood Mental Health Consultation (ECMHC; Cohen & Kaufman, 2005) are also increasingly used in early childhood.

In summary, the following recommendations are made:

(1) Strengthen the infrastructure to conduct screening by increasing the qualifications of CW workers in child development through education, training, and on-the-job supervision or mentoring;

(2) Increase CW-EI collaboration through agreements such as memoranda of understanding that clearly indicate the need for case-level information sharing, joint service planning, and protocol concerning responsibility for consent, involvement of biological parents, and uninterrupted services for children placed in out-of-home care;

(3) Expand screening to include children with open CW cases, regardless of substantiation;

(4) Secure consent for screening from caregivers as a means of increasing engagement ;

(5) Increase the availability of interventions to enhance children's social-emotional development, including a defined service system for young children with social-emotional problems that centers on parent-child relationships and trauma-informed care.

Introduction

Child welfare agencies play a pivotal role in linking vulnerable children with care for early developmental and mental health problems. Children involved with child welfare have high rates of these problems (Stahmer et al., 2005; Burns et al., 2004), yet too few receive services that may help alleviate their concerns and increase their chance of long-term positive outcomes. Research shows that among 0 to 3-year-olds who are investigated for maltreatment, 30 to 35% have developmental scores suggesting they may qualify for early intervention services, but just 13% of these children received such services following child welfare referral (Casanueva, Cross, & Ringeisen, 2008). One-third of 2 to 5-year-olds investigated show clinical-level behavior problems, but just 7% were receiving mental health services at intake to child welfare, or in the preceding 12 months (Burns et al., 2004).

Screening children at intake to child welfare (CW) and over time is one strategy that may increase the likelihood that children have access to early intervention (EI) services. Recognizing service gaps, the federal Child Abuse Prevention and Treatment Act (U.S. DHHS, 2003) and the Individuals with Disabilities in Education Act (IDEA, 2004) were amended to strengthen the link between CW and EI providers. Early intervention, funded through the IDEA Part C, is the care and coordination system for children ages birth to 3 who have developmental disabilities, delays, or evidence high risk for such delays (IDEA, 2004). Children ages 3 to 5 are served through IDEA, Part B, a similar care and coordination system for children this age.

In 2008, the Pennsylvania Department of Public Welfare, Office of Children, Youth, and Families implemented a comprehensive policy to screen children involved with CW using a standardized instrument, the Ages & Stages Questionnaires® (ASQ; Squires, Potter, & Bricker, 1999)[1] and its Social-Emotional version (ASQ:SE; Squires, Bricker, & Twombly, 2003)[2]. The policy *requires* that all children ages 0 to 3 who are substantiated for maltreatment be screened, and strongly encourages county child welfare agencies to expand the screening to include all children under age 5 who are receiving services (Commonwealth of Pennsylvania, 2008). Goals are to *"adequately assess the needs of children, to match services to these needs, and to mitigate the effects of child abuse and neglect by intervening to prevent recurrence, and ensure that the child is not further harmed by the potential deleterious effects of abuse and neglect on normal development."* Pennsylvania is a state-supervised, county-administered CW

---

[1] Ages & Stages Questionnaires® (ASQ™): A Parent-Completed, Child-Monitoring System, Second Edition, Bricker and Squires. Copyright © 1999 by Paul H. Brookes Publishing Co., Inc. Ages & Stages Questionnaires is a registered trademark and ASQ and the ASQ logo are trademarks of Paul H. Brookes Publishing Co., Inc.

[2] Ages & Stages Questionnaires®, Social-Emotional (ASQ:SE™): A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors, Squires, Bricker, & Twombly. Copyright © 2002 by Paul H. Brookes Publishing Co., Inc. Ages & Stages Questionnaires is a registered trademark and the ASQ:SE logo is a trademark of Paul H. Brookes Publishing Co., Inc.

system, meaning that counties have considerable flexibility in designing services that will best meet the needs of their community.

The Ages & Stages Questionnaires® were selected because of their ease of use, ability to detect children who need further developmental or social-emotional assessment, and monitoring format that emphasizes the importance of regular, periodic screenings to meet the rapid changes of early childhood development.

The ASQ assesses children's *developmental* skills in five areas: communication, gross motor, fine motor, problem-solving, and personal-social skills. The Ages & Stages Questionnaires: Social-Emotional (ASQ:SE)® complements the ASQ to identify children ages 3 to 66 months who may need further evaluation for behavioral difficulties or concerns about their social-emotional development or competence. This may include a child's ability to calm oneself down, enjoy people and activities, and establish secure relationships with adults. Children with a qualifying score on the ASQ or ASQ:SE are referred to Early Intervention Services for further assessment (Commonwealth of Pennsylvania, 2008).

Research

The Child Welfare Education and Research Programs of the University of Pittsburgh, School of Social Work is conducting a three-phase study of the screening initiative. Objectives of the evaluation are to:

- document the number of children who are screened, statewide;
- document the results of screening, including the number of children who screen positive, their area(s) of delay or concern, and their demographic characteristics;
- describe screening policies and practice across the state;
- view the extent to which screening is administered in a manner that engages families, and;
- examine the extent to which screening is related to families' access to early intervention, pre-school special education, and mental health services.

The Phase I Implementation Study was conducted June through September 2009, and examines policies and procedures that local CW and EI providers have put into place to implement the screening. The study involved phone survey interviews with CW and EI representatives from each of Pennsylvania's 67 counties.

The Phase II Screening Results Study tracks children's ASQ screenings through a statewide database used by county CW agencies. The database was developed by the Pennsylvania Child Welfare Training Program (CWTP) and is web-enabled and user-friendly. Information includes children's screening results, demographic characteristics, and living situations. Counties can run reports of children's schedule for follow-up screenings and screening results. Agencies began using the database in July 2009.

The Phase III Outcomes study focuses on caregiver's experiences with the screening and access to EI and related services. In-person interviews will be conducted with a random sample of 250 caregivers to find out their experiences with screening, engagement in the process, and family strengths, resources, and concerns. The outcomes study began in June 2010.

Results reported here are from the Phase I study. Further information about the project can be found at: **http://www.pacwcbt.pitt.edu/ASQ.htm**

Methods

To find out about county-level policies and practice to implement screening, CW and EI provider representatives were interviewed from each of Pennsylvania's 67 counties. Participants were recruited for the study by purposive sampling. County CW agency directors were asked to nominate the person in their agency "most knowledgeable to answer questions about the ASQ screening initiative, agency policy and practice, and coordination with early intervention services". Child welfare representatives were interviewed by phone in Summer 2009. The total number of CW participants was 85, representing all 67 counties. Some agencies chose to have more than one respondent participate in the interview.

To recruit EI provider participants, CW participants were asked to name the primary early intervention coordinating agency and individual who would be best to speak with about the screening initiative. Interviews were completed with EI representatives in August and September, 2009. A total of 57 EI participants were interviewed, representing 66 of 67 counties (12 agencies serve multiple counties, and one county did not complete an interview).

The interviews took 30 to 60 minutes to complete and included questions regarding: (1) policies and procedures to implement screening, (2) family engagement, (3) CW-EI service coordination, and (4) services and resources. Interviews were completed by the study project coordinator or principal investigator. Items were scaled and open-ended. Many were developed specifically for this project, but approximately one-third were based on Stahmer and colleagues' survey of state CW-EI policy (2008), and several items concerning CW-EI coordination were drawn from the National Survey of Child and Adolescent Well-being (NSCAW), Caring for Children in Child Welfare (CCCW) study (Landsverk et al., 2006).

The following is an overview of measures. Please see Appendix B and C to view the full interviews.

Policies and procedures. Respondents were asked to identify which children are being screened using the ASQ: (1) children following the parameters of federal CAPTA and IDEA only (under age 3, substantiated) or (2) a larger group. Counties screening a larger group were asked to specify. Respondents were asked whether additional children in the household are screened, who conducts screening (EI or CW), whether caregivers consent to have their child screened and if yes, who consents for children in foster care.

Family engagement. Respondents were asked a series of questions concerning engaging caregivers in the ASQ screenings. Respondents rated their agencies' success completing screens: All of the time, most of the time, some of the time, or hardly ever. Respondents reported whether differences exist by caregiver in completing screens and if yes, which caregivers were the most challenging to complete screening.

Two open-ended items inquired about what caregivers are told about what it means for their child to have a positive developmental screen and a positive social-emotional screen. Responses were coded by two raters. Respondents reported level of father participation in screenings using a 10-point scale from 0 (never participate) to 10 (always participate).

CW-EI service coordination. Items focused on the methods that agencies use to track children's screenings and mechanisms of coordination between CW and EI. Child welfare respondents were asked to indicate whether the following case-level information is kept by their agency:

- dates of completed screens
- schedule for follow-up screens
- copies of full completed screens
- screening information summary
- overall comments on the screening
- whether or not the screening revealed a concern
- children's screening results over time on the same form or file
- Individualized Family Service Plans
- developmental services referred to and received.

Items were dichotomous (yes/no) and for items answered yes, respondents were asked to indicate whether the information is stored electronically or in case files.

Twelve dichotomous items were modeled after national survey items (Landsverk et al., 2006), asking respondents to indicate whether the following mechanisms exist to carry out the project:

- designated person or team in the agency to lead the project
- within or cross-agency meetings about the completion status of individual screenings
- tracking databases
- shared databases
- memoranda of understanding about sharing case-level information
- joint service or project planning
- standard referral forms
- training materials.

Services. Early intervention providers were asked to rate the availability of services to address 11 types of developmental and mental health concerns in young children. The scale ranged from 1 (very low availability) to 10 (very high availability). Examples included services for autism spectrum disorders, substance-exposed infants, and conduct or behavior problems. Respondents were similarly asked to rate the availability of evidence-based or promising parenting interventions for at-risk families.

Respondents were asked two items about service gaps, "are there any gaps in services to meet children's developmental needs" and "are there any gaps in services to meet children's social-emotional needs?" Respondents reporting gaps were asked to specify reasons for these gaps.

EI respondents were asked whether or not the following evidence-based interventions for young, at risk children were available in their community: Nurse-Family Partnership, Parents as Teachers, Parent-Child Interaction Therapy, The Incredible Years, Healthy Families America, and other evidence-based interventions. Those indicating "other" were asked to specify.

Results

Policies and Procedures to Implement Screening

In 2008, Pennsylvania CW agencies received 3,246 reports of children under age 3, of which 767(approximately 24%) were substantiated. Another 20% of children investigated for maltreatment are ages 3 to 5 (U.S. DHHS, 2005). The volume of children who need to be screened following the federal CAPTA and state policy goals can quickly overwhelm agency resources. Because Pennsylvania mandates screening among children ages 0 to 3 with substantiated maltreatment, but *strongly encourages* counties to screen all children ages 0 to 5 receiving agency services, a key study question is whether agencies decide to implement mandated screening only, or screen to reach a larger group of children. Research shows that children are not distinguished developmentally based on whether or not maltreatment was substantiated; children referred to child welfare but unsubstantiated experience similar levels of need (Casanueva et al., 2008). Thus, agencies that screen based on substantiation status are likely to miss many children who may benefit from early detection and services.

Who is being screened?

As shown in Table 1, twenty-nine counties (43%) screen only children who fall within the CAPTA parameters (under age 3, substantiated for maltreatment). Twenty-seven counties (40%) screen all children under age five who are receiving CW services. The remaining counties screen children under age 3 who are receiving agency services (8 counties or 12%), or children under age five with substantiated maltreatment (5%)

Table 1. Agency reports of the age-range and CW status of children being screened

Group	Number of counties	%
Under age 3, substantiated only	29	43
Under age 5, open to services	27	40
Under age 3, open to services*	8	12
Under age 5, substantiated	3	5
Total	67	100

*one county screens children required by CAPTA and children under age 12 months who are receiving agency services

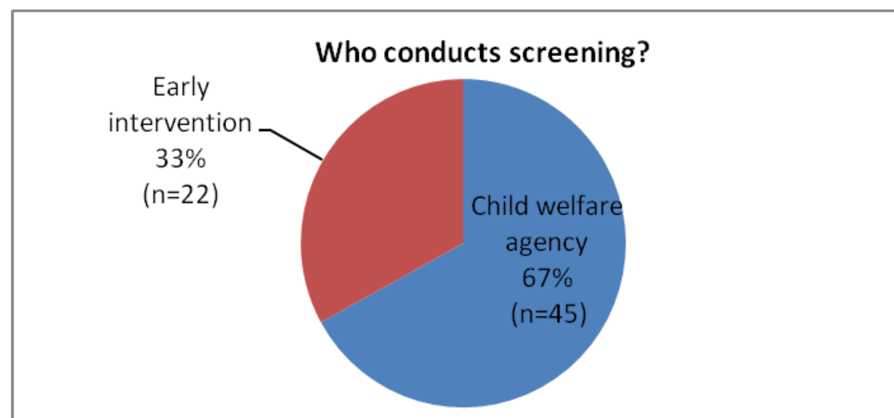
Just over one-half of CW agencies (52%) report that they also screen other young children in the household. Among counties that contract with EI to provide the screening (n=22), 11% report that other young children in the household are screened.

At this point it is not clear what factors relate to county policies around which children to screen—children mandated by federal and state parameters only, or a larger group. Some anecdotal information suggests that current caseload size, the number of workers and the ability to secure additional funding through a request for Act 148 or through the Needs Based Budget may play a role in this decision. For counties that contract with EI providers to conduct screening, their workforce issues and the contract cost relative to the number of screenings may be other factors in the decision process. Research suggests that workforce, resources, and neighboring counties' policies or practices relate to service decision making (McCrae, Rauktis, & Cahalane, 2010; Rauktis, McCarthy, Krackhardt, & Cahalane, 2010).

Which agency conducts the screening?

An important local decision point in implementing screening is which agency should conduct the screening. Private agencies, funded through the IDEA, typically provide both intervention and screening services for young children (3 and under) with developmental delays. This study found that approximately one third of PA CW agencies (33% or 22) subcontract ASQ screenings to EI agencies, but most counties (67%) have CW conducting the screenings themselves (Figure 1).

Figure 1. CW agency reports of which agency conducts ASQ screening



Note: In 4 counties, there was conflicting information, or procedures changed between the time that we interviewed CW and when we interviewed someone from EI. In other words, 22 EI agencies were identified by CW as conducting screening (as reported in Figure 1), but when we interviewed EI, only 18 identified themselves as conducting the screening (Figure 2). Some of this discrepancy was actually a change in procedure (probably 2 out of the 4 discrepancies), and some was just lack of clarity about which agency was conducting screening.

Which CW workers conduct screening?

Within the CW agency, who conducts screenings? It appears to fall under the job tasks for caseworkers—84% of CW agencies responsible for screening report that screening is done by

caseworkers. Other counties report that case aides (9%) or program or other specialists (7%) complete screening.

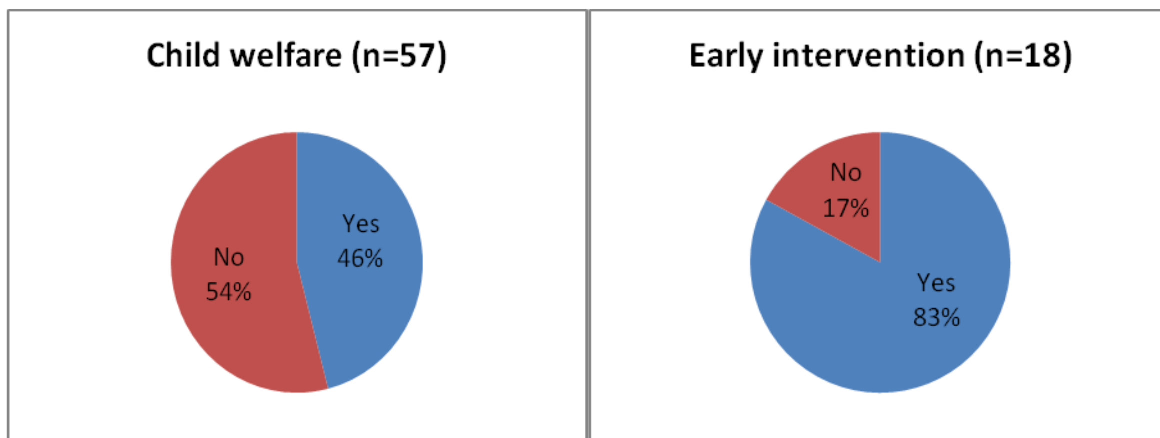
A further question is whether screening is assigned to a specialized unit, or if all caseworkers should be expected to complete screenings. Approximately one-half of CW agencies (53%) report that workers in all units (e.g. intake, in-home, adoption) conduct screenings. A smaller percentage of counties (31%) limit the role to the in-home or family services unit, and the remaining counties (16%) use specialized units. This division of labor may reflect the rural landscape of Pennsylvania, such that it is impossible to specialize workers in small counties who must cover large areas. A worker may be expected to do it all—investigate for abuse and neglect, screen for delays, provide case management of services and supervise foster parents. If the majority of screening is being done by generalist caseworkers who may have limited training in assessing development delays or early behavioral/emotional problems, then this has implications for training and supporting caseworkers.

<u>Do Caregivers Consent for Screening?</u>

Caregivers should be fully informed of the purpose of screening, including what to expect from the items and process, and the services that are available should the child's screening indicate a concern. One recommended practice is to obtain consent from caregivers for screening (Squires et al., 2003).

Figure 2 displays whether caregivers (defined as whoever is living with the child at the time) provide consent for screening. While Pennsylvania's policy does not require that consent be obtained, it can be viewed as part of the process of engaging and informing caregivers. Forty-six percent (46%) of CW agencies report that they obtain consent to perform the screening compared to 83% of EI agencies.

Figure 2. Do caregivers provide written consent for screening?



When children are in foster care, agencies report wide-ranging practice concerning who consents for screening (Table 2). Child welfare agencies more often obtain consent from the biological parent (46%), while EI agencies obtain consent from either the biological or a surrogate parent (23%).

Table 2. CW and EI provider reports of who consents for children in foster care

Response	CW (n=26) %	EI (n=26) %
Biological parent only	46	15
Biological and foster parent	8	0
Biological or surrogate parent	0	23
Both biological and surrogate parent	0	8
CW agency	31	15
CW agency and parent	15	0
CW agency and foster parent	0	8
Guardian	0	8
Other	0	15

A fair number of CW (31%) and EI agencies (15%) report that the CW agency consents for children in foster care. An opportunity for collaboration with biological parents and caregivers is missed when agency consent is utilized. Unlike CW agencies, EI agencies also reported obtaining consent from guardians, "other", and a combination of foster parent/child welfare agency. This may reflect that EI providers likely have less access to biological parents or are unclear about how to contact biological parents.

Key findings: Policies and Procedures

- 43% of counties screen children ages 0 to 3, substantiated for maltreatment only and 34% screen all children under age 5 receiving CW services. At this point it is not clear what drives county decisions about which children should be screened, but those that screen children based on substantiation status are likely to miss many children in need.

- Screening is conducted by CW agencies in 67% of counties, predominantly caseworkers not assigned to particular units (53%), although a fair number (31%) limit screening to caseworkers who work with families on a on-going basis (e.g. in-home unit compared with intake).

- Screening performed by CW tends to include screening other young children in the household while screening conducted by EI tends to include the referred child only.

- Screening performed by EI more frequently includes obtaining consent from caregivers, while screening by CW does not; however, agencies report a wide-range of practice concerning who provides consent for children in foster care—biological parent, foster parent, CW agency.

Family Engagement

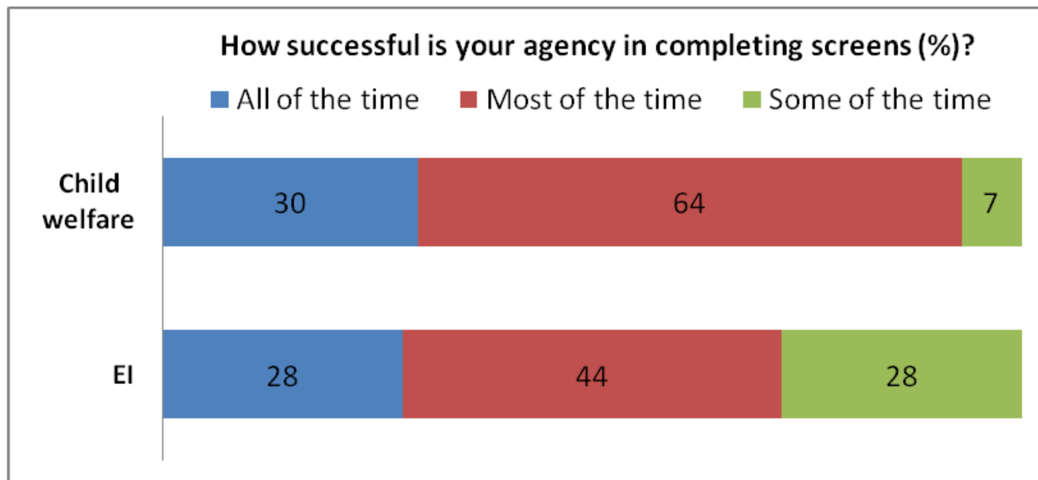
Family intervention is critical to strengthening the environmental context for children and providing families with supports and resources needed to promote positive outcomes. While CW

workers want caregivers to nurture and protect their children, engaging families in services remains a challenging issue (Berg & Kelly, 2000; Kemp, Marcenko, Hoagwood & Vesneski, 2009). For young children with developmental and socio-emotional problems, family engagement is particularly critical as research shows that when families are actively engaged in services, children are more likely to benefit (Hoagwood, 2005; McKay & Bannon, 2004). Low rates of service use reduce the likelihood that parents can address the problems that led to CW involvement and the possibility that families achieve reunification or lasting connection (Bellamy, 2008; Carlson, Matto, Smith & Eversman, 2006; Lau, Litrowik, Newton & Landsverk, 2003). The ASQ screening process provides an opportunity for CW workers to engage families collaboratively and with a partnership and service emphasis that is often compromised by the necessary focus on child safety, risk assessment, and investigation.

How successful are agencies completing screens?

Child welfare and early intervention providers reported how often their agency is successful in completing screens with qualifying children. As shown in Figure 3, 94% of CW respondents reported that screens are completed "all" or "most of the time". Among EI providers, the success rate was 72%. These rates are similar to other national findings among CW agencies with comprehensive screening policies, wherein key informants estimate that 90% of children entering foster care receive developmental screening (Stahmer, Leslie, Landsverk, Zhang, & Rolls, 2006). True rates of completed screenings among qualifying children would inform this picture.

Figure 3. Agency reports of success completing screens



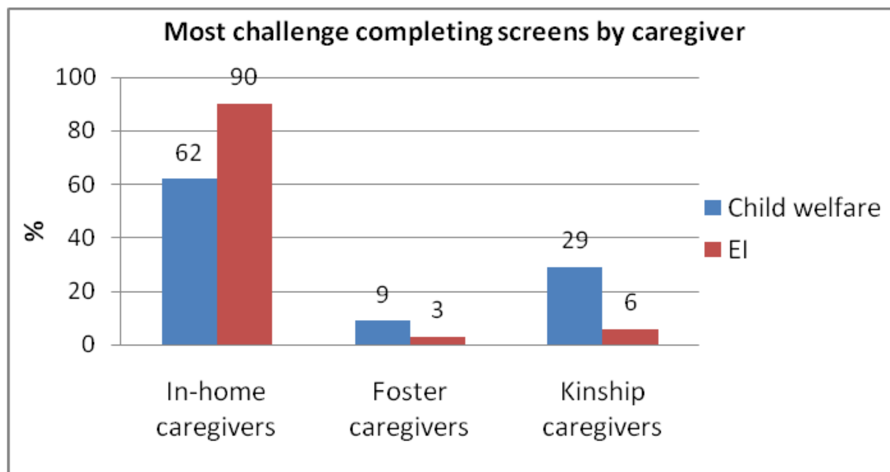
Note. CW total n=61 EI total n=18.

Is there a difference completing screens according to children's living situation?

Biological parents who maintain custody of a child who has been substantiated for maltreatment may be likely to view workers with suspicion and mistrust. Respondents were asked whether there is a difference in their ability to complete screens according to children's living situation

(in-home, foster, or kinship care). Early intervention providers not conducting the ASQ screenings were asked to rate this item concerning other evaluations or assessments.

Figure 4. Agency reports of challenge completing screens by type of caregiver



As shown in Figure 4, most CW and EI agencies report that there is no notable difference completing screens by children's living situation (64% and 53%, respectively). When differences are reported, in-home caregivers were rated as the most challenging.

Clearly, EI providers report more challenge completing screens with children overall, as over one-quarter (28%) report that screens among qualifying children are completed "some of the time". This may have to do with difficulty securing agreement for the screening from caregivers, or children moving. Many EI providers report that they are not notified (38%), or are sometimes notified (3%), when a child has moved.

<u>Are biological caregivers contacted regarding screening results when a child is in foster care?</u>

When a child is in foster care, best practice involves both birth and foster parents in service decisions. This is especially relevant since most children are returned home and family engagement is associated with improved outcomes in children's mental health (Freisen, Pullmann, Koroloff & Rea, 2004; McKay et al., 2004; National Research Institute, 2008).

Respondents were asked whether attempts are made to contact biological parents about screening results when a child is in foster care. Nearly all CW (95%) and EI respondents (85%) reported that attempts are made to contact biological parents. Among EI agencies that inform biological parents (n=12), 33% reported that CW does the contacting, and 58% reported that EI does the contacting. The remaining 8% indicated that another agency does the contacting.

<u>To what extent are fathers involved in screening?</u>

Engaging fathers is a recognized national issue in CW (Malm, Murray, & Geen, 2006) and is noted as an area for enhancement in Pennsylvania's Program Improvement Plan. Using a 10-point scale from 0=never to 10=always, respondents were asked how often the child's father or a father figure

participates in ASQ screening. EI agencies not conducting screening rated this item concerning assessments or other evaluations.

Nearly 60% of CW respondents reported that fathers participate in ASQ screening less than half of the time (Table 3). Even more striking is that that many CW respondents either didn't know whether fathers participate or felt that the question was not applicable. These findings suggest that contact with fathers is often not considered at all or that attempts to establish a connection with fathers is limited. The high number of single parents in child welfare (U.S. DHHS, 2005), indicates the extra effort that is needed to engage fathers in discussions about their child's development. Interviews with caregivers may help to clarify what the barriers are to involving fathers and what engagement strategies may be most helpful in strengthening father participation. Ensuring that fathers receive written materials about children's developmental status is one option when fathers are unable to participate.

Table 3. Father participation in ASQ screenings or evaluations

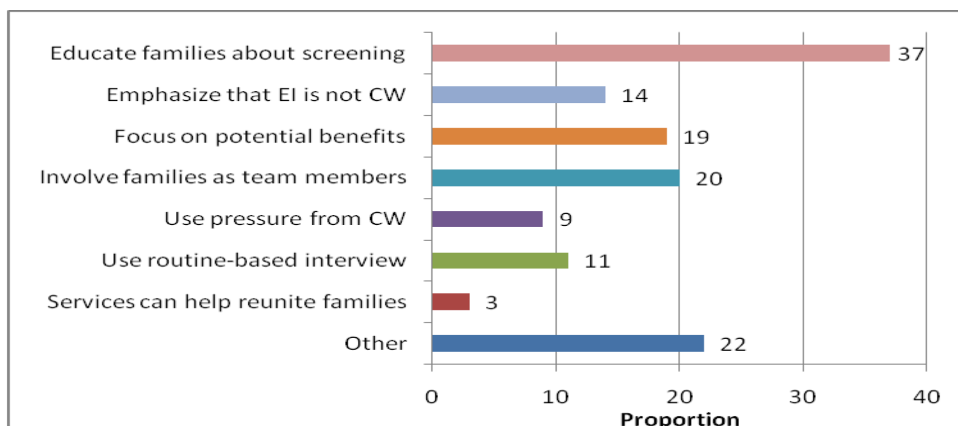
Response	%	
	Child Welfare (n=44)^	Early Intervention (n=65)
Less than ½ the time	57	60
About ½ the time	41	35
More than ½ the time	2	5

^Scale ranges from 0 (father never participates) to 10 (father always participates). Responses 0 to 3 were considered "less than ½ the time", 4 to 6 were considered "about ½ the time" and responses 7 to 10 were considered "more than ½ the time". Twenty CW respondents answered "don't know" and 3 answered "not applicable". One EI provider responded "don't know".

<u>What are successful strategies to engage families in screening?</u>

Early intervention providers (n=66) were asked their opinion about the most successful strategies to engage CW-involved families in screening or assessments. Responses were coded into 8 categories (Figure 5). Respondents could report more than one strategy.

Figure 5. EI reports of the most successful strategies to engage families in screening



Most frequently, respondents indicated that educating families, either about the purpose (37%) or benefits of screening (19%), is effective to engaging them in the process. A fair number report that emphasizing families' participation as valued team members is important to engagement (20%). Less frequently, EI providers report that engagement strategies include distinguishing their agency from CW (14%) or using pressure from CW (9%). This may be more likely to occur in communities where the relationship between CW and EI is strained, or there is a particularly high level of stigma associated with families who receive CW intervention.

Communication with caregivers around positive screens

While some caregivers may realize that their child has developmental difficulties or is not meeting developmental milestones at the time of screening, other caregivers may not and screening will be the first indication. Respondents were asked two questions: "what are caregivers told about what it means to have a positive developmental screen?" and "what are caregivers told about what it means to have a positive social-emotional screen?" Two doctoral level researchers experienced in qualitative analysis read the comments multiple times and created a list of themes which were then given descriptive codes. These codes were further developed using a constant comparative process, resulting in 8 final codes.

Most commonly, EI responses emphasized that the child needed further assessment (29% of responses) or services (20% of responses). Child welfare workers responded similarly, with 22% of responses emphasizing the need for services and 17% indicating the need for further assessment. Other responses were to explain EI services in detail (roughly 7%), or emphasize the importance of helping the child master age-appropriate milestones (roughly 5%).

Regarding the social-emotional screen, respondents again tended to emphasize that the child needs additional services (28% of CW responses and 23% of EI responses), or needs further assessment (18% and 23%, respectively). A fair number of CW responses (17%) indicated that they didn't know what caregivers are told about what it means to have a positive social-emotional screen. This may have to do with the person interviewed not having such specific information, or a lack of protocol or understanding about what a conversation with families around ASQ:SE screening results should entail.

Key findings: Family Engagement

- Early intervention providers report more challenge completing screens overall, and both agencies report that the most challenging situation is with caregivers of children who remain at home

- Education, creating a team environment, and focusing on the potential benefits of screening are strategies reported by EI to engage caregivers in screening and assessment

- A small number of EI agencies report that engagement strategies include distinguishing their agency from CW (14%) or using pressure from CW (9%); this may be more likely to occur in

communities where the relationship between CW and EI is strained, or there is a particularly high level of stigma associated with families who receive CW intervention

- Agencies are clear that biological parents are contacted about the results of screening when a child is in foster care, but it is unlikely that this contact includes biological fathers

- Fathers infrequently participate in screening, suggesting that many miss out on hearing about their child's development and strategies to parent or navigate services that may help alleviate children's difficulties

Child welfare and early intervention service collaboration

The very nature of meeting young children's needs in child welfare requires coordination and collaboration among multiple agencies, including income and housing assistance, early intervention, medical care, substance abuse treatment, and in some cases, the judicial system. When children are in foster care, services are coordinated between foster and biological parents. Child welfare agencies must integrate services effectively with other providers and monitor families' progress on particular problems to achieve desired outcomes, such as reunification (Marsh, Ryan, Choi, & Testa, 2006).

Child welfare workers likely have the most comprehensive view of children's maltreatment and family history because of information that is gathered during an investigation, case file records of children's CW involvement, and knowledge of family resources and strengths. Children's exposure to environmental risks, such as the trauma of maltreatment, chronic neglect, or violence in the home, have an impact on their developmental, social-behavioral, and academic trajectories (Dodge, Pettit, & Bates, 1994; Rouse & Fantuzzo, 2009). When shared with other agencies appropriately, this should inform service planning.

What information is shared between CW and EI?

Early intervention providers were asked how frequently they receive information from CW concerning children's exposure to environmental risks. As shown in Table 4, EI providers tend to receive information about children's foster care status, but inconsistently receive other types of information. Roughly one-third report that they never receive information about children's maltreatment (29 to 39%), and one-half (51%) report that children's positive toxicity at birth is never or only sometimes shared. This lack of communication has implications for their developmental risk and services that may address mental health risk, such as exposure to trauma. Nearly all (97%) EI providers report that children's EI eligibility status is reported back to CW.

Table 4. EI provider reports of how often information is shared about children's exposure to environmental and medical risks

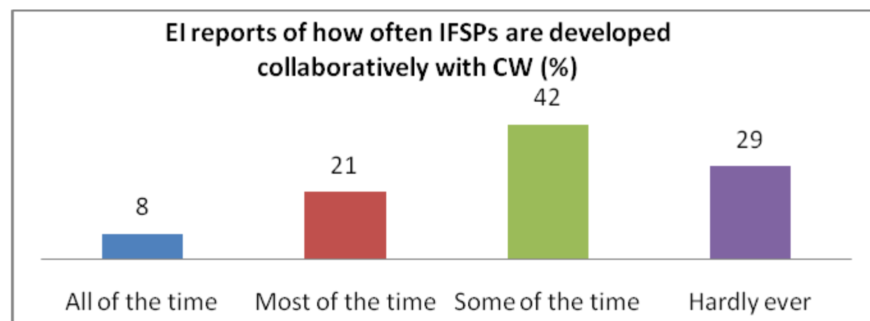
Information	%		
	Always	Sometimes	Never
Type of maltreatment	31	40	29
Severity of maltreatment	23	38	39
Current foster care status	79	18	3
History of multiple placement moves	9	40	51
Diagnosed medical conditions	49	42	9
Positive for substances at birth	49	29	22
Current caregiver substance abuse	23	55	22
Exposure to domestic violence	20	51	29
Legally mandated services plan	8	32	60

<u>To what extent is there joint service planning?</u>

An Individualized Family Service Plan (IFSP) is a written document that is developed by a multidisciplinary team, including children's parents, when a child receives EI services (IDEA, 2004). The IFSP includes information about children's current developmental, physical, and social-emotional health status, family strengths and resources, outcome goals for the child and family, and services and steps that will be taken to meet children's needs and transition them to later preschool-age services. Respondents were asked a number of questions about joint CW and EI service planning.

As shown in Figure 6, EI providers report a range of practice concerning collaborative planning around the development of children's IFSP. Many EI providers report that IFSPs are developed collaboratively "all" or "most of the time" (29%). However, nearly three-quarters (71%) report collaborative IFSPs "sometimes" or "hardly ever". It could be that in some cases, children are no longer receiving CW services when the IFSP is developed, or that some families prefer not to have CW included in service planning. Since many children, however, will have open CW cases and qualify for EI, joint service planning between the two agencies along with the family will likely to lead to a more integrated set of family and child service goals. Families may also view CW and EI as united team members.

Figure 6. EI provider reports of how often children's IFSP is developed collaboratively with child welfare



Which areas of the IFSP are typically developed collaboratively with CW?

Respondents were asked whether or not each area of the IFSP is typically developed collaboratively with CW, when joint planning occurs (Table 5). Results show that most frequently, EI and CW collaborate on EI services that will be provided (65%), family resources related to enhancing children's development (58%), and major outcome goals for the child (47%).

Table 5. Areas of EI-CW collaboration on IFSP

Area	%
Family resources related to enhancing child development	58
Major outcome goals for the child	47
Major outcome goals for the family	38
Criteria for determining child progress	34
Criteria for determining family progress	29
Specific early intervention services that will be provided	65

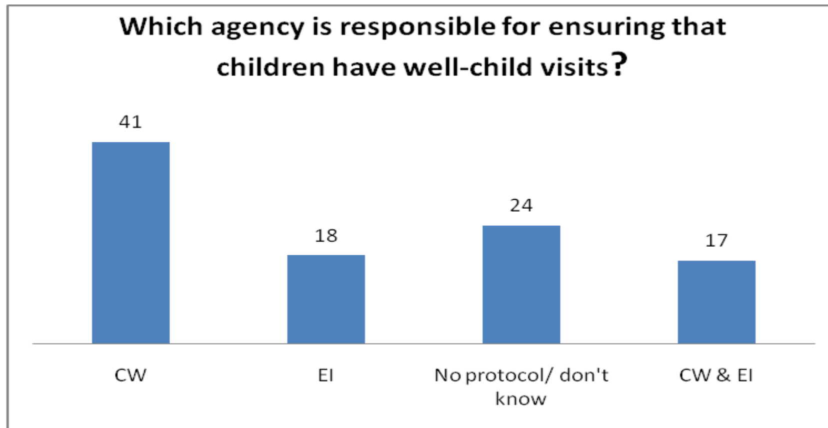
When a child is in foster care, EI respondents report a range of practice concerning whether IFSP's include services for biological parents. About one-half report this occurs "some of the time" (46%), and 21% report this occurs "hardly ever". EI providers also report being split concerning whether biological parents are eligible to receive EI services, if the child is in out-of-home placement and reunification is the goal (59% yes; 41% no). Since reunification is nearly always the first goal when a child is placed in foster care, it is important that the service strategy includes a working relationship with children's biological parent(s) to the extent possible around the developmental goals for the child.

Who ensures that children have up-to-date physical health assessments?

The American Academy of Pediatrics (2000) recommends nine well-child preventive visits at defined intervals before a child turns age 1. Visits become less frequent as a child reaches age 2, but are recommended at least yearly through age 18. Well-child visits include physical examination, immunizations, check-ups on developmental skills, and conversations between doctors or nurses and parents about their child's nutrition and parenting issues. Research shows that compliance rates with well-child visits are highest for infants and decrease with age, and that lower income families overall are less likely to ensure their child's visits (Selden, 2006).

Early intervention providers were asked which agency is responsible for ensuring that children have up-to-date physical health assessments, such as well-child visits (Figure 7). Results show that 41% indicate that CW is responsible, 18% report that EI is responsible, and 17% report shared responsibility. That this totals three-quarters of PA counties, indicates that agencies are clear about ensuring that children have access to pediatric care.

Figure 7. EI reports of agency responsibility for ensuring that children have well-child visits



Record-keeping and tracking

A method of ensuring that all children who qualify for screening actually receive it should be part of every agency's screening initiative.

Respondents were asked, prior to using the database developed for this project, the types of tracking mechanisms that are kept by their agency concerning children's screenings (Table 6). Results show that about one-third of CW agencies keep a master record of children who qualify *and* receive screening (38%). Databases to store such information are rare, particularly among CW agencies; less than one-quarter (22%) report that they keep tracking information electronically, such as in a spreadsheet. One-half of EI agencies report using a tracking database.

Table 6. Methods of record-keeping reported by CW and EI concerning ASQ screenings

Mechanism	%
Child welfare:	
Master record of children who qualify for screening	44
Master record of children who receive screening	40
Master record of children who qualify and receive screening	38
Database	22
Within-agency meetings about screening completion status on individual children	40
Early intervention:	
Database	50
Within-agency meetings about screening completion status on individual children	24
Joint mechanisms:	
Memorandum of Understanding (MOU) about information sharing-CW report	57
Memorandum of Understanding (MOU) about information sharing-EI report	80
Training received by EI concerning working with CW-involved families	44

Results show that 40% of CW and 24% of EI agencies report within-agency meetings about the completion status of screenings. This could indicate that workers discuss screenings through other venues, such as one-on-one supervision, that meetings about this are unnecessary, or that more ought to be done to track children's screenings. That 60% of CW agencies reported no master record of children who quality and receive screening, and that agencies do not typically have meetings about it, suggests that this is an area for improvement. Pennsylvania now uses a database and addresses the issue here, but other states considering implementing screening may want to establish protocol around this at the outset.

The majority of EI respondents reported that they would like more information or training about child welfare services (70%, n=42). This included training regarding CW regulations, methods of collaborating, and social and psychological issues frequently encountered within children involved with child welfare. Less than one-half of EI agencies (44%) reported that one or more workers at their agency have received training in working with child welfare-involved families after the CAPTA and IDEA amendments in 2003-2004.

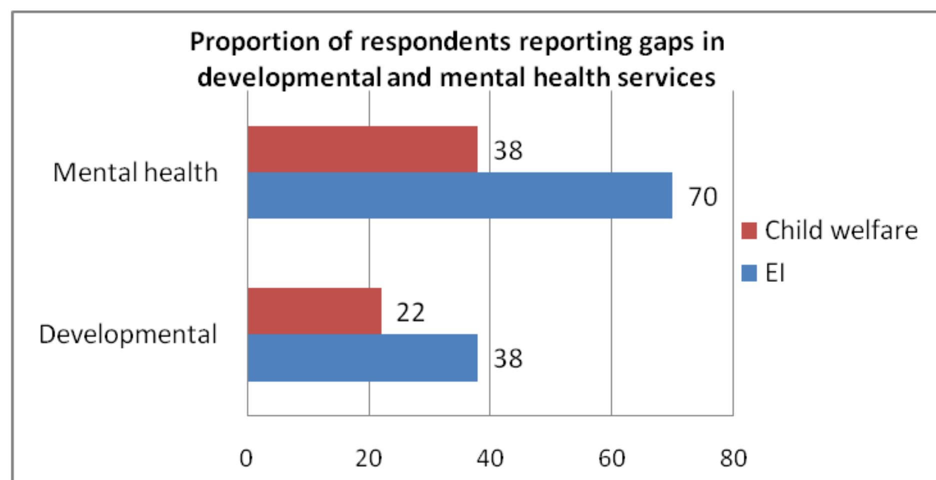
Summary of cross system collaboration

- CW agencies inconsistently share information with EI about children's exposure to environmental and medical risks that likely relate to their development and mental health.
- Although many agencies report having MOU's to share case-level information, there may still be concerns about confidentiality.
- Collaborative planning on children's IFSP is atypical. This could be because some children are not actively receiving CW services at the time the IFSP is developed, or some families prefer not to have CW involved. Joint service planning to the extent possible along with families is likely to lead to a more integrated set of family and child service goals.
- Agencies are clear about ensuring children's access to pediatric care well-child visits; 76% of counties have protocol concerning which agency is responsible
- Many agencies did not begin the project with the intention of tracking which children who qualify for screening actually receive it

Services and service gaps

An important part of conducting mental health and developmental screening is linking children with services to meet their needs. Child welfare and EI providers were asked about gaps in services (Figure 8). Regarding mental health needs, 38% of CW and 70% of EI providers indicated there are service gaps. Less than one-quarter of CW respondents (22%), and just over one-third of EI respondents (38%) indicated there are developmental service gaps.

Figure 8. Proportion of respondents reporting gaps in developmental and mental health services



What contributes to developmental and mental health service gaps?

Respondents who indicated mental health service gaps were asked to specify reasons for those gaps (Table 7). For both CW agencies and EI, having too few providers was a large concern (32% and 36%, respectively). For child welfare, waiting lists or a long wait for evaluations (32%) was an issue, but such wait lists were not an issue for EI. EI providers frequently noted there are mental health service shortages for certain child age groups (29%), most commonly among children under 3 years old.

Table 7. Reasons for mental health service gaps

Response	CW (n=22)	EI (n=45)
Too few providers	32	36
Families have trouble accessing due to distance	14	18
Waiting list or wait for evaluations is too long	32	0
Shortage because of child age	14	29^
Other	9	38

Respondents who indicated developmental service gaps were also asked to specify. Again, some differences emerge between the responses of CW and EI. Most CW agencies pointed to issues with waiting lists or a long wait for evaluations, while such waits were not an issue for EI. The reason for this is unclear. One-quarter of CW agencies reported shortages due to the child's age, which was not an issue for EI. For EI providers, too few providers (48%) and gaps in specific services (44%) were the biggest problems (Table 8).

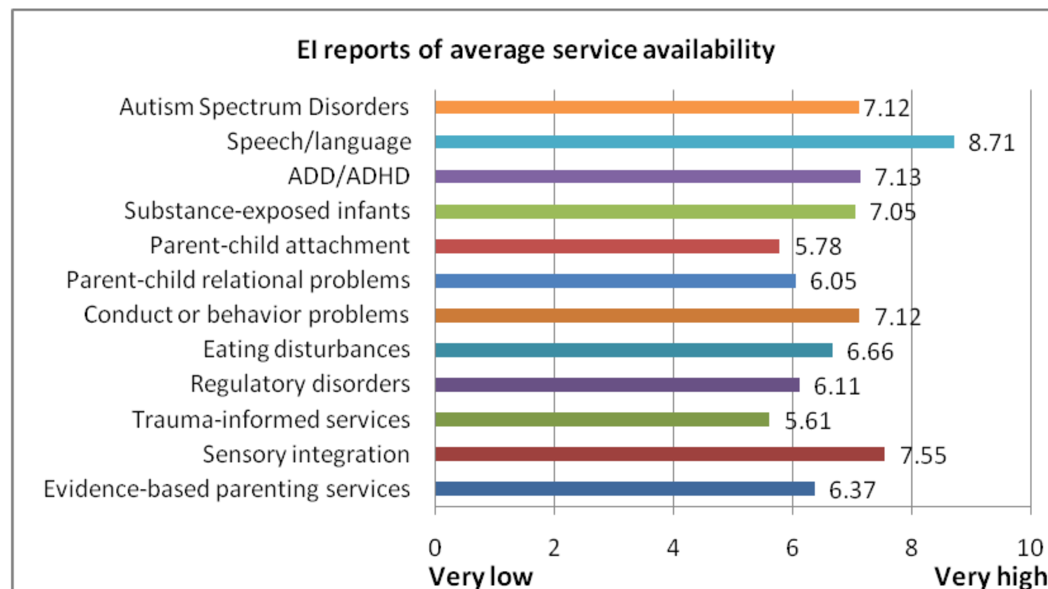
Table 8. Reasons for developmental service gaps

Response	CW (n=12)	EI (n=25)
Too few providers	17	48
Families have trouble accessing due to distance	17	36
Waiting list or wait for evaluations is too long	42	0
Gap in specific services (e.g. speech)	25	44
Shortage because of child age	25	0

What is the availability of services for particular types of problems?

EI providers were asked to rate the availability of 12 specific types of services to meet children's developmental and social-emotional needs. The scale ranged from 1 (very low availability) to 10 (very high availability). As shown in Figure 9, speech/language and sensory integration services were reported as most available. The least available services were trauma-informed services, and those focused on parent-child attachment, and parent-child relational problems. This is interesting considering that children are referred to child welfare for problems of neglect, maltreatment and other concerns that center predominantly on their relationship with parents and caregivers.

Figure 9. EI provider reports of the availability of specific services



To what extent are evidence-based services for young, at-risk children available?

EI providers were asked about the availability of five specific evidence-based or promising practices relevant to young children at risk for maltreatment, developmental or mental health problems,

or who are exhibiting behavior problems (Table 9). A brief description of each intervention is provided in Appendix A.

Respondents were asked whether or not these programs are available and provided to at-risk children in their community. Nurse-Family Partnership (67%) and Parents as Teachers (49%) were the most commonly available programs. Only 17% reported the availability of PCIT, and fewer than 10% reported The Incredible Years, Healthy Families America, or other promising practices. More than 40% of respondents reported that they didn't know whether PCIT, The Incredible Years, Healthy Families America, or other programs are available. That NFP is frequently available is positive, but also limiting, because the program is designed for first-time parents. Overall, results indicate a shortage or lack of awareness of evidence-based parenting programs for at-risk families among EI respondents.

Table 6. EI reports of the availability of evidence-based practices for at-risk families or young children with behavioral difficulties

Service	%		
	Yes	No	Don't Know
Nurse-Family Partnership (NFP)	66.7 (n=44)	22.7 (n=15)	10.6 (n=7)
Parents as Teachers (PAT)	48.5 (n=32)	31.8 (n=21)	19.7 (n=13)
Parent-Child Interaction Therapy (PCIT)	16.7 (n=11)	40.9 (n=27)	42.4 (n=28)
The Incredible Years	7.7 (n=6)	45.5 (n=30)	45.5 (n=30)
Healthy Families America	7.7 (n=5)	50.8 (n=33)	41.5 (n=27)
Other evidence-based or promising interventions for at-risk families	7.7 (n=5)	50.8 (n=33)	41.5 (n=27)

Summary of Services and Service Gaps

- CW and EI differ in their perception of the availability of mental health services for young children, indicating that perhaps CW agencies have more information about available services, or that EI providers feel that existing services are insufficient

- There are more mental health and parent-child service gaps reported compared with developmental services

- Many CW agencies report that wait lists for evaluations are problematic (30-40%), yet this is not reported by EI. This may reflect an actual difference in the perception of EI and CW agencies around how soon children are provided assessments, or social desirability reporting bias by EI respondents such that they are reluctant to indicate problems with wait lists due to EI policy around time frames for assessments

- Results indicate a shortage or lack of awareness of parenting programs for at-risk families among EI respondents, including evidence-based services

Key Findings and Implications

Child welfare and EI agencies in Pennsylvania have successfully implemented large-scale standardized screening among young, maltreated children at high risk of developmental and mental health problems. Several key findings inform our practice and policy recommendations:

1. A predominance of children are screened by CW caseworkers, compared with EI;
2. 43% of counties screen children ages 0 to 3, substantiated for maltreatment only;
3. Collaborative service planning and information-sharing between CW and EI is inconsistent;
4. Protocol for children in foster care varies;
5. There is a lack of available services to address young children's social-emotional competence.

Each of the findings is addressed in the following recommendations.

Workforce development

Child welfare workers come from a variety of academic disciplines, some that may not equip them with skills in early childhood development. This may relate to the finding that children screened by EI in PA have over three times the rate of developmental concerns on the ASQ compared with children who are screened by CW (McCrae, Cahalane, & Fusco, under review). Rates of concerns in other studies are much higher than those found in PA (Jee et al., 2010), suggesting that screening in PA does not meet its full potential. The following are models that may help improve the process of screening.

- **Child development specialist roles in CW agencies.** Specialists would develop competency in early childhood development and mental health, to handle a specialist caseload, mentor and advise others, and serve as a liaison with EI.
- **Screening conducted jointly between workers from CW and EI.** Pair CW and EI workers to initially meet with the family, engage them in screening and discussion of developmental milestones, and tailor services to address particular family needs.
- **Developmental or mental health consultation.** A consultant model such as Early Childhood Mental Health Consultation, pairs early childhood consultants with agencies to implement promotion, prevention, or intervention activities (Cohen & Kaufman, 2005).
- **Centralized assessment.** Create a system of centralized screening that includes regional screening offices with screeners and an Early Intervention Liaison who is employed

specifically for this purpose. This model is used in Illinois (Bruhn, Duval, & Louderman, 2008).

Educational infrastructure is also needed to prepare bachelor and master-level social workers that specialize in CW services to implement developmentally-oriented services.

Screening policy

There is unequivocal evidence that young children involved with CW have similar rates of developmental and mental health concerns regardless of whether maltreatment was substantiated (Casanueva et al., 2008; McCrae et al., under review; Rosenberg & Smith, 2008; Stahmer et al., 2005). Pennsylvania's policy to require screening among children substantiated for maltreatment only likely misses many children in need.

Collaboration

Case-level sharing. Children referred to CW face a number of risks that have implications for their long-term outcomes, but that are not consistently shared between agencies. Case-level sharing is likely to occur by obtaining caregiver consent, and having clear operating procedures between CW and EI, such as through a Memorandum of Understanding (MOU) delineating the responsibility and expectations by each agency to protect family confidentiality. Despite high rates of MOU's found in this study (up to 80%), agencies inconsistently share information. Processes that streamline family assessment help prevent families from completing duplicate paperwork, and repeating the same information with multiple providers. Child welfare and EI agencies should decide the most important pieces of information to share about children and families and do so to inform service planning.

Consent and practice for children in foster care. Practice concerning protocol for children in foster care is unclear. The study shows a wide-ranging response to whom provides consent for screening for a child in foster care. Early intervention providers have less access or connection to biological parents, perhaps resulting in consents that are frequently provided by parent surrogates, or a combination of biological parents, surrogates, and the CW agency. Child welfare practice is less variable, but is split between counties that obtain consent from biological parents only (46%), the CW agency (31%), and the CW agency and an unspecified or foster parent (23%). Overall, EI agencies more clearly obtain consent as standard practice for all children (83%) compared with CW agencies (46%). Consent is recommended by the developers of the ASQ screening tools (Squires et al., 1999).

Joint service planning. This study shows that collaborative CW-EI service planning may not be occurring to a desired extent. It could be that in some cases, children are no longer receiving CW services when an IFSP is developed, or that some families prefer not to have CW included in developmental service planning. Since many children will, however, have open CW cases upon referral to EI, joint service planning between the two agencies along with the family will likely to lead to a more integrated set of service goals.

Service resources

Respondents report greater service gaps concerning children's mental health, parent-child interventions, and exposure to trauma compared with developmental service gaps, such as in speech and language. With nearly three-quarters of EI providers reporting gaps in mental health services and the likely influx of children with social-emotional problems being referred to them as a result of the screening initiative, it is clear that an ideal service system does not currently exist for these children. Qualitative (open-ended) responses to items concerning what caregivers are told about a positive social-emotional screen indicate that children may be referred to any one of the following: a psychiatrist, pediatrician, community mental health center, private mental health clinician, or developmental specialist. There does not appear to be a defined service system for young children with social-emotional problems that focuses on parent-child relationships or strengthening parent-child attachment as a way of promoting their social and emotional skills.

Conclusion

In summary, the evaluation has revealed some challenges in screening children in the child welfare system. However, Pennsylvania has been progressive in implementing a statewide system of developmental screening, and all 67 counties are participating in this important initiative. As a result of the screening policy, many young children in the child welfare system will have developmental needs identified early, when there is the greatest likelihood of effective treatment.

References

American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine (2000). Recommendations for Preventive Pediatric Health Care. *Pediatrics, 105*, 645-646.

Bellamy, J. L. (2008). Behavioral problems following reunification of children in long-term foster care. *Children and Youth Services Review, 30*, 216-228.

Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services*. New York: W. W. Norton & Company.

Bruhn, C.M., Duval, D., & Louderman, R. (2008). Centralized assessment of early developmental delays in children in foster care. *Children and Youth Services Review, 30*, 536-545.

Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 960-969.

Carlson, B., Matto, H., Smith, C., & Eversman, M. (2006). A pilot study of reunification following drug abuse treatment: Recovering the mother role. *Journal of Drug Issues, 22*, 878-902.

Casanueva, C.E., Cross, T.P., & Ringeisen, H. (2008). Developmental needs and individualized family service plans among infants and toddlers in the child welfare system. *Child Maltreatment, 13*, 245-258.

Cohen, E., & Kaufmann, R. *Early Childhood Mental Health Consultation*. DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

Commonwealth of Pennsylvania, Department of Public Welfare, Office of Children, Youth, and Families (2008). *Developmental Evaluation and Early Intervention Referral Policy.* (3490-08-01). Harrisburg, PA.

Dodge, K. A., Pettit, G. S., & Bates, J. E. (1994). Effects of physical maltreatment on the development of peer relations. *Development and Psychopathology*, *6*, 43-55.

Ericson, E. (2001). *Healthy families America*. U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Retrieved on January 30, 2010 from http://www.ncjrs.gov/pdffiles1/ojjdp/fs200123.pdf.

Friesen, B. J., Pullman, M., Koroloff, N. M., & Rea, T. (Eds.). (2004). *Multiple perspectives on family outcomes in children's mental health* Austin, TX: PRO-ED, Inc.

Hoagwood, K. (2005). Family-based services in children's mental health: A research review and synthesis. *Journal of Child Psychology & Psychiatry: Annual Research Review, 46*, 690-713.

Individuals with Disabilities Education Act (IDEA). (2004). Individuals with Disabilities in Education Act (IDEA), 20 U.S.C. 1400. Retrieved February 5, 2010, from http://www.congress.gov/cgi-bin/cpquery/R?cp108:FLD010:@1(hr779)

Jee, S.H., Szilagyi, M., Ovenshire, C., Norton, A., Conn, A.M., Blumkin, A., Szilagyi, P.G. (2010). Improved detection of developmental delays among young children in foster care. *Pediatrics*, *125*(2), 282-289.

Kemp, S. P., Marcenko, M. O., Hoagwood, K., & Vesneski, W. (2009). Engaging parents in child welfare services: Bridging family needs and child welfare mandates. *Child Welfare, 88*(1), 101-126.

Landsverk, J., Kelleher, K.J., Burns, B.J., Leslie, L.K., Hurlburt, M.S., Slymen, D.J., Rolls, J.A., Barth, R., Fairbank, J, & Kolko, D. (2003). *Overview, design, and field experience of "Caring for Children in Child Welfare", a national study of the impact of organization and financing policy on mental health service provision*. Unpublished manuscript.

Lau, A. S., Litrowik, A. J., Newton, R. R., & Landsverk, J. (2003). Going home: The complex effects of reunification on internalizing problems among children in foster care. *Journal of Abnormal Child Psychology, 31*, 345-358.

Leslie, L.K., Gordon, J.N., Ganger, W., & Gist, K. (2002). Developmental delay in young children in child welfare by initial placement type. *Infant Mental Health Journal*, *23*(5), 496-516.

Lieberman, A.F., & Van Horn, P. (2009). Giving voice to the unsayable: repairing the effects of trauma in infancy and early childhood. *Child and Adolescent Psychiatric Clinics of North America, 18*, 707-720.

Malm K., Murray J., & Geen R. (2006). *What About the Dads? Child Welfare Agencies' Efforts to Identify, Locate and Involve Nonresident Fathers*. (Washington, D.C.: The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation).

Marsh, J.C., Ryan, J.P., Choi, S., & Testa, M.F. (2006). Integrated services for families with multiple problems: Obstacles to family reunification. *Children and Youth Services Review, 28*, 1074-1087.

McCrae, J.S., Cahalane, H., & Fusco, R. (under review). Directions for developmental screening in child welfare based on the Ages and Stages Questionnaires. *Children and Youth Services Review*.

McCrae, J.S., Rauktis, M.E., & Cahalane, H. (January, 2010). *Beyond the mandate: What influences county decisions to implement best practice developmental screening in child welfare?* Poster presented at the 23rd Annual Children's Mental Health Research & Policy Conference, Tampa, Florida.

McKay, M. M., & Bannon, W. M., Jr. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of America, 13*, 905-921.

McKay, M. M., Hibbert, R., Hoagwood, K., Rodriguez, J., Murray, L., Legerski, J., Fernandez, D. (2004). Integrating evidence-based engagement interventions into "real world" child mental health settings. *Brief Treatment and Crisis Intervention, 4*(2), 177-186.

National Research Institute Inc. (2008). NRI Projects: Center for Mental Health Quality & Accountability. Retrieved October 5, 2008, from http://www.nri-inc.org/projects/CMHQA/about.cfm.

Olds, D.L. (2006). The Nurse-Family Partnership: An evidence-based preventative intervention. *Infant Mental Health Journal, 27*(1), 5-25.

Rauktis, M.E., McCarthy, S., Krackhardt, D., & Cahalane, H. (2010). Innovation in child welfare: The adoption and implementation of Family Group Decision Making in Pennsylvania. *Children and Youth Services Review, 32*, 732-739.

Reid, M.J., Webster-Stratton, C., & Hammond, M. (2003). Follow-up of children who received The Incredible Years intervention for Oppositional-Defiant Disorder: Maintenance and prediction of 2-year outcome. *Behavior Therapy, 34*, 471-491.

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.

Rouse, H.L., & Fantuzzo, J.W. (2009). Multiple risks and educational well being: A population-based investigation of threats to early school success. *Early Childhood Research Quarterly, 24*, 1-14.

Schuhmann, E.M., Foote, R.C., Eyberg, S.M., Boggs, S.R., & Algina, J. (1998). Efficacy of Parent-Child Interaction Therapy: Interim report of a randomized trial with short-term maintenance. *Journal of Clinical Child Psychology, 27*, 34-45.

Selden, T.M. (2006). Compliance with well-child visit recommendations: Evidence from the medical expenditure panel survey, 2000-2002. *Pediatrics, 118*, e1766-e1778.

Squires, J., Bricker, D., & Twombly, E. (2003). *Ages and Stages Questionnaires, Social-emotional.* Baltimore, MD: Brookes.

Squires, J., Potter, L., & Bricker, D. (1999). *Ages and Stages Questionnaires: A parent-completed, child-monitoring system.* Baltimore, MD: Brookes Publishing.

Stahmer, A.C., Leslie, L.K., Hurlburt, M., Barth, R.P., Webb, M.B., Landsverk, J., & Zhang, J. (2005). Developmental and behavioral needs and service use for young children in child welfare. *Pediatrics, 116*, 891-900.

Stahmer, A.C., Leslie, L.K., Landsverk, J.A., Zhang, J., & Rolls, J.A. (2006). Developmental services for young children in foster care: Assessment and service delivery. *Journal of Social Service Research, 33*, 27-38.

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*(2), 99-108.

U.S. Department of Health and Human Services, Administration for Children and Families (2003). *The Child Abuse Prevention and Treatment Act as Amended by the Keeping Children and Families Safe Act of 2003.* Washington DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, Administration for Children and Families (2005). *National Survey of Child and Adolescent Well-Being: CPS sample component wave 1 data analysis report.* Retrieved June 20, 2009, from: http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/

Wagner, M.M., & Clayton, S.L. (1999). The Parents as Teachers program: Results from two demonstrations. *The Future of Children, 9*, 91-115.

Appendix A

Nurse-Family Partnership (NFP) is a program that was developed in the 1970s and has been empirically tested through multiple randomized control trials (Olds, 2006). NFP is designed for low income first time mothers, and involves nurse home visitation to provide education and support. Some demonstrated family outcomes include reduced rates of child maltreatment and improvement of the maternal life course, such as fewer subsequent pregnancies and reduced dependence on public welfare.

Parents as Teachers (PAT) is another parent education program that involves home visitation and begins prenatally or at the birth of a child (Wagner & Clayton, 1999). Parent educators help parents strengthen their parenting skills and their knowledge of child development. This program has also been tested in randomized control trials and has shown roughly a one month developmental advantage per 10 home visits for children in the program.

Parent-Child Interaction Therapy (PCIT) was developed for children with conduct behavior problems and their families (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). It has two main foci: 1) to improve parent-child interaction and 2) to increase child compliance through developing stronger parenting skills. PCIT outcome research has demonstrated significant improvements in parent-child relationships and a reduction of disruptive behavior in children.

The Incredible Years is a program designed to improve social competency and reduce oppositional behaviors in young children (Reid, Webster-Stratton, & Hammond, 2003). This program contains interventions aimed as parents, teachers, and children to promote prosocial behavior at home, in school, and with peers. This program has been evaluated in randomized control trials and has been shown to reduce conduct problems, increase emotional regulation, and improve social competence.

Healthy Families America is a voluntary home visitation program designed to improve the parenting skills of parents with newborn or small children, encourage child health and development, and prevent child abuse and neglect (Ericson, 2001). Outcome evaluations have shown that families in the program received more prenatal care, were better linked with medical services, and were less likely to engage in child maltreatment.

Appendix B

ASQ Child Welfare Agency Survey

Interviewer: ______________________________ Interview date: ________________

Start time: ________________________________ Stop time: _____________________

Informed consent reviewed and informant agrees to complete interview:

[ ] YES [ ] NO

Debriefing completed: ______________________ Data Entry completed: ______________________

Interviewee Job Title: _____________________________________Years in current position: ________

How many years of public child welfare experience do you have? _________

What is your highest educational degree?

1	Less than high school	5	Bachelor's degree _______________
2	High school diploma or GED	6	M.S.W.
3	Associate's degree	7	Master's degree _________________
4	Bachelor's degree in Social Work	8	Ph.D.

The purpose of this survey is to help us understand how your county is implementing developmental and socio-emotional screening for young children involved with child welfare using the Ages and Stages Questionnaires. Topics include the characteristics of children being screened, the relationship between child welfare and early intervention services, family engagement, and methods of tracking children.

You will not be asked about any specific children or cases. If you are unable to answer any question, or if someone else would be better able to answer any of these questions, please let me know. Any information you provide will not be linked to you; we will not use your name, agency, or county name in any reports.

The survey should take about 20 minutes to complete. Before I begin, do you have any questions?

SECTION 1. Policies and Procedures for Screening Implementation

This first section is about your county child welfare agency's policy and procedures for conducting the ASQ screenings.

1. Which children are being screened using the ASQ? Is it only those children required by CAPTA? This would be children younger than age 3 who are substantiated for maltreatment.

   1 YES (only CAPTA) 2 NO (some other group)

   If No: Please describe children who are being screened using the ASQ, including the age-range of children screened, substantiation status, and other characteristics that identify children for screening, for example, placement in foster care.

____

2. What is the policy concerning other children in the household? Are children other than the identified child screened using the ASQ?

   1 YES (other children are screened) 2 NO (only the identified child is screened)

   If Yes: Please specify which children are screened in addition to the identified child.

____

3. Next, we would like to know who conducts the ASQ screenings and where the screenings take place. Are county child welfare workers completing the ASQ screenings?

   1 YES (child welfare conducts screenings) 2 NO (child welfare does not conduct screenings)

If Yes: Which workers conduct the screenings? Include unit, role in the agency, and other qualifications such as education-level.

____

If No: Who conducts the ASQ screenings?

Agency Name(s): ____

We would like to contact the primary agency that conducts the ASQ screenings that are part of the child welfare-early intervention initiative to interview them about their experiences (similar to this interview). Would this be acceptable to you? 1 YES 2 NO

Who is best to contact?

Name: ____

Phone: _________________________ Email: ____

4. Where are ASQ screenings conducted? **Check all that apply.**

   - ☐ In family's homes
   - ☐ At the child welfare agency
   - ☐ At an early intervention provider agency
   - ☐ Another location (specify: ____)

5. The ASQ is designed to be completed by either caregivers (with professional assistance) or workers. Which is true in your county regarding the policy of who actually completes the screen?

   1 Caregivers complete the screen

   2 Workers complete the screen

   3 Other (Describe: ____)

The final questions in this section concern scoring the ASQ and referring children to services.

☐ **CHECK HERE IF EARLY INTERVENTION OR ANOTHER PROVIDER CONDUCTS THE SCREENINGS (Q3=NO) & SKIP TO QUESTION 9.**

6. You indicated that child welfare workers conduct the ASQ screenings. Who scores the instruments?

   1 Workers themselves 2 Someone else at the child welfare agency (_____________)

   3 Early intervention provider (SKIP TO Q 9)

4 Other (specify: ________________________________)

-8 Not Applicable (Q3=NO)

7. How successful would you say your agency is in gaining families' participation to complete the ASQ screening? Would you say you are successful all of the time, Most of the time, Some of the time, or Hardly ever?

1 All of the time 2 Most of the time 3 Some of the time 4 Hardly ever

8. How are children referred to early intervention or other services if the screening reveals a need?

Check all that apply.

	In-home	Foster care
1 Child welfare worker contacts provider	☐	☐
2 Caregivers are given information to self-refer	☐	☐

3 Other (Describe ____)

-8 Not Applicable (Q3=NO)

9. What methods are used to communicate a referral to early intervention?

Check all that apply.

☐ Telephone ☐ Email ☐ Fax ☐ Face-to-Face ☐ Other

☐ Not Applicable (Q3=NO)

10. (IF Q3=YES OR Q6=1 OR 2, SKIP). How is child welfare notified of children whose screening reveals a concern?

Check all that apply.

☐ No notification ☐ Email ☐ Face-to-face contact

☐ Phone call ☐ Fax ☐ Joint agency meeting

☐ Other (specify: ______________________) ☐ Not Known

☐ Not Applicable (IF Q3=YES OR Q6=1 OR 2)

SECTION 2. MECHANISMS FOR TRACKING CHILDREN

This next section is about the mechanisms that your county has in place to track children who are screened using the ASQ. When I say "children", I mean children involved with child welfare specifically.

11. To date, is there a master record that is kept of individual children who qualify for the ASQ screening in your county? For example, a list of children ages 0 to 3 who are substantiated for maltreatment?

1 YES 2 NO

If Yes, specify method: 1 Electronic 2 Written

Record location: 1 County child welfare 2 Other (specify: ___________________)

12. To date, is there a master record that is kept of individual children who have received at least one ASQ screening?

1 YES 2 NO

If Yes, specify method: 1 Electronic 2 Written

Record location: 1 County child welfare 2 Other (specify: __________________)

13. Please indicate which of the following information is kept *by child welfare* concerning ASQ screenings on individual children.

Storage:

a. Dates of completed ASQ screenings	YES	NO	Written case file	Electronic
b. Schedule for follow-up screenings	YES	NO	Written case file	Electronic
c. Full, completed ASQ instruments	YES	NO	Written case file	Electronic
d. ASQ information summaries	YES	NO	Written case file	Electronic
e. ASQ information summary concerning the "Overall" comments	YES	NO	Written case file	Electronic
f. Whether or not a screening reveals a concern	YES	NO	Written case file	Electronic
g. Screening summaries on individual child over time (e.g. 4-month results on same form or in same electronic file as their 6-month results; pp. 79-83 of the ASQ manual)	YES	NO	Written case file	Electronic
h. Individualized Family Service Plans (IFSP)	YES	NO	Written case file	Electronic
i. Developmental services that children and/or their families are referred for	YES	NO	Written case file	Electronic
j. Developmental services that children and/or their families receive	YES	NO	Written case file	Electronic

Notes:____

____

SECTION 3. FAMILY ENGAGEMENT

These next questions are about interactions with families around the ASQ screenings.

14. Do caregivers give written consent for their child(ren) to be screened?

1 YES 2 NO

IF YES: Who gives consent for a child in foster care? ____

15. What happens if a parent, guardian, or foster parent refuses to allow (*give consent for*) their child to be screened?

____

____

16. What happens if a parent, guardian, or foster parent does not show up for a scheduled appointment for an ASQ screening?

____

____

17. (IF QUESTION 3 = NO, SKIP). You indicated that child welfare workers complete ASQ screenings. How are parents informed about the purpose and objectives of screening? Do workers use a verbal standard script?

1 YES (standard script) 2 NO (no standard script) -8 NOT APPLICABLE (Q3=NO)

18. Is scoring of the ASQ done immediately? That is, in the presence of caregivers?

1 YES 2 NO

19. What are caregivers told about what it means to have a positive developmental screen?

____

____

20. What are caregivers told about what it means to have a positive socio-emotional screen?

____

____

21. In the event that the child is in foster care, are attempts made to inform biological parents of the results of screening? 1 YES 2 NO

22. Children may remain at home, be placed in foster care, or placed with relatives following contact with child welfare. Which of these groups of caregivers—in-home, foster care, or relatives (kinship) - would you say your county has the most success with in conducting the ASQ screens? You can also answer that there is no notable difference.

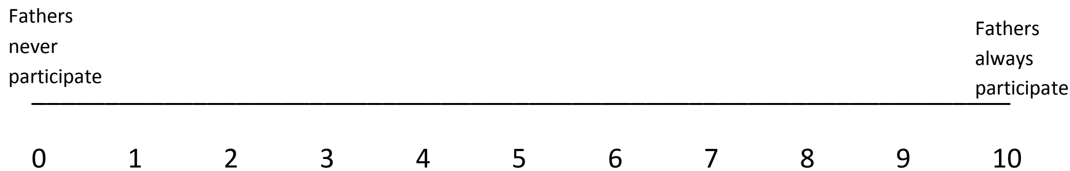
1 IN-HOME 2 FC 3 RELATIVES 4 ALL THE SAME

23. Which would you say your county has the least success with in conducting the ASQ screens?

1 IN-HOME 2 FC 3 RELATIVES 4 ALL THE SAME

24. The next question concerns involving fathers in the ASQ screenings.

Using the following 10-point scale, how often would you say the child's father or a father figure participates in ASQ screening?



SECTION 4. SERVICES

This section is about early intervention services in your community.

25. Are there any gaps in services to meet children's developmental needs?

1 YES 2 NO

IF YES: Specify: ____

26. Are there any gaps in services to meet children's socio-emotional needs?

1 YES 2 NO

IF YES: Specify: ____

27. To what extent do you agree or disagree with the following statement. Early intervention services are made available to families in a timely manner.

1 Strongly agree 2 Agree 3 Disagree 4 Strongly Disagree

28. Does your county child welfare agency have any of the following mechanisms in place to carry out the ASQ project? For items a,b, e, and f, please answer concerning the project's organization apart from this research.

a. Designated person in the child welfare agency who is leading the ASQ project	YES	NO
b. Designated team in the child welfare agency who is responsible for the ASQ project	YES	NO
c. Within-agency (child welfare) meetings about the completion status of ASQs on individual children	YES	NO
d. Cross-agency meetings (e.g. with early intervention) about the completion status of ASQs on individual child	YES	NO
e. Tracking database, such as an Excel spreadsheet or ACCESS database, kept by child welfare	YES	NO
f. Tracking database, such as an Excel spreadsheet or ACCESS database, kept by another agency	YES	NO
g. Shared database or MIS between early intervention and child welfare	YES	NO
h. Memorandum of understanding or joint agreement about sharing verbal or written information with early intervention (coordinating agency) on individual cases	YES	NO
i. Joint service planning with early intervention (coordinating agency) at the case level	YES	NO
j. Joint administrative or planning meetings with early intervention (coordinating agency) about the overall project	YES	NO
k. Standard referral form	YES	NO
l. Training materials for caseworkers about the ASQ initiative (written, video)	YES	NO
m. Other	YES	NO

29. How many individuals in your agency have received training in administering the ASQ?

____

SECTION 5. ASQ INITIATIVE

This is the last section, which has 15 statements about the ASQ initiative in your county. Please indicate how much you agree or disagree with these statements.

30. We can deal with the bumps in the road associated with implementing the ASQ initiative.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

31. We were prepared for this project from the start.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

32. There are people in my county outside this agency who are dedicated to ensuring that this project is successful.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

33. My county/agency was doing a good job of ensuring that young, maltreated children were screened for socio-emotional concerns prior to this project.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

34. My county/agency was doing a good job of ensuring that young, maltreated children were screened for developmental problems prior to this project.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

35. Leaders in this agency are willing to put forth a great deal of effort to make sure that implementing the ASQ initiative is successful.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

36. Caseworkers and supervisors in my agency support the need for developmental screening for very young children.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

37. Caseworkers and supervisors in my agency support the need for socio-emotional screening for very young children.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

38. We have access to experts who know how to implement developmental screening for very young children.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

39. We have access to experts who know how to implement socio-emotional screening for very young children.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

40. Individuals are encouraged to challenge or make suggestions about how to implement the ASQ project.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

41. The agency has the resources necessary to support the ongoing implementation of the ASQ project.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

42. Screening for developmental and socio-emotional problems in young children is seen as a permanent part of the way this agency conducts business.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

43. I am confident that children who qualify for the screening actually receive it.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

44. Our agency has the information technology to capture and share information about the developmental screening.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

45. Is there anything else you would like to tell us?

____

____

____

46. What have been the challenges and successes with implementing the screening?

____

____

____

47. To date, approximately how many screens has you county conducted? _________________

Appendix C

Early Intervention Provider Survey

Interviewer: ______________________________ Interview date: ________________

Start time: ________________________________ Stop time: _____________________

Informed consent reviewed and informant agrees to complete interview:

[ ] YES [ ] NO

Debriefing completed: ______________________ Data Entry completed: ______________________

Additional Informant(s) Utilized: NO YES (Attach AI sheet(s) as needed)

Interviewee Job Title: ___________________________________Years in current position: ____________

What is your highest educational degree?

1	Less than high school	5	Bachelor's degree (other ____________________________)
2	High school diploma or GED	6	M.S.W.
3	Associate's degree	7	Master's degree (other ______________________________)
4	Bachelor's degree in Social Work	8	Ph.D.

The purpose of this survey is to help us understand how your agency is working with child welfare services to implement developmental and socio-emotional screening using the Ages and Stages Questionnaires. Topics include the relationship between child welfare and early intervention services, family engagement, service coordination, and meeting child and family service needs.

You will not be asked about any specific children or cases. If you are unable to answer any question, or if someone else would be better able to answer any of these questions, please let me know. Any information you provide will not be linked to you; we will not use your name, agency, or county name in any reports.

The survey should take about 20 minutes to complete. Before I begin, do you have any questions?

SECTION 1. Policies and Procedures for Receiving Referrals from Child Welfare

This first section is about your agency's policies and procedures for receiving referrals from child welfare concerning the ASQ screenings to meet 2003 CAPTA and 2004 IDEA amendments.

6. How are children referred to you from child welfare? ***Check all that apply.***

☐ Telephone ☐ Email ☐ Fax ☐ Face-to-Face (including meetings)

☐ Other (Describe**:** ____)

7. At what point do you receive a referral from child welfare?

1 When a child is eligible for the ASQ screening

2 After the ASQ screening has been completed, but not scored

3 After the ASQ screening has been completed and scored

4 Other (Describe**:** ____)

☐ **CHECK HERE IF YOUR AGENCY DOES NOT COMPLETE OR SCORE ASQ SCREENINGS FOR CHILD WELFARE-INVOLVED CHILDREN & PLEASE SKIP TO QUESTION 7. OTHERWISE, CONTINUE.**

8. The ASQ is designed to be completed by either caregivers (with professional assistance) or workers. Which is true regarding your agency's policy of who actually completes the screen?

1 Workers complete the screen

2 Caregivers complete the screen

3 Other (Describe: ____)

-8 Not applicable (AGENCY DOES NOT COMPLETE OR SCORE ASQ SCREENINGS)

4. How does your agency notify child welfare of children whose screening reveals a concern?

Check all that apply.

☐ No notification ☐ Email ☐ Face-to-face contact ☐ Phone call

☐ Fax ☐ Joint agency meeting ☐ Other (Specify: ______________________)

☐ Not applicable (AGENCY DOES NOT COMPLETE OR SCORE ASQ SCREENINGS)

5. (If notification is provided) What screening information is shared with child welfare?

1 copies of full, completed screens

2 copies of the ASQ summary sheet (scores, including those that fall in a grey-shaded region)

3 Other (Describe: ____)

-8 Not applicable (AGENCY DOES NOT COMPLETE OR SCORE ASQ SCREENINGS)

6. What is your agency's policy concerning screening other young children in the household? Are children other than the referred child screened?

1 YES (other children are screened) 2 NO (only the referred child)

-8 Not applicable (AGENCY DOES NOT COMPLETE OR SCORE ASQ SCREENINGS)

6a. Specify age/other criteria of children screened: ____________________________________

7. What types of information do you receive from child welfare concerning children who are newly referred for ASQ screening or Part C eligibility assessment? Please indicate how often you receive the following information:

a.	Child positive for substances at birth	Always	Sometimes	Never
b.	Type of maltreatment	Always	Sometimes	Never
c.	Severity of maltreatment	Always	Sometimes	Never
d.	Current foster care status	Always	Sometimes	Never
e.	Child's history of multiple placement moves	Always	Sometimes	Never
f.	Child diagnosed medical conditions	Always	Sometimes	Never
g.	Child's exposure to family violence	Always	Sometimes	Never
h.	Caregiver substance abuse problems	Always	Sometimes	Never

i. Legally mandated services plan — Always — Sometimes — Never

j. Other (Describe: ____)

8. Is there a designated individual or team in your agency who is responsible for the ASQ screening initiative with child welfare?

1 YES   2 NO

8a. Specify: ____

Section 2. Engagement with Families

This next section is about engaging families around the ASQ screening.

☐ **CHECK HERE IF YOUR AGENCY DOES NOT COMPLETE ASQ SCREENING & SKIP TO QUESTION 9a.**

9. How successful would you say your agency is in gaining families' participation to complete the ASQ screening? Would you say you are successful all of the time, most of the time, some of the time, or hardly ever?

1 All of the time   2 Most of the time   3 Some of the time   4 Hardly ever

-8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

9a. How successful would you say your agency is in gaining families' participation in evaluations or developmental assessments? Would you say you are successful all of the time, most of the time, some of the time, or hardly ever?

1 All of the time   2 Most of the time   3 Some of the time   4 Hardly ever

10. What strategies would you say are most successful in engaging child welfare-involved families around ASQ screening? If your agency does not complete the ASQ screenings, please answer according to your experience engaging families in evaluations or other developmental assessments.

____

10a. What are the barriers, if any, to completing ASQ screenings with child welfare-involved families? If your agency does not complete the ASQ screenings, please answer according to your experience engaging families in evaluations or other developmental assessments.

____

☐ **CHECK HERE IF YOUR AGENCY DOES NOT COMPLETE ASQ SCREENING & SKIP TO QUESTION 19.**

11. Who is the primary contact in your agency to communicate initially with families about their children's eligibility/need for screening?

1 EI eligibility specialist

2 EI child evaluator

3 Other EI staff member ____________________

4 Multiple people in the agency make initial contact with families

-8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

12. How does that person make their first contact with the family?

1 A telephone call is made to the primary caregiver

2 A letter is sent to the primary caregiver

3 In-person visit

4 Other method(s) ____

-8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

13. Do caregivers give written consent for their child(ren) to be screened?

1 YES 2 NO -8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

(IF YES): Who provides consent for children in foster care? ______________________________

14. Is scoring of the ASQ done immediately? That is, in the presence of caregivers?

1 YES 2 NO -8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

15. What are caregivers told about what it means to have a positive developmental screen?

____

____

16. What are caregivers told about what it means to have a positive socio-emotional screen?

____

____

17. How are ASQ results shared with caregivers?

1 Verbally, right after the child(ren) is screened

2 A written document/report is given to the caregiver

3 Both verbally and in writing

4 Other method ______________________________________

-8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

18. In the event that the child is in foster care, are attempts made to inform biological parents of the results of screening?

1 YES 2 NO -8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

Who is responsible for contacting biological parents?

1 EI 2 CW 3 Other

-8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

19. Children may remain at home, be placed in foster care, or placed with relatives following contact with child welfare. Which of these groups of caregivers—in-home, foster care, or relatives (kinship)- would you say your county has the most success with in conducting the ASQ screens? You can also answer that there is no notable difference. If your agency does not complete the ASQ screenings, please answer according to your experience engaging families in evaluations or other assessments.

1 IN-HOME 2 FC 3 RELATIVES 4 ALL THE SAME

20. Which would you say your county has the least success with in conducting the ASQ screens? If your agency does not complete the ASQ screenings, please answer according to your experience engaging families in evaluations or other assessments.

1 IN-HOME 2 FC 3 RELATIVES 4 ALL THE SAME

21. The next question concerns involving fathers in the ASQ screenings. If your agency does not conduct ASQ screenings, please answer according to your experience engaging fathers in evaluations or other assessments.

Using the following 10-point scale, how often would you say the child's father or a father figure participates in ASQ screening?

Fathers never participate										Fathers always participate
0	1	2	3	4	5	6	7	8	9	10

22. In your opinion, what is the best way to share ASQ screening results with caregivers? If your agency does not conduct ASQ screens, please answer according to your thoughts of best practice.

____

____

____

23. What happens if a parent, guardian, or foster parent refuses to allow (*give consent for*) their child to be screened or assessed?

____

____

24. What happens if a parent, guardian, or foster parent does not follow through with a scheduled appointment for an ASQ screening or developmental assessment?

____

____

25. Is a caregiver's refusal for screening or assessment communicated to child welfare?

1 YES 2 NO -8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

IF YES: Please describe any procedures for documenting or communicating a caregiver's refusal.

____

____

26. What strategies would you say are successful in engaging difficult-to-reach caregivers?

____

____

Section 3. Service Coordination, Information Sharing, & Tracking Children

Next, we'd like to focus on what happens after a child is screened. First a little about record-keeping.

27. To date, does your agency keep a master record or list of individual children who have been referred from child welfare for ASQ screenings?

1 YES 2 NO -8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

If Yes, specify method: 1 Electronic 2 Written 3 Both

28. To date, does your agency keep a master record or list of individual children who have received the ASQ screening, following referral from child welfare?

1 YES 2 NO -8 Not applicable (AGENCY DOES NOT COMPLETE ASQ SCREENINGS)

If Yes, specify method: 1 Electronic 2 Written 3 Both

29. Is your agency notified by child welfare when a child has moved?

1 YES 2 NO

IF YES: What is this process? ____

____

30. Is children's Part C early intervention eligibility status shared with child welfare?

1 YES 2 NO

31. Does your agency have any of the following mechanisms in place to carry out the ASQ project?

a. Within-agency meetings about the completion status of ASQs on individual children referred from child welfare	YES	NO
b. Cross-agency meetings (e.g. with child welfare) about the completion status of ASQs on individual children	YES	NO
c. Tracking database, such as an Excel spreadsheet or ACCESS database kept by your agency	YES	NO
d. Shared database or MIS between early intervention and child welfare	YES	NO
e. Memorandum of understanding or joint agreement about sharing verbal or written information with child welfare on individual cases	YES	NO
f. Joint service planning with child welfare at the case level	YES	NO
g. Joint administrative or planning meetings with child welfare about the overall project	YES	NO

32. How often would you say that a child's IFSP is developed collaboratively including someone from your agency and someone from child welfare?

1 All of the time 2 Most of the time 3 Some of the time 4 Hardly ever

33. What are your criteria for offering tracking services for families involved with child welfare?

____

____

34. Please indicate which areas of the IFSP your agency and child welfare typically collaborate.

a. Family's resources relating to enhancing children's development	1 YES	2 NO
b. Major outcome goals for the child	1 YES	2 NO
c. Major outcome goals for the family	1 YES	2 NO
d. Criteria for determining child progress	1 YES	2 NO
e. Criteria for determining family progress	1 YES	2 NO
f. Specific early intervention services that will be provided	1 YES	2 NO
g. Date services will begin	1 YES	2 NO
h. Duration of services	1 YES	2 NO

35. Who ensures that a child will receive services outlined on the IFSP?

1 Our EI worker/EI agency is responsible

2 The child welfare or court is responsible

3 Both the EI worker/agency and child welfare/court take responsibility

4 Some other entity is responsible (Describe: ____)

35a. Who ensures that children have up-to-date physical health assessments, such as well-child check-ups or visits?

CW EI Neither – no specified protocol for this

36. Since the 2003 CAPTA and 2004 IDEA amendments, have any workers at your agency received specialized training in working with child-welfare involved families?

1 YES 2 NO

What training(s), if any, is needed at your agency concerning working with child welfare-involved families? ____

Section 4. This next section concerns the criteria that your agency uses to determine whether children need further evaluation following the ASQ screening and service availability in your area.

37. Please think about children referred from child welfare who do not already have an identified condition, diagnosis, biological, or medical risk factor. Please indicate which of the following criteria prompt further evaluation for a child. By further evaluation, I mean any service beyond the screening, including a developmental assessment, a full evaluation, additional screening, or referral for health or medical tests or procedures.

a. ASQ score in the grey-shaded region in one or more **developmental** areas. This would be scores that are at least 2 standard deviations below the mean.

1 YES 2 NO

b. ASQ score that is close to, but not within, the grey-shaded region in one or more **developmental** areas.

1 YES 2 NO

(Describe additional criteria used, such as children within 5 units of a cut-point):

____

c. Clinical opinion of concerns, although all ASQ **developmental** scores are in the normal-range

1 YES 2 NO

If yes, specify:____

d. Family overall comments of concern on the **developmental** screen, which are the last 7 or 8 items concerning hearing, communicating, etc.

1 YES 2 NO

Describe:____

For these next 4 items, please indicate which of the following prompt further evaluation or assessment following a child's ASQ:SE screening.

e. ASQ:SE score that is above the cutoff score, regardless of the referral considerations on the summary sheet.

1 YES 2 NO

f. ASQ:SE score that is above the cutoff score, as long as the referral conditions on the summary sheet have been considered.

1 YES 2 NO

g. ASQ:SE score that is close to, but not above, the cutoff score.

1 YES 2 NO Describe_____________________________________

h. Other criteria for further evaluation following an ASQ:SE screening specifically. ________

____

38. Do any of the following criteria prompt further evaluation? Again, by further evaluation I mean any service beyond the screening, including a developmental assessment, a full evaluation, additional screening, or referral for health or medical tests or procedures.

a. Child has substantiated maltreatment, regardless of their ASQ scores

1 YES 2 NO

-8 Not applicable (AGENCY DOES NOT COMPLETE OR SCORE ASQ SCREENINGS)

If yes, specify:____

b. Child is living in foster care, regardless of their ASQ scores

1 YES 2 NO

-8 Not applicable (AGENCY DOES NOT COMPLETE OR SCORE ASQ SCREENINGS)

If yes, specify:____

c. Child has been exposed to other substantial environmental risk, such as domestic violence at home, parental substance abuse, homelessness, or low cognitive functioning of the caregiver

1 YES 2 NO

-8 Not applicable (AGENCY DOES NOT COMPLETE OR SCORE ASQ SCREENINGS)

If yes, specify:____

d. Other criteria that prompt further evaluation on children involved with child welfare, in particular.____

39. What tools or instruments does your agency use to conduct developmental assessments? (e.g. Battelle Developmental Inventory; BDI, Temperament and Atypical Behavior Scale; TABS)

____

____

40. Think about children who are in foster care. What would you say is best practice concerning when to conduct ASQ screening? For example, right away or after a certain period of time?

____

____

Next, we would like to know about services that are available to meet children's developmental and social-emotional needs.

41. Please think about services that are provided to families for specific developmental and social-emotional problems. Please rate the extent to which services are available to children ages 0 to 5 in your county to meet the following needs.

	Very Low Availability									Very High Availability
a. Autism Spectrum Disorders	1	2	3	4	5	6	7	8	9	10
b. Speech or Language Delay	1	2	3	4	5	6	7	8	9	10
c. Attention Deficit/Hyperactivity Disorder	1	2	3	4	5	6	7	8	9	10
d. Substance-exposed infants	1	2	3	4	5	6	7	8	9	10
e. Parent-child attachment	1	2	3	4	5	6	7	8	9	10
f. Parent-child relational problems	1	2	3	4	5	6	7	8	9	10
g. Conduct or behavior problems	1	2	3	4	5	6	7	8	9	10
h. Eating disturbances	1	2	3	4	5	6	7	8	9	10
i. Regulatory disorders	1	2	3	4	5	6	7	8	9	10
j. Trauma-informed or specific services	1	2	3	4	5	6	7	8	9	10
k. Sensory integration	1	2	3	4	5	6	7	8	9	10
l. Evidence-based or promising parenting interventions for at-risk families with young children	1	2	3	4	5	6	7	8	9	10

42. There are a number of evidence-based or promising interventions to improve outcomes for very young, at-risk children, such as those referred to child welfare. Which of the following are available in your community?

a. Nurse-Family Partnership	YES	NO	DON'T KNOW
b. Parents as Teachers	YES	NO	DON'T KNOW
c. Parent-Child Interaction Therapy	YES	NO	DON'T KNOW
d. The Incredible Years	YES	NO	DON'T KNOW
e. Healthy Families America	YES	NO	DON'T KNOW

Others, specify:____

____

43. Are there any gaps in services to meet children's developmental needs?

1 YES 2 NO

IF YES: Specify: ____

44. Are there any gaps in services to meet children's socio-emotional needs?

1 YES 2 NO

IF YES: Specify: ____

45. Please think about children in foster care. How often would you say IFSP's include services for biological parents?

1 All of the time 2 Most of the time 3 Some of the time 4 Hardly ever

46. Who is eligible to receive EI services? ***Check all that apply:***

☐ Foster parents (1)

☐ Biological parents, if child is in out-of-home placement but reunification is a goal (2)

☐ Biological parents only if the child is at home (3)

☐ Biological parents always (4)

47. Is there anything else you would like to tell us?

____

____

____

____

48. To date, approximately how many children receiving services from child welfare have you screened?
____

Section 5: ASQ INITIATIVE

This last section has five statements about the ASQ initiative in your county. Please indicate how much you agree or disagree with these statements.

49. There are people in my county outside this agency who are dedicated to ensuring that this project is successful.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

50. My county/agency was doing a good job of ensuring that young, maltreated children were screened for socio-emotional concerns prior to this project.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

51. My county/agency was doing a good job of ensuring that young, maltreated children were screened for developmental problems prior to this project.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

52. The agency has the resources necessary to support the ongoing implementation of the ASQ project.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree

53. I am confident that children who qualify for the screening actually receive it.

1 Strongly Agree 2 Agree 3 Disagree 4 Strongly Disagree