



# Opportunities to Strengthen Developmental Screening for Children Involved in Child Welfare Systems

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# Why Early Intervention is Important

Early childhood is a critical time to intervene for children experiencing physical, behavioral or cognitive developmental delays. Development during the early years is foundational and rapid, and often the success of early intervention depends in large part on early identification of problems.<sup>1</sup> Screening young children for vision and hearing impairments and developmental delays is essential to identifying and triaging concerns that could grow if left untreated.

Timely screening, identification and intervention are essential for infants and young children involved with the child welfare system. Nearly half of all children entering the child welfare system are between birth and age five.<sup>2</sup> Approximately 50 percent of all young children in foster care exhibit developmental delays – up to five times the rate seen in children in the general population.<sup>3</sup> In fact, studies of young children in foster care have identified significant rates of motor development problems and delays (25 percent) and language delays and disorders (50 percent).<sup>4</sup> Roughly one-third of children birth to three referred for maltreatment have developmental concerns that qualify for early intervention (EI) services.<sup>5</sup> Developmental delays in these young children impede school readiness<sup>6</sup> and hamper their ability to form healthy bonds and relationships – which, for children in foster care, can also impact placement stability and potential for timely reunification or other successful permanency options.<sup>7</sup>

When conducted as recommended, screening has the potential to detect developmental delays or challenges early on, allowing for referral to appropriate interventions and supports when children are most susceptible and treatments hold the greatest chance for success. Importantly, studies show that for children in foster care, routine developmental screening identifies problems earlier,<sup>8</sup> allowing for timely intervention.

As documented in other areas of child health, racial and ethnic disparities exist in the diagnosis and treatment of developmental and behavioral conditions in early childhood.<sup>12</sup> Studies show that early in life – by 24 months of age – black children are almost five times less likely than white children to receive EI services. Also, black children who qualify based on developmental delay alone are less likely to receive services as compared to children with a diagnosed condition.<sup>13</sup> These findings suggest that children of color are disproportionately underrepresented in EI services and are less likely than white children to be diagnosed with developmental delays. While disparities exist in the screening, evaluation and referral process, increasing collaborations with health care and community programs such as Early Head Start and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and improving training and cultural competency of providers can help reduce these disparities. These opportunities are highlighted in the recommendations that follow.

**Poverty is the single greatest threat to child well-being and a predictor of abuse and neglect.<sup>9</sup> While most families that experience poverty do not come in contact with the child welfare system, for young children, the stress that often arises from conditions of chronic adversity, including exposure to poverty, can have a significant detrimental impact on early brain development and lasting consequences for life-long health, academic success and productivity as working adults.<sup>10</sup> Importantly, many challenges seen in cases of child neglect, including unsafe housing, homelessness and lack of stable child care, disproportionately impact families of color, and in particular, mothers of color with low-wage jobs.<sup>11</sup>**

Federal requirements have recognized the importance of developmental screening for young children including those with child welfare system involvement, providing states with opportunities to better serve this population. These include provisions of the *Individuals with Disabilities Act* (IDEA) and the *Child Abuse Prevention and Treatment Act* (CAPTA) which require referral of all children birth to age three substantiated for maltreatment to early intervention when developmental problems are detected. These and other federal requirements related to EI screening and services are highlighted in Appendix A. Despite existing federal requirements for developmental screening of children involved in the child welfare system, there are significant practice gaps in ensuring that appropriate screening occurs. In 2010, the Center for Health Care Strategies (CHCS) conducted a 50 state survey to better understand the extent to which state child welfare agencies require physical, behavioral and oral health screenings and assessments upon a child's removal from the home.<sup>14</sup> The survey found that while virtually all states require an initial screening in at least one of three health domains (i.e., physical, behavioral and oral health), just over half of states require an initial screening in all three

domains, and one-third require full assessments in all three domains. Even so, state-mandated timeframes for initial health screening vary significantly and do not consistently reflect nationally recognized guidelines. Also unclear is the extent to which screening is happening in practice. Further, state mandates for in-depth assessments are less rigorous than for initial screening.

Although routine screening services under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit are required to be provided for children involved in the child welfare system,<sup>15</sup> low EPSDT screening rates are an issue for this population. A 2015 report by the Office of the Inspector General found that nearly one-third of children in foster care who were enrolled in Medicaid did not receive at least one required EPSDT health screening and that roughly one-quarter received at least one required screening late.<sup>16</sup> As these findings suggest, there is much room for improvement and opportunities to enhance compliance with nationally recognized screening guidelines, such as those outlined by the American Academy of Pediatrics (AAP) and Council on Accreditation (COA).

Specifically, the American Academy of Pediatrics (AAP) recommends developmental and behavioral screening when a child is 9, 18 and 24 or 30 months of age, as well as at any other age if there is a concern. Additionally, the Council on Accreditation (COA) recommends initial screening from a qualified medical practitioner within 72 hours of a child's entry into foster care to identify the need for immediate medical or mental health care, assess for infectious and communicable diseases, as well as follow-up assessments within 30 days of foster care entry.<sup>17</sup>

Data suggest that there are additional barriers to obtaining access to services for children involved in the child welfare system – even if they have been screened and a need for services has been identified. For instance, while child welfare caseworkers are primary referral sources under EI law, research has found that reliance on their assessments of a child's developmental needs is often inadequate. Research shows that IDEA Part C and other early intervention programs are underused for children with child welfare system involvement,<sup>18</sup> in part resulting from (a) low intervention participation and high attrition for parents and guardians and (b) the failure of child welfare professionals to recognize potential developmental problems (resulting in low referral rates).<sup>19</sup> This gap in screening and access to services has significant consequences for children's future growth, healthy development and school readiness and success.

For children who have been abused or neglected, the child welfare systems that are responsible for their safety and stability must simultaneously ensure that children receive necessary and appropriate screenings, as well as referral and ultimately any needed EI services. The recommendations below highlight strategies for improving the delivery of developmental screening and early intervention for children who become known to state and local child welfare systems.



# Recommendations for Strengthening Child Welfare Practices around Developmental Screening and Early Intervention for System-Involved Children

**(1) Provide routine screening for all young children who come to the attention of child welfare agencies to ensure that all have equal opportunity to receive early care and intervention as needed.**

Child welfare agencies should augment their screening practices to ensure that all children involved in child welfare are routinely screened and linked to appropriate EI services, regardless of their placement or substantiation status. Data suggest that children involved in the child welfare system who are not removed from their families are at risk of being underserved for developmental and mental health needs,<sup>20</sup> and no significant differences in screening results are found for children with substantiated versus unsubstantiated maltreatment.<sup>21</sup>

While recognizing that families that are not under court order cannot be required to have their children screened, states should develop voluntary and engaging screening methods that encourage family participation. It is important for states to seek ways to go beyond existing federal requirements to refer children with substantiated maltreatment for screening and also refer children who come to their attention through unsubstantiated investigations and differential response (DR)<sup>22</sup> pathways. For states utilizing DR, referrals for developmental screening should be included as a specific responsibility of that work. Screening and early identification should also be a part of work with birth families and with kinship families that become caregivers for young children who come to the attention of the child welfare system, but live with kin outside of child welfare system custody arrangements.

For example, **Pennsylvania's** model of expanded screening<sup>23</sup> identified as a best practice the need for further developmental and social-emotional assessment and potential eligibility for early intervention services among all young children involved in the child welfare system. In an evaluation, the state found that (1) routine screening identified developmental and social-emotional concerns among young children in the child welfare system, with multiple risks and early-onset problems that may have gone undetected; (2) statewide implementation led to expanded screenings; and (3) two years after implementing the expanded screening model, there was an increase in the number of counties going above and beyond the federal screening mandate.<sup>24</sup> Results also showed that a majority of children being screened were living in their biological homes, suggesting that the implementation of routine screening detected concerns that may have remained unnoticed.

In **Colorado**, State law (C.R.S. 26-5-108) mandates that children under the age of five who are victims of abuse or neglect should be referred by child welfare to an entity that conducts developmental screening. With supervision by the Colorado Department of Human Services (CHDS) county departments of human/social services are responsible for referring children birth through age four for developmental screening when abuse or neglect is founded. For children birth through age two, the local Community Centered Board is responsible for responding to CAPTA referrals from child welfare for developmental screening and the local Special Education Administrative Unit is responsible for conducting screening and evaluation to determine eligibility for Part C early intervention services. The CDHS Office of Early Childhood assures statutory compliance of the Part C system.

**(2) Strengthen training for the child welfare workforce and other key stakeholders on the importance of developmental screening and early intervention for young children at risk for or experiencing developmental delays and bolster the referral and linkage pathways to services.**

Research suggests that child welfare caseworkers are often not trained to identify the developmental needs of children in foster care and may have limited knowledge about EI services,<sup>25</sup> with caseworkers recognizing less than one-fourth of children with developmental problems in one particular study.<sup>26</sup> In

another study, detection rates for developmental problems were significantly higher when done by early intervention workers as compared to child welfare workers.<sup>27</sup> Child welfare caseworkers often lack the necessary training, support and resources to appropriately identify children in need of developmental screening, or to conduct screening, provide referrals and follow up. Child welfare professionals need training, resources and better information about EI, especially about how to refer families for services.

A more concerted effort is needed to overcome barriers to identifying and serving children who need EI. This involves strengthening the infrastructure around screenings through targeted education, training, supervision and mentoring for child welfare caseworkers so that they understand both the requirements to refer for screening and are equipped to identify children's needs. Ideally, child welfare and Part C agencies, among others, should have specialists who work with families involved in both child welfare and EI programs like Part C. These specialists could act as liaisons between the two programs for families. As an example, in **Santa Clara County, CA**, Public Health Nurses provide care coordination and follow-up services to fully address the health and developmental needs of families and young children who are involved with the child welfare system. These services include providing developmental and behavioral health screenings and coordinating referrals to KidConnections<sup>28</sup> for developmental screening, assessment and early intervention and intervention services.

Innovative training programs for the child welfare workforce help to build the capacity of frontline workers to appropriately identify and connect children in need of screening, referrals and services to necessary supports in the community. In **Michigan**, for example, mental health agencies provide training to child welfare staff on behavioral health services and evidence-based practices. In tandem, the child welfare staff, foster parents and other child welfare experts train these mental health professionals on the unique needs of children in child welfare.

Private providers, birth and foster parents, kinship caregivers, guardians ad litem and court personnel, among others who are responsible for the well-being of children in the child welfare system are also not always trained to identify the developmental needs of children and may have limited knowledge about developmental screening, referral processes or EI and related supports in the community. It is equally important for child welfare agencies to consider training opportunities for these stakeholders. For instance, the importance of developmental screening should be included as content for kinship and foster parent trainings. In **Florida**,<sup>29,30</sup> Broward's Infrastructure Design to Guide and Sustain Permanency for Young Foster Children (BRIDGES) program developed several trainings for child care providers, court officers, child welfare staff, foster parents and caregivers on the developmental needs of young children.

### **(3) Institute policies and accountability procedures within states and local child welfare agencies.**

In order to ensure that child welfare agencies are providing or referring children for developmental screening and creating linkages to EI and related services, state policies, protocols and procedures should clearly identify roles, responsibilities and accountability mechanisms for the various partners involved, including collecting and sharing relevant data.

In **Colorado**, the State's "Developmental Screening Educational tool" provides guidance to communities on meeting federal and state requirements on developmental screening. This tool also clarifies screening roles for various stakeholders including welfare caseworkers, EI personnel, special education personnel and other screening professionals. Additionally, Colorado's Partnership in Early Childhood Education and Services (PIECES)<sup>31,32</sup> was designed to encourage collaboration and cross-system partnerships between early childhood service providers including Head Start and EI and child welfare service agencies. Among the key project components are a data system for tracking referrals between child welfare and early childhood. An evaluation of PIECES reviewed data collected by local sites to describe changes in access to early childhood services among children involved with child welfare. While developing robust data systems remained a challenge, evaluation data highlight the value of tracking and sharing data, suggesting that 61-71 percent of children screened were eligible and received some type of early childhood service, about one-third of those screened qualified for EI and one-third enrolled in Head Start.

#### **(4) Increase effective care coordination, collaborative practice and data-sharing among child welfare systems and other developmentally focused programs such as Early Intervention, Medicaid, Head Start, Early Head Start and child care.**

Child welfare does not and cannot do this work alone. An effective response to identifying and responding to developmental delays and the effects of early exposure to trauma and chronic stress in young children involved in the child welfare system demands a coordinated and collaborative approach across systems of services and supports. Child welfare should collaborate with other agencies to coordinate early childhood services to support the healthy and optimal development of young child welfare system-involved children. With an increased focus on prevention, child welfare can be a visible and active part of a coordinated system ensuring the well-being of all children, especially those who are most vulnerable.

As an example, **Help Me Grow**, originally implemented in **Connecticut** and replicated throughout the country with initiatives in 25 states, provides a comprehensive, statewide, coordinated system for early identification and referral of children birth to age five at risk for developmental and behavioral problems.<sup>33</sup> **Help Me Grow** provides families or any agency working with families, including the child welfare system, with supports to access developmental screening by working with pediatricians and by making developmental screening tools like the Ages and Stages Questionnaire (ASQ) directly available to families via telephone, technology and partnership strategies.<sup>34</sup>

Of note, in January 2017, the U.S. Departments of Education and Health and Human Services issued a joint statement<sup>35</sup> outlining a vision for stronger partnerships, collaboration and coordination between the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) and IDEA Part C. The statement noted that MIECHV awardees must give priority to high-risk populations including families that have a history of child abuse or neglect or have had interactions with child welfare services and encouraged collaboration across MIECHV and IDEA Part C to address the needs of families with a substantiated case of child abuse or neglect. The statement also highlighted the value of centralized intake, screening and referral systems at state, regional or local levels as an effective way to ensure that these families have timely access to appropriate services that meet their needs, pointing to **Help Me Grow** as an example of such a system.

## **Summary**

Child welfare agencies that are responsible for ensuring the safety, permanency and well-being of children and youth have a critically important role to play in assuring that the young children they serve are appropriately screened for developmental delays and related concerns and effectively linked to necessary early intervention services and supports. This work must happen in partnership with other developmentally focused programs such as EI, Medicaid, Head Start, Early Head Start and child care. It demands capacity-building for both the child welfare workforce and other key stakeholders, as well as an approach that ensures that all children have equal opportunity to receive early care and intervention as needed. State and local child welfare agencies can and should implement policies and accountability procedures to ensure that children in need of developmental screening, assessment and early intervention receive these services. In doing so, child welfare systems will better promote healthy development and child well-being.

# Appendix A: Current Federal Requirements for Developmental Screening

IDEA and the *Child Abuse Prevention and Treatment Act* (CAPTA) require referral of all children birth to age three substantiated for maltreatment to early intervention when developmental problems are detected. IDEA Part C was amended in 1997 to encourage states to increase opportunities for children under age three who are in need of early intervention services, and to improve collaboration and service expansion for children at high risk for delays.

*Keeping Children and Families Safe Act of 2003* (P.L. 108–36), which reauthorized CAPTA, required states to develop “provisions and procedures for referral of a child under age three who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Improvement Act” (§ 106(b)(2) A)(xxi)). The 2004 reauthorization of IDEA contains parallel language. It also details specific requirements for state Early Intervention Programs (EIPs), which are administered by lead agencies in each state that apply annually for their Part C grant awards and must meet certain requirements to participate.

*Fostering Connections to Success and Increasing Adoptions Act of 2008* requires each state to develop a plan, in coordination with pediatricians and other experts, for the oversight and coordination of health care services for children and youth in foster care. Among other elements, these plans must include an outline of a schedule for initial and follow-up screenings, as well as how any health needs identified through screenings will be treated.

*Child Care and Development Block Grant (CCDBG) of 2014* (Pub. L. 113–186) requires states to provide consumer education about developmental screenings to families, the public and child care providers. Specifically, this information should include (1) existing resources and services that can be used in conducting developmental screenings and providing referrals to services for children who receive child care assistance and (2) a description of how a family or eligible child care provider may use those resources and services to obtain developmental screenings for children who receive child care assistance and may be at risk for developmental delays. This information about resources may include the coordinated use of Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) under Medicaid and developmental screening services available under section 619<sup>36</sup> and part C of the IDEA. On January 19, 2016, the Administration for Children and Families issued guidance on provisions in the CCDBG Act of 2014 related to developmental and behavioral screenings in child care and afterschool care programs, and potential policies for implementation. This was followed by a Final Rule, published on September 30, 2016. The final rule adds a new paragraph which requires states to provide information on developmental screenings as part of their consumer education efforts during the intake process for families receiving CCDF assistance and to caregivers, teachers and directors through training and education. It specifies that information on developmental screenings, as other consumer education information, should be accessible for individuals with limited English proficiency and individuals with disabilities. It also notes that states should ensure that all providers are knowledgeable on how to access resources to support developmental and behavioral screening, and make appropriate referrals to specialists, as needed, to ensure that children receive the services and supports they need as early as possible.

Federal *Head Start* Program Performance Standards require that within 45 days of entry into the program, children should be screened for “developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual and emotional skills,” using age- and culturally-appropriate tools. The Head Start standards also state that Early Head Start programs (serving infants and toddlers up to age three) must assess whether children have received regular medical screenings and care, and if not, help connect them to needed services.

*Medicaid’s Early and Periodic Screening, Diagnostic and Treatment* (EPSDT) program provides prevention, diagnostic and treatment services for low-income infants, children and adolescents under age 21 and is a required benefit for all children (under age 21) who are enrolled in Medicaid, including children enrolled in Title IV-E programs. (For foster children not enrolled in IV-E, there are other mandatory and optional pathways to coverage.) States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate and medically necessary services needed to correct and ameliorate health conditions, including physical, mental, vision, hearing and dental services.

EPSDT consists of screening, diagnostic and treatment services. Specifically, screening services include: comprehensive health and developmental history; comprehensive unclothed physical exam; appropriate immunizations (according to the Advisory Committee on Immunization Practices); laboratory tests (including lead toxicity screening); and health education (anticipatory

guidance including child development, healthy lifestyles and accident and disease prevention). The screenings and services must be provided at regular intervals that meet “reasonable” medical or dental practice standards. Consistent with EPSDT states flexibility over the recommended frequency and timing of screenings although most states align screening practices with the American Academy of Pediatrics Bright Futures Guidelines.<sup>37</sup> Even when conducted, screening is only meaningful if it leads caregivers and professionals to take concrete steps to connect children to treatment – including EI or other appropriate services in a timely manner. Yet today, more children are in need of services than are currently being served. The requirements that define coverage for treatment in EPSDT are also not well understood by some providers (including those in child welfare) resulting in children often not receiving needed treatments.

*Medicaid* and the *Children’s Health Insurance Program* (CHIP) now require states to report on developmental screening for children under age three as part of federal Health Care Quality Measures (HCQM), providing them with both the opportunity and the impetus to look closely at that data to identify areas where access to screening and services can be improved. The CHIP Reauthorization Act of 2009 (CHIPRA) first introduced the Child Core Set of HCQM for Children in Medicaid and CHIP as one of a number of child health quality activities. There are nine measures in the Child Core Set, including a [Developmental Screening Measure](#), which assesses the share of children who received developmental screening using a standardized tool that meets four criteria. While reporting on these measures at the provider and practice level can encourage reporting on the state-level Child Core Set Measures, reporting on the core set was initially voluntary for states. The CMS data set only includes measures that are reported by at least 25 states. In FY 2016, the developmental screening measure hit that threshold for the first time with 26 states reporting. For that year, age-appropriate screening rates ranged from a low of 1.6 percent of eligible children in Alaska to 77.5 percent in Massachusetts.<sup>38</sup> In January 2018, Congress passed a Continuing Resolution that included a 10-year CHIP funding extension. This funding extension included several important new provisions, including a new requirement for states to report quality measures in the Child Core Set beginning in FFY 2024. A move to mandatory reporting of measures, including the Developmental Screening Measure, will make the quality data set more useful for child health stakeholders.

# Appendix B: Promising Partnerships and Financing Strategies to Improve Developmental Screening

An effective response to early exposure to trauma and chronic stress – and the often complex needs of children involved in the child welfare system – necessitates a coordinated and collaborative approach across systems of services and supports. Developing partnerships between child welfare and other systems, including early intervention, early childhood and health care, can ensure that the developmental needs of maltreated children are identified early on and that targeted strategies are deployed in response. Below are several opportunities states could consider.

IDEA, CAPTA, Head Start and Early Head Start, CCDBG and Medicaid (EPSDT requirements under law) have each established screening policies, making them natural partners for child welfare systems interested in augmenting existing developmental screening strategies for system-involved children. These programs and other funding streams outlined below can be utilized for screening and early intervention services for abused and neglected children and relevant training for professionals.

As noted earlier, IDEA details specific requirements for state early intervention programs administered by lead agencies in each state. Lead agencies must apply annually for their Part C grant awards and must meet certain requirements to participate. Among Part C requirements, states must ensure that appropriate EI services will be available to all eligible infants and toddlers in the state, including those who are in foster care, in the custody of a public child welfare agency, or otherwise considered a ward of the State. Although the process for eligibility determination varies by state, a referral process, eligibility determination, initial Individualized Family Service Plan (IFSP) (a written plan that sets functional outcomes for the child and family and describes the services that will be provided to the child and family), IFSP review and renewal and transitioning planning occur before a child enters the EI system.

The Basic State Grant program under CAPTA provides funding to fully implement the legislation's requirement that states refer children under age three with substantiated abuse or neglect to IDEA Part C Early Intervention Programs. In many states, referred infants and toddlers receive a comprehensive evaluation to determine whether they are eligible for Part C services. Additionally, CAPTA funds can be used for community-based prevention-focused services designed to strengthen families, including interdisciplinary training, building interagency partnerships, identification, screening, evaluation and respite care. As an example, **Oklahoma's** Department of Health uses CAPTA Community-Based Child Abuse Prevention Grants and state funding to provide parenting support, developmental screening and behavioral and mental health consultation.

Since its inception, Head Start has included developmental screening in the array of comprehensive health services and family supports provided to children and families. Federal Head Start Program Performance Standards specify that within 45 days of entry into the program, each child should be screened for developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual and emotional skills, using age and culturally appropriate tools. The Head Start standards also require Early Head Start, which serves infants and toddlers up to age three, to assess whether children have received regular medical screenings and care, and if not, the program must help connect children and families to these services.

CCDBG prioritizes services for children involved with or at risk of involvement with child protective services. The program requires states to provide information about how parents can obtain a developmental screening and referrals to services for children with identified needs. While most states do not use CCDBG funds to conduct developmental screening, some have used the CCDBG quality set-aside to build the capacity of providers to conduct developmental screening.

Medicaid is the primary federal funding stream for children's developmental screening given that screening is included in the EPSDT benefit. The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is essential to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services. As part of the mandate, states are required to screen for and furnish all Medicaid coverable, appropriate and medically-necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.

Many abused and neglected children not placed in foster care will meet income eligibility for Medicaid or CHIP and nearly all children in out-of-home placement are eligible for Medicaid. All Medicaid-eligible children are entitled to receive EPSDT and states use Medicaid to finance an array of required services, including early intervention services and developmental screening.

Child welfare systems can build on the EPSDT benefit to better meet the needs of children and youth in care and state and local policymakers should enhance coordination with Medicaid to ensure delivery of required screening and assessments, as well as subsequent, periodic screening for this population.

The Maternal and Child Health Block Grant Program (Title V of the Social Security Act) provides a health services safety-net for women and children to assure access to basic healthcare and can be used for screening, assessments and follow-up medical care. States can also use Title V funds for special projects of regional and national significance, including training for professional staff. Additionally, states can use these collaboration dollars to fund community-based agencies providing the nonmedical infrastructure around EPSDT.

Lastly, states have explored other opportunities to enhance screening for children in child welfare. As an example, **Delaware** has used Race to the Top-Early Learning Challenge (RTT-ELC) dollars to offer cross-sector professional development for child care, child welfare and home visiting professionals in the Ages & Stages Questionnaire (ASQ) screening tool.

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- often referred to as alternative response (AR). Higher risk families receive the traditional Investigative Response (IR) which includes the intent to determine whether or not there is evidence that a maltreatment incident occurred and to identify the perpetrator(s).
23. In 2008, Pennsylvania's Office of Children, Youth and Families implemented developmental and social-emotional screening for very young children who are referred for child welfare services in response to federal policies through the Child Abuse Prevention and Treatment Act and the Individuals with Disabilities in Education Act. Using a standardized series of age-appropriate questionnaires, screening is required for all children ages 0 to 3 who are substantiated for maltreatment. The state-issued policy strongly encouraged expanding the screening to all children up to age 5 who are receiving child welfare services.
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  27. McCrae, J.S., Cahalane, H. & Fusco, R.A. (2011). Directions for developmental screening in child welfare based on the Ages and Stages Questionnaires. *Children and Youth Services Review*, 33(8), 1412-1418.
  28. The KidConnections Network (KCN) of Providers is a collaboration between the Santa Clara County Behavioral Health Services Department (BHSD) and FIRST 5 Santa Clara County and provides high quality, developmental screening and behavioral health assessment, home visitation and therapeutic services. It also provides links to educational programs and resources, such as Early Start Program and FIRST 5 Family Resource Centers.
  29. Ibid.
  30. Klein, S., Falconer, MK, Benson, S.M. (October 2015). *Early Care and Education for Children in the Child Welfare System: Evaluations of Two Training Programs*. *Journal of Public Child Welfare* 10(2):1-27.
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  32. *Evaluation PIECES Series of findings and discussion of the Colorado Partnership in Early Childhood Education & Services (PIECES) Project*. Available at [http://www.thebutlerinstitute.org/images/projects/co-pieces/COPieces\\_V1.pdf](http://www.thebutlerinstitute.org/images/projects/co-pieces/COPieces_V1.pdf)
  33. Help Me Grow National Center. *What is Help Me Grow?* Retrieved from <http://www.helpmegrwnational.org/pages/what-is-hmg/what-is-help-me-grow.php>
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  35. Available here: <https://www2.ed.gov/about/inits/ed/ear:lylearning/files/ed-hhs-miechv-partc-guidance.pdf>.
  36. EPSDT covers regular screening services, all medically necessary services included within the categories of mandatory and optional services listed in Section 1905(a), physical and mental health and substance use disorder services, medically necessary personal care services, dental services, and vision and hearing services. States must also offer appointment scheduling assistance and are required to assure necessary transportation to and from medical appointment for children enrolled in Medicaid. States must further ensure language access and culturally appropriate service provision.
  37. Available here: <https://brightfutures.aap.org/Pages/default.aspx>
  38. Brooks, T. (November 7, 2017) *Reporting on FY 2016 Child Core Set Includes Key Developmental Screening Measure* [Blog Post]. Available here: <https://ccf.georgetown.edu/2017/11/07/reporting-on-fy-2016-child-core-set-includes-key-developmental-screening-measure/>



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