4-2009

Children at Risk in the Child Welfare System: Collaborations to Promote School Readiness - Final Report

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April, 2009

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ACKNOWLEDGEMENTS

Children at Risk in the Child Welfare System: Collaborations to Promote School Readiness was made possible by Grant # 90YE0076 from the Office of Planning, Research and Evaluation, Administration for Children and Families in the U.S. Department of Health and Human Services. We are grateful to them for their support.

We are also grateful to the members of our Advisory Committee. Throughout our research we have benefited from their wise counsel. These individuals were selected both for their multi-disciplinary expertise, their representation of the various state agencies relevant to the topic of this study and their knowledge of the communities we were studying. The listing below represents the affiliations of members at the time that we conducted this study.

We are indebted to staff at the agencies and programs which serve this population for allowing us to interview them for the field study part of our research in Colorado.

We are also grateful to the many county and private non-profit child welfare agencies in Colorado for helping us to conduct our statewide surveys of caseworkers and foster parents.

We would like to thank Anne Bernard and Mary Joseph at our Institute for their work in designing and formatting this report.

Most of all, we wish to express our appreciation to the many foster parents and caseworkers who participated in this study. They went to considerable lengths to share with us their personal experiences with addressing the needs of this vulnerable population of young children and navigating the various systems which serve them. Confidentiality prevents us from thanking them by name but without their candor and insights this report would not have been possible.

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Disclaimers: This report was made possible by grant number 90YE0076 from the Office of Planning, Research and Evaluation, Administration for Children and Families in the U.S. Department of Health and Human Services. The contents are solely the responsibility of the authors and do not represent the official views of the funding agency, nor does publication in any way constitute an endorsement by the funding agency.

Furthermore, the findings from our study reflect the experiences and opinions of the research participants only and the policy recommendations we include in this report are those of the staff at the Cutler Institute and at Oldham Innovative Research who conducted this study. While the Advisory Committee helped us to conceptualize and carry out this study, and individual members provided us with comments on our recommendations, the final conclusions do not necessarily reflect the opinions of the individuals who served on that Committee.

How this Report is Organized

This study examines the degree to which key players in the child welfare, early intervention/preschool special education (EI/Preschool SPED) and early care and education (ECE) systems (e.g. Head Start, preschool, child care centers, family child care homes) collaborate to meet the developmental needs of children ages 0 to 5 who are involved in the child welfare system. This research includes an analysis of data from the National Survey of Child and Adolescent Wellbeing (NSCAW) as well as a case study in Colorado involving interviews with key stakeholders and statewide surveys of caseworkers and foster parents.

The first section of the report is a discussion of our major findings from those sources and their implications for program and policy. At the end of this section, we include "suggested strategies" which we believe, based on our findings, will improve collaboration. We also include descriptions of the various agencies, programs and policies which are referenced in our research findings.

Section II includes a description of the methodology used for our analysis of the NSCAW and the major findings from that data. Section III includes more detailed reporting of our research questions, methodology and findings from our statewide surveys of foster parents and caseworkers in Colorado. The Appendices includes frequencies from our NSCAW analysis as well as the survey instruments and frequencies from our statewide surveys.

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SECTION ONE

The Challenges of Collaboration: Highlights of Findings and Suggested Strategies

Introduction

Research demonstrates that very young children in the child welfare system are at significantly higher risk for developmental problems than are other children.[1]

- Nationally, 50% to 60% of foster children are found to have developmental problems compared with only 5% to 10% of the general pediatric population (Jaudes & Shapiro, 1999; Takayama, 1998).
- In our own analysis of the National Survey of Child and Adolescent Wellbeing (NSCAW) conducted as a part of this study, almost half of children ages 0 to 5 (47.3%) in the child welfare system were found through assessments to have developmental problems on one or more of three measures of functioning used in that study.

Yet many of these at-risk children are being missed by child welfare caseworkers and may not be getting the help they need at an early age, when intervention is the most effective.

- In the NSCAW cited above, intake (investigative) workers, asked at the time of their investigation whether children aged 0-5 had any developmental concerns, were able to identify less than one quarter of the children (22.0%) whose assessment scores indicated developmental problems.
- In Oakland, California, only one third of children in foster care were identified by caseworkers as having delays compared with 84% who were discovered through assessments to have developmental delays (Halfon, 1999).

[1] We use the term "developmental problem" throughout this report to include developmental delays as well as emotional and behavioral problems.

If developmental problems go unaddressed at an early age, the chances for success in school are diminished. Children involved in the child welfare system are at higher risk for poor educational outcomes.

- In a study in Washington State, twice as many youth in foster care, at both the elementary and secondary levels, repeated a grade compared to youth not in care (Burley & Halpern, 2001).
- In a study conducted in three states of youth aging out of care (the Midwest Study), youth interviewed primarily after completing 10th or 11th grade, on average read at only the seventh grade level (Courtney, et al., 2004).
- Over one third of nineteen year old foster youth in the Midwest study had not received a high school degree or GED compared with only 10% of their same-age peers in a comparable national sample (Courtney, et al., 2005).
- Only 18% of foster youth who were enrolled in school in the Midwest Study were in a 4-year college compared with 62% of their same age peers in a comparable national sample. (Courtney, et al., 2005).

Because of growing concern over these outcomes, the Adoption and Safe Families Act (ASFA) requires states to address the educational needs of children in the child welfare system as one of the child well being indicators the federal government uses to measure states' performance. Despite research demonstrating the critical impact of early learning environments on educational success later in life (Bardige, 2005; Karoly, et al, 2005; Smart Start Evaluation Team, 2003; The Kauffman Early Learning Exchange, 2002; Bowman Donovan, and Burns, 2000; Shonkoff and Phillips, 2000; Reynolds and Temple, 1998), to date, states have focused their efforts primarily on the school aged child. Focusing on the educational needs of very young children may be a comparatively new concept to those outside of the early care and education (ECE) field and collaboration with the public schools may seem a more obvious task to many child welfare caseworkers and administrators than negotiating the complex patchwork of agencies and service providers which exist for very young children.[2]

Recently, however, the emphasis has started to shift. For example, greater collaboration between child welfare and the Early Intervention program under Part C of the Individuals with Disabilities Education Act (IDEA) is being encouraged, at least for children ages 0 to 3, through amendments to the Child Abuse Prevention and Treatment Act (CAPTA), as well as the reauthorized IDEA of 2004. Specifically, the CAPTA amendments require that states which receive funding under the Act establish procedures and processes for referring all children under age three who are in cases of substantiated child abuse and neglect to Part C for screening.[3] Mirroring the CAPTA requirement, Congress in 2004

[2] Please see a description of all of the programs discussed in this report and how they are structured in Colorado at the end of this section.

[3] Throughout this report we use specific terms to describe the process of monitoring children's development and determining whether they have any developmental problems that require intervention. When we refer to the need for ongoing surveillance of children's development by foster parents, caseworkers, etc. we use the terms "assess" or "monitor." When a concern about children's development is

added a provision to the reauthorization of IDEA that requires states participating in Part C to refer for early intervention services any child under the age of 3 who is involved in a substantiated case of child abuse or neglect; or is identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure.[4]

These statutory provisions, which mandate greater interagency collaboration, emphasize the critical role child welfare caseworkers can play in connecting young children involved in the child welfare system with the services that research has shown make a difference in promoting school readiness for children at-risk for developmental problems (Bardige, 2005; Karoly, et al, 2005; Smart Start Evaluation Team, 2003; The Kauffman Early Learning Exchange, 2002; Bowman Donovan, and Burns, 2000; Shonkoff and Phillips, 2000; Reynolds and Temple, 1998). These include ECE programs such as Early Head Start/Head Start as well as special, targeted interventions through the Early Intervention/Preschool Special Education (EI/Preschool SPED) Programs under IDEA.[5]

Caseworkers can also establish important partnerships with the service providers for these programs by relying on their expertise and judgment. ECE and EI/Preschool SPED professionals are in frequent contact with the child and have the knowledge to effectively identify and address the child's developmental needs. In formal and informal ways, both EI/Preschool SPED service providers and ECE providers can offer assessments of the child's developmental progress and alert caseworkers to any problems that might warrant attention. They are also in frequent contact with the child's foster or biological parent, if the child is remaining in the home under a family preservation plan, and can offer support to them, as well as useful insights to caseworkers, about the child's home situation (Dicker and Gordon, 2004).

Our Study Methodology

This study examines the degree to which the developmental needs of young children involved in the child welfare system are being addressed through these kinds of partnerships across the systems and agencies which serve them. To examine the prevalence of developmental problems among this population of young children, and the degree to which these problems are being identified and children referred for early intervention services, we analyzed data from the National Survey of Child and

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raised as a result of that surveillance or monitoring, the child is referred to a professional that referral is for a "screening." The purpose of that "initial screening" is to determine whether there is a possible developmental problem warranting a full "assessment." The purpose of the "assessment" is to identify the existence, and determine the specific nature, of the developmental problem and what services may be recommended.

[4] During the time that we collected our data in Colorado, these provisions were still being interpreted and rules promulgated at the state agency level.

[5] Early intervention services for children ages 0 to 3 are provided under Part C of the Individuals with Disabilities Education Act (IDEA) and preschool special education for children ages 3 through 5 are provided under Section 619 of Part B of IDEA. Unless we are referring specifically to one or the other, in the interest of brevity we will refer to both as one system by using the term "EI/Preschool SPED."

Adolescent Wellbeing. The NSCAW collected data from current caregivers. caseworkers, teachers, and children and conducted developmental assessments regarding a nationally representative sample of children involved in the child welfare system. This national data also enabled us to determine the degree to which this population of children are enrolled in an ECE program.

Next, we conducted a more in-depth case study in Colorado, using qualitative and quantitative methods, to examine the extent to which state and local agencies were collaborating to connect these children with EI/Preschool SPED services and ECE programs and to identify the facilitators and constraints of such collaborations. How are caseworkers ensuring that developmental concerns are being identified and children referred to the appropriate resources to address those needs? What role do foster parents play? Do they know how to identify developmental concerns and are they aware of the resources available to children in this population? Once a problem is identified and a child is referred, to what degree do the key players in that child's life communicate with one another about the child's needs and progress? What training is provided to professionals in all three systems to enable them to meet the developmental needs of this population of children? What barriers do the key stakeholders face in their attempts to collaborate with each other and help children and families access these services?

Our study methodology is summarized in the table below. More detail on our methodology for the NSCAW data analysis and our surveys in Colorado is included in Sections II and III of this report.

Summary of Methods

Analysis of data from National Survey of Child and Adolescent Well-being (NSCAW)	**Field Study Interviews Colorado n=134 2004-2005**	**Foster Parent Survey Colorado n=266 2005-2006**	**Child Welfare Caseworker Survey Colorado n=339 2005-2006**
Taken from the NSCAW, a nationally representative sample of 2,102 children ages 0 to 5 (CPS sample) who had entered the child welfare system at the time of sampling and 268 children ages 1 – 5 who had been in foster care for approximately one year at the time of sampling. (LTFC Sample)	*Professionals (*Child Welfare, Early Intervention, and Early Care and Education) *and foster and biological parents of children under 5 in the child welfare system; conducted in Adams, Alamosa, Arapahoe, Conejos, and El Paso counties.*	*Statewide survey of Colorado foster parents drawn from public and private agency lists of licensed families. 38% response rate.*	*Statewide survey of Colorado child welfare caseworkers and caseworker supervisors drawn from public and private agency lists. 32% response rate.*

Limitations of the Data

Qualitative Research:

The findings from our qualitative research are based on 134 interviews with medical, service and child care providers, child welfare caseworkers, judicial personnel and foster and biological parents who responded to the recruitment efforts we conducted in five counties (out of a total of 64 counties) in Colorado. Interviews were conducted in Adams, Arapahoe, El Paso, Alamosa and Conejos counties.

Field Study Interviews Conducted	# Completed
Child Find Coordinators	8
Early Childhood Connections Caseworkers, Directors	8
DSS Supervisors	8
DSS Caseworkers	15
Privately Contracted Caseworkers	4
Judges /Magistrates	7
Court Appointed Special Advocates	6
Guardians ad Litem	6
DSS Prosecuting Attorneys	2
Head Start	6
Child Care	13
Family Child Care	7
Resource and Referral Agency	4
Pre-K	6
Medical Professionals	6
Therapists	9
	115
Foster Parents	16
Biological Parents	3
Total	134

Caution should be exercised in weighing the significance of our findings from these interviews. While the state agency provides oversight to insure that counties comply with federal laws and regulations, there is some variation from county to county in how child welfare is administered. In addition, there are differences in how the EI/Preschool SPED

programs under IDEA are structured from one locality to another, as well as variations in the availability of ECE programs. Our findings are not necessarily representative of the opinions of the population of providers and parents in the state as a whole, nor do the practices we report here necessarily represent practices elsewhere in Colorado or in other states. Nevertheless, our findings from our qualitative research, with few exceptions, are remarkably similar to our findings from our quantitative research involving statewide surveys of samples of child welfare caseworkers and foster parents.

Quantitative Research:

Our analysis of the NSCAW data was based on a nationally representative sample of children involved in the child welfare system and provided a framework for our case study in Colorado by examining the degree to which young children were or were not being identified and referred for EI/Preschool SPED and ECE programs. However, researchers began collecting data for the NSCAW in October, 1999. Caseworker and caregiver awareness of the developmental needs of young children in the child welfare system may have evolved since this nationally representative survey was conducted.

For our case study in Colorado, we conducted surveys of child welfare caseworkers and foster parents who responded to a mailing giving them the option of completing a paper or on-line survey. For the foster parent survey we had a response rate of 38% and a confidence interval of +/- 4.8 percentage points. For the child welfare caseworker survey we had a response rate of 32.1% and a confidence interval of +/- 4.4 percentage points. However, given the fact that there is some variation in programs among the 64 counties in Colorado, it is important to note that some counties declined to provide us with lists of foster parents and/or caseworkers and, in a few of the smaller counties, even though we were able to obtain lists, no foster parents and/or caseworkers responded to our request for participation. As a result, not all counties were represented among the survey participants.[6] (See Section III for more information about our survey methodology.)

Overall Themes

Our analysis of data from the NSCAW indicates that nationally, young children in the child welfare system may not be getting the early interventions they need to overcome disadvantage and gain the skills needed to succeed in school. Specifically, the NSCAW data indicated:

- A high prevalence of developmental problems among young children ages 0 to 5 in the child welfare system.

[6] The foster parents who participated in the survey came from 34 of the 64 counties in Colorado. The participants in the child welfare caseworker survey came from 52 of the 64 counties in Colorado.

- Evidence that these developmental problems are often missed by caseworkers and caregivers, resulting in children not getting referred for needed services.
- Low levels of enrollment in ECE programs in light of the particular need for these early learning experiences for children in this population who are at greater risk for developmental problems.

Our findings from our case study in Colorado revealed the challenges of collaboration across systems to connect young children to the early interventions they need. Our data suggest that:

Levels of Awareness/Training:

- Training seems to make a difference. Most caseworkers reported having received at least some training on child development and related issues and they demonstrated a high level of *awareness* of the developmental risks among children in this population.
- We also found a significant correlation between caseworker training on the benefits of ECE in particular and higher reported levels of *knowledge* about child development, greater knowledge of the Child Find/Early Childhood Connections programs and higher reported levels of enrollment of children in ECE programs.
- The level of knowledge about developmental needs and resources seems to be in inverse proportion, however, to the amount of time each key player in the child welfare system (i.e. foster parents, case workers, Guardians ad Litem (GALs), Court-Appointed Special Advocates (CASAs) and Judges) spends with the child. Those who spent the least amount of time with the child exhibited the most sophisticated understanding of child development and available resources.
- Caseworkers and foster parents expressed the need for more thorough, ongoing training on the stages of normal child development, the early warning signs of developmental delays and disabilities, the effects of early trauma and parental substance abuse on child development and the importance/availability of EI/Preschool SPED programs.
- Caseworkers and foster parents were more likely to recognize the EI/Preschool SPED Programs under IDEA as an intervention to meet the developmental needs of children in the child welfare system than they were to see ECE programs as an intervention.

Assessment, Referral and Access:

- There was confusion among the key players over who is primarily responsible for assessing the development of the child and appropriately referring that child if concerns are identified.

- Caseworkers and foster parents rely largely on informal means of assessing development, based on their own personal knowledge and observations. Use of a formal screening tool was rare.
- There was a lack of uniformity in where caseworkers referred children for developmental assessments, and differing perceptions about the thoroughness of those assessments. Many caseworkers seemed to lack an understanding of how the referral system worked in their communities.
- While satisfaction with special services such as OT and Speech, once a child is identified as having a developmental delay or disability, was high, some barriers to access were reported such as a lack of providers who will accept Medicaid, specialist appointments that conflict with work schedules and transportation issues.
- Barriers to enrollment in ECE programs for children in the child welfare system resulted, at least in part, from funding limitations, restrictive eligibility policies for child care assistance and a lack of awareness on the part of some caseworkers and foster parents about ECE enrollment priorities.

Interagency Collaboration, Communication and Information Sharing:

- Collaboration appeared stronger between child welfare and the EI/Preschool SPED systems than it did between child welfare and the ECE system.
- There was a lack of basic information for ECE providers and EI/Preschool SPED staff about the special needs of children in the child welfare system and how to handle situations that might arise in addressing the developmental needs of these children.
- Information sharing about children in the child welfare system was inconsistent, with foster parents, ECE providers and medical providers in particular, expressing frustration at not receiving the information they felt they needed to adequately care for the child.
- In locations where formal Memoranda of Understanding or informal agreements were developed between agencies, and in smaller, more rural communities, collaboration seemed to run more smoothly, there was more consistency in the referral process and less confusion about the roles of the various key players in meeting the developmental needs of children.

Highlights of Findings

National Survey of Child and Adolescent Wellbeing (NSCAW)

The NSCAW data we examined were drawn from developmental assessments of, and caregiver and caseworker interviews regarding, a nationally representative sample of children involved in the child welfare system. From this sample, we examined data regarding two subsamples of children:

1. **Child Protective Services (CPS) Subsample** of 2,102 children ages 0 to 5 who had just entered the child welfare system when the sample was drawn and were receiving CPS services.[7]
2. **Longer- Term Foster Care (LTFC) Subsample** of 268 children ages 1 to 5 who had been in "out-of-home placements" for approximately one year at the time the sample was drawn.

These subsamples enabled us to examine caregiver and caseworker practice with regard to addressing developmental needs at different points during a child's involvement with the child welfare system. (See Section II and the Appendices for more information about our analysis of the NSCAW.)

Major findings from the NSCAW analysis indicate:

A significant proportion of young children in the child welfare system, when assessed by researchers, exhibited developmental problems on one or more measures of functioning, indicating the need for interventions at an early age to address these concerns.

- Almost half (47.3%) of all children in the CPS sample had developmental problems in one or more areas of functioning (cognitive skills, communication skills and/or behavior) as measured by assessments of the children. For those in the LTFC sample, the prevalence rate was higher (57.3%).

Despite the high prevalence of developmental problems, caregivers and caseworkers often fail to recognize these problems and refer children for developmental assessments.

[7] In order to compare caregiver perceptions and services provided, data collected from interviews with caregivers regarding children in "in-home placements," (meaning children who remained with their biological families and were receiving CPS services), were reported separately from data collected from caregivers regarding children in "out-of-home placements."

- *Intake (investigative) workers* were able to identify only 22.0% of the children in the CPS sample found to have developmental problems as a result of assessments of the children conducted by researchers. While the focus of these investigative caseworkers is understandably on the safety of the child, failure to identify developmental problems when children first enter the child welfare system can mean missed opportunities for addressing these needs early when interventions are most effective.
- According to reports by *caregivers* in the NSCAW, among children in the CPS sample, 78.6% who were in in-home placements and 62.8% who were in out-of-home placements had never been assessed for learning problems or developmental disabilities by an education or health professional.[8] That figure for the LTFC sample was 56.5% which indicates that when children are in the system longer, they are more likely to receive an assessment.
- The data indicate a lack of awareness of the *need* for assessments by caregivers. Among those caregivers of children who had never been tested, the majority (77.7% of caregivers of children in in-home placements, 67.3% of caregivers of children in out-of-home placements and 79.2% of caregivers of children in the LTFC sample) thought the child didn't need to be tested for developmental problems.
- Among *service caseworkers* of children in the CPS sample, less than one-quarter (23.2%) reported that the child needed an assessment to identify a learning problem or developmental disability. For service caseworkers of children in the LTFC sample that figure was higher – 39.2%, suggesting, again, that the longer a child is in the child welfare system, the more caseworkers are likely to recognize the signs of developmental problems among these children. However, these rates are still low considering the proportion of children found to have identified developmental delays when assessed, as well as the additional children who are likely to be "at risk" for developmental problems.

As stated earlier, comprehensive, quality ECE programs can offer important benefits to children at risk for developmental problems. However, the NSCAW data indicate that enrollment rates for center-based ECE programs are not as high as they should be given the risk for developmental problems in this population of children.[9]

- According to reports by caregivers, among children ages 0 to 2 in the CPS sample, a little more than one quarter (26.4%) of children placed in in-home care and 29.7% of children in out-of-home placements were enrolled in any kind of center-based ECE program. Among children ages 3 to 5 in the CPS sample, about

[8] See footnote #7.
[9] The NSCAW only asked about enrollment in center-based programs, not family child care or informal arrangements with neighbors or family members.

half are enrolled (45.1% for children in in-home placements and 54.8% for children in out-of-home placements).

- Of the LTFC sample, only about one-quarter of children ages 0 to 2 (25.8%) and a little more than half (59.4%) of children ages 3 to 5 were reported to be in any type of center-based ECE program.
- Only a small proportion of children were enrolled in Head Start programs even though many Head Starts make enrolling children in the child welfare system a priority. For children ages 3 to 5 in the CPS sample who are in in-home placements, the enrollment rate in Head Start was only 14.9%, for children in out-of-home placements, 17.4% and for those in the LTFC sample, 19.0%.

Case Study in Colorado

In light of these findings from the NSCAW, our case study in Colorado examined what policy, programmatic and other barriers may be preventing children from receiving the early interventions they need. The following are highlights of our findings in Colorado, drawn from our qualitative and quantitative research:

Awareness of Developmental Concerns:

Are all of the key players involved in the lives of young children in the child welfare system aware of the increased risk for developmental problems and the importance of early intervention?

***Awareness* of the increased likelihood of developmental problems as well as the importance of early identification of delays appears to be high among those providing services and support to children in the child welfare system.**

The large majority of caseworkers we surveyed in Colorado received some training on the effects of abuse and neglect on development (84.8%), developmental milestones (81.2%), the importance of early identification (76.4%), and identifying developmental delays (67.0%). Our survey of foster parents produced similar results with 85.3% receiving training on developmental stages and 70.9% receiving training on the early warning signs of developmental delays and disabilities.

This awareness was also evident in our interviews with child welfare caseworkers, foster parents and EI/Preschool SPED and ECE staff; almost all spoke to the increased risk for developmental delays among children in the child welfare system and the need to address these concerns at an early age.

Among *court personnel*, on the other hand, the level of awareness varied with those working in courts with *specialized* child welfare dockets being more likely to focus on

developmental concerns. Interviews with a number of caseworkers and Judicial personnel indicated that in courts where there is no specialized child welfare docket, Judges are generally not as aware of developmental issues and are less likely to address these concerns when adjudicating cases. If these issues are raised, they are less likely to demonstrate an awareness of the importance of early intervention and instead tend to adopt a "wait and see" approach before considering whether a child should be evaluated further. Again, this can mean missed opportunities for connecting children with interventions at the most optimal time in their development.

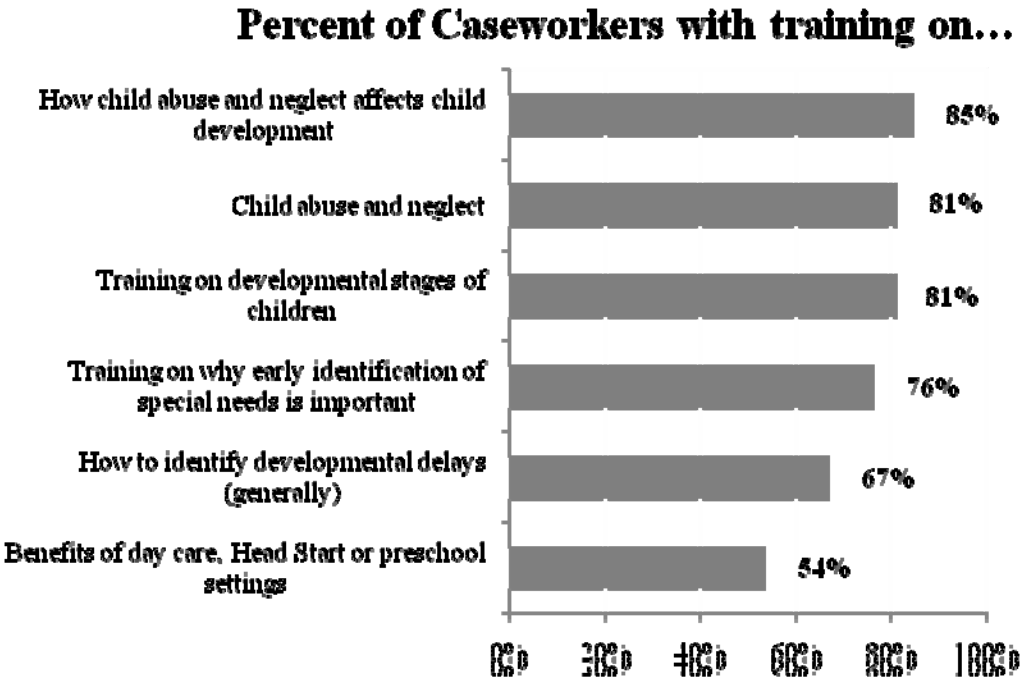
While most caseworkers and Judicial personnel interviewed were aware of the increased risk for developmental delays, they typically did not emphasize ECE programs as a developmental intervention unless a child had already been diagnosed as having a developmental delay or disability.

As discussed earlier, connecting young children in the child welfare system with quality ECE programs can serve as a vital developmental intervention (Dicker & Gordon, 2004). Yet our case study in Colorado indicates that many of these children are not enrolled in ECE programs. Over half (52.2%) of caseworkers surveyed reported that less than half of their 3-5 caseload were enrolled in an ECE program. Almost three-quarters (72.7%) had less than half of their 0-2 caseload enrolled.

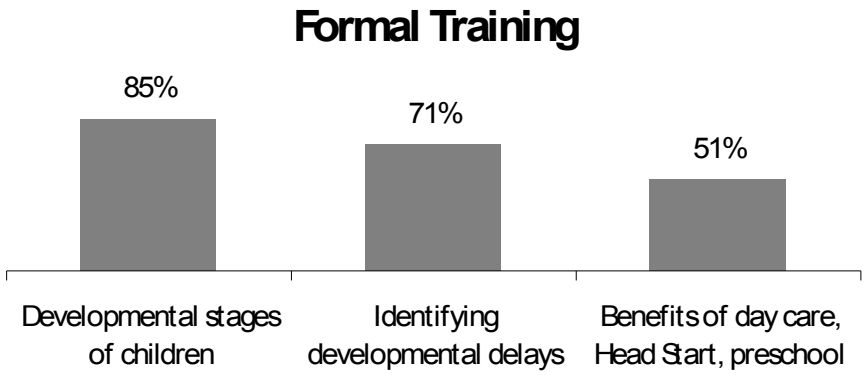
Only about half of caseworkers (53.6%) surveyed reported having received any training on the role ECE can play in a child's development.

"Not many of my caseload are in an [ECE] program - I don't know that they need it."

DHS caseworker



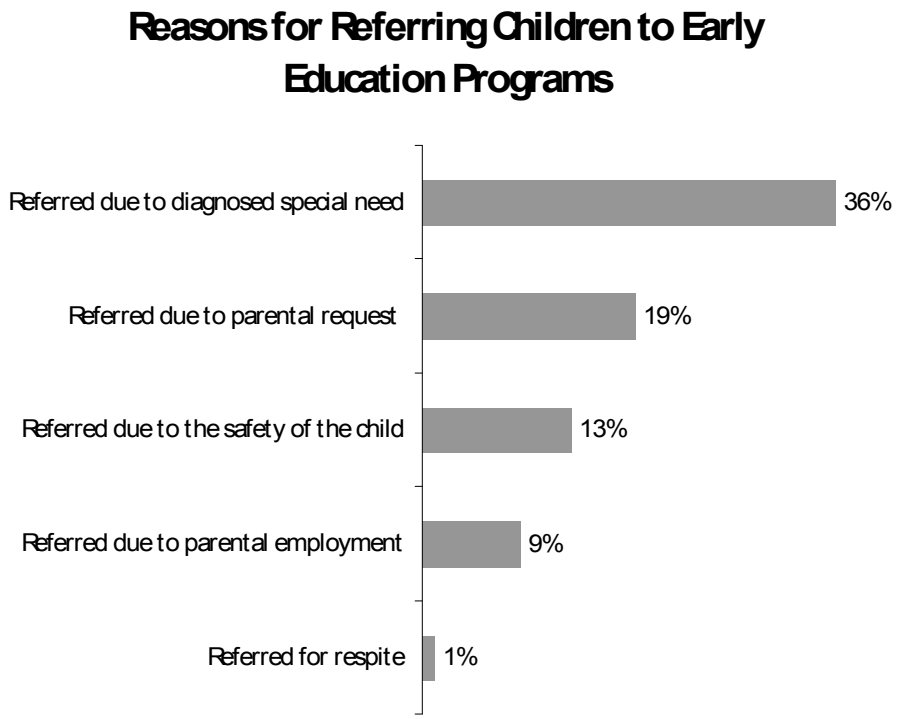
A similar proportion (51.0%) of foster parents surveyed reported receiving training on this topic.



Less than one in ten caseworkers (8.1%) rated their knowledge of ECE programs as "excellent" and almost half (47.1%) rated their knowledge as only "basic." When asked for the most common reason why they would place a child in an ECE program, caseworkers most often cited "when there is a diagnosed special need" (35.9%) with other frequent responses being "the parent requested it" (18.5%) and "the safety of the child" (13.0%).

"In general, kids are not 'placed' in an early care and education setting. If they attend a program, it is because their parents decided to send them to one."

Part C case manager



With a few notable exceptions, caseworkers interviewed did not seem to be as aware of the preventive benefits of enrollment in ECE for all "at-risk" children and instead considered it only as an intervention *after* a child had been identified as having a developmental delay or if the child was an "only child" and needed socialization. In our interviews with court personnel, it also seemed that Judges were much more likely to recognize EI/Preschool Special Education as an intervention than to consider ECE programs when adjudicating cases. This may leave out many children who are at risk and would benefit developmentally from a high quality ECE program.

"Most kids in foster care are not in Head Start or other [ECE] programs. They're usually at home. A lot of times I don't know if it's even been brought up."

Early Intervention Therapist

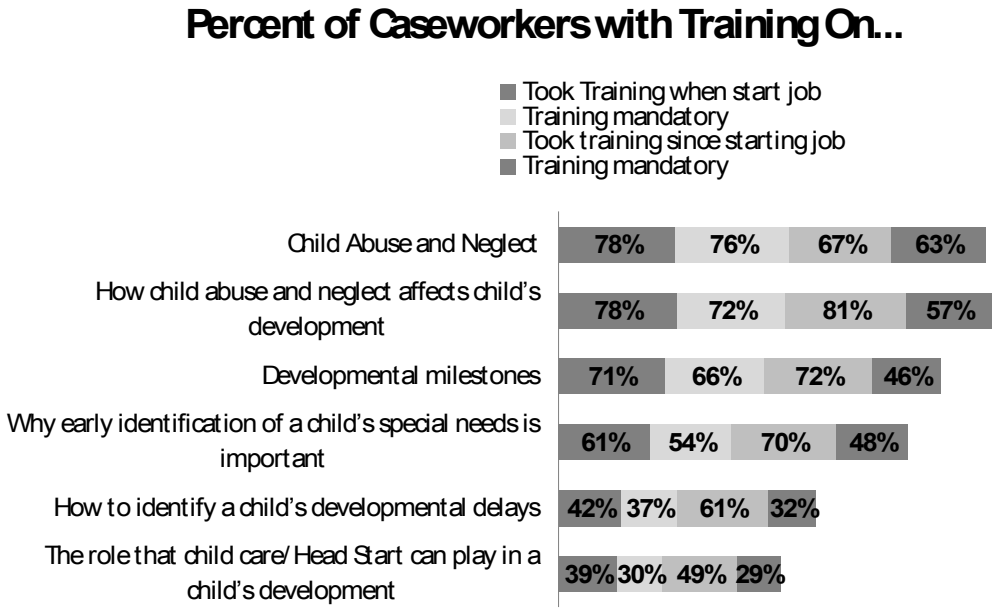
Training of Key Players:

Do all key players receive adequate training on how to address the developmental needs of this population of children?

Despite evidence in our findings of the positive impact of training on caseworker practice, many caseworkers as well as foster parents did not believe that the training available to them on these topics was adequate.

In our survey of caseworkers, we looked at the differences in knowledge and practice between caseworkers who had received different types of training and those who had not. The results showed that those who received training on the benefits of ECE were significantly more knowledgeable about the variety of ECE programs available (62.1% vs. 43.1%). They were also more likely to enroll children ages 3-5 in an ECE program (73.6%) compared with those without training (62.8%). Similarly, caseworkers with training on identifying developmental delays were more likely to perceive themselves as knowledgeable about ECE programs (58.9% vs. 38.9%); knowledgeable about agencies which provide Early Intervention services (51.9% vs. 38.6%) as well as more likely to refer to Child Find (83.3% vs. 71.2%).

Unfortunately, our survey revealed that many of these trainings were not mandatory when caseworkers started their jobs – while training about "child abuse and neglect" was mandatory for three-quarters (76.4%) of the caseworkers surveyed when they started their jobs, only about one-third of caseworkers were required to take training on "the role that child care can play in a child's development" and on "identifying a child's developmental delays"(30.0% and 36.7% respectively)



In our interviews, many caseworkers, as well as foster parents, expressed the desire to receive more in-depth training, on an on-going basis, on child development, the early signs of developmental delay as well as available resources and how to access them. Caseworkers did report that on occasion they were given printed material on various resources available to address developmental needs but that the distribution of these seemed to them "haphazard."

A number of caseworkers and EI/Preschool SPED case managers expressed a desire for more opportunities for cross-training. One Early Intervention Director said she has included this in Memoranda of Understanding (MOUs) with other agencies in her catchment area, including child welfare, and she, herself, has conducted training for CASAs.

ECE providers and EI/Preschool SPED case managers and specialists lacked training on the unique needs particular to young children in the child welfare system and what strategies they could employ to meet those needs.

Our findings from our interviews with ECE providers suggest that just as caseworkers and foster parents need to consider the potential of ECE programs as valuable developmental interventions, ECE providers need training to increase their awareness of the effect of early trauma on child development and appropriate interventions in the classroom for children in the child welfare system who are at risk for developmental problems. As an example, one child care director interviewed commented, "I don't know what to say to a child who says, 'I don't see my mommy because she hits me.' We usually send him over to play with blocks." In addition to this concern, the director said that she was "unsure of what to do" when she suspected that a child might still be a victim of abuse. Another ECE provider stated that often when children return from visitations with their biological parent(s), she finds it hard to know what to say or how to comfort them when they become upset. Head Start providers were much more likely than other ECE providers to have relevant training available to them on these issues, as well as on-site support from mental health specialists.

Staff at one of the Qualistar offices (Qualistar is Colorado's Child Care Resource and Referral program) reported that they conduct training on "children with emotional and behavioral concerns;" "infants and toddlers with developmental disabilities;" "families with diverse backgrounds" and "working with children who have experienced trauma." However, many of the child care providers we interviewed were unaware of these opportunities and seemed unfamiliar with Qualistar. Qualistar staff expressed regret that they didn't have the funding to conduct more outreach with, and provide more training to, providers. One staff person suggested that it would be helpful if the existing training the county child welfare office offers to foster parents could be opened up to ECE providers.

Similarly, in order to do their jobs effectively, EI/Preschool SPED case managers may also need help understanding the special needs unique to this population of children and families. Some child welfare caseworkers we interviewed raised concerns that personnel in the EI/Preschool SPED system were not accustomed to working with families involved in the child welfare system and were frustrated when families were too stressed to be responsive to requests and didn't follow through with paperwork. They felt that the EI/Preschool SPED personnel sometimes looked down on these parents and, by association, on the child welfare caseworkers representing them. This was not a universal impression, however, although it did surface often enough that it would seem to point to a

need for specialized training for this sector similar to that indicated by our findings above for ECE providers.

Assessment and Identification of Developmental Needs

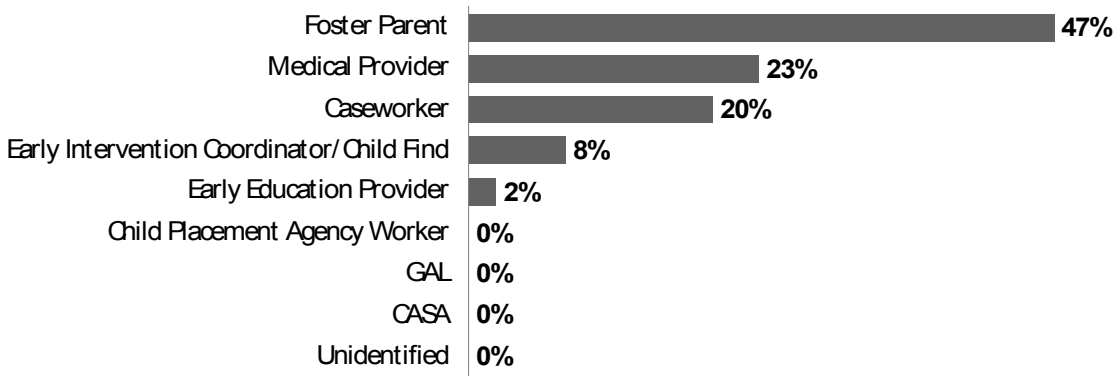
Are the key players clear about who is responsible for monitoring and assessing the developmental progress of young children in the child welfare system and do those who do that monitoring have the knowledge and resources needed to effectively identify developmental concerns?

There is confusion over who is primarily responsible for identifying developmental needs, and on what role each professional can and should play in that process.

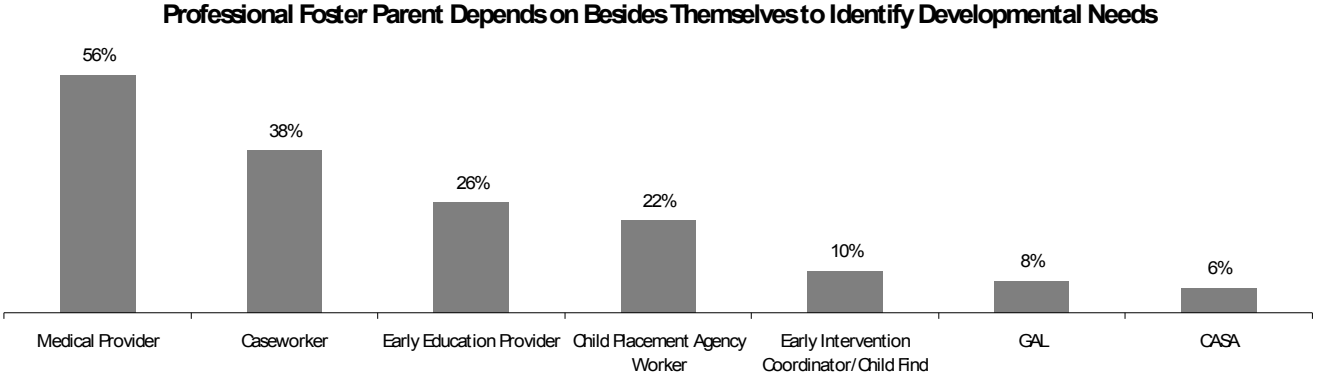
> *"You have Early Childhood Connections, Child Find, child welfare caseworkers, Medicaid, medical providers, hospital child development clinics, foster parents. It's so confusing – there's no clearly identified chain of command."*
>
> DSS caseworker

Children in the child welfare system have multiple adults playing a part in their lives including child welfare caseworkers (sometimes two caseworkers if both a private and a public agency is assigned to their case), foster parents, biological parents, GaLs, CASAs, Judges, etc. When roles and responsibilities are not clearly defined, the developmental needs of the child may go unaddressed. Our survey data and interviews in Colorado uncovered a significant level of confusion about who was primarily responsible for making sure children's developmental needs are identified. Most *caseworkers* (47.0%) thought the foster or biological parent had primary responsibility.

Percent of Caseworkers Indicating Primary Responsibility for Identifying Developmental Needs



Caseworker *supervisors* interviewed, however, felt *caseworkers* were primarily responsible for making assessments and referrals for children on their caseload but only one-fifth (19.6%) of caseworkers surveyed saw themselves in this role. When *foster parents* surveyed were asked who, in addition to themselves, they rely on to identify developmental needs, more than half (56.1%) rely on their medical provider, 38.2% rely on caseworkers, and 26.0% on their child care provider. (Foster parent respondents could select all that applied.)



The confusion over roles was lessened to some degree in counties where child welfare caseworkers reported specific policies and procedures that required that every child under age three who enters the child welfare system be automatically referred for a screening to the early intervention system under Part C of IDEA. At the time of our data collection, this policy had been adopted in several counties as an early response to the CAPTA

amendments referred to earlier which mandated that states develop a plan for referring children ages 0 to 3 in the child welfare system to the Part C Early Intervention Program under IDEA.[10]

The level of knowledge about developmental needs and resources seems to be in inverse proportion to the amount of time spent with the child.

Our overall impression from our field study interviews was that the level of sophistication about child development needed to effectively monitor developmental progress and identify concerns may be lacking for many of the key players who are in the most frequent contact with the child. The Judges and Magistrates we interviewed seemed to rely much more on GALs and CASAs than on caseworkers to monitor children's developmental progress and act on any concerns. Judges, Magistrates, GaLs and CASAs in courts with specialized child welfare dockets demonstrated a sophisticated understanding of developmental theory and milestones. Judges seemed confident in the GaLs' and CASAs' ability to assess and refer for developmental services and many were under the impression that these court personnel had adequate time with the child to do so.

However, foster parents reported seldom having contact with GaLs, and CASAs were not assigned to most cases. Our statewide survey data indicate that over half of foster parents (51.7%) see their GaL "yearly or less;" a finding confirmed by the foster parents and EI/Preschool SPED specialists we interviewed; they reported that GaLs are not typically involved in developmental issues and may not actually have much or any contact with the child before the court case is adjudicated. CASAs were consistently reported as having high levels of involvement with the child, as well as training in child development, but were assigned only to the most complicated cases – typically a low percentage of children in the child welfare system. Only 7.5% of foster parents surveyed relied on GaLs and 5.8% on CASAs to identify developmental needs. No (0%) caseworkers surveyed felt GaLs or CASAs had *primary* responsibility to identify delays.

> *"They know they're representing this child, but they don't even know what he looks like. The GaLs are not real involved"*
>
> -Foster Parent

> *"I do not think that the training caseworkers receive about child development in the initial core training is adequate. I have experienced caseworkers reporting children as being 'on-target' when my own assessment would have been "failure-to-thrive.'"*
>
> –DHS caseworker supervisor

Conversely, although foster parents and caseworkers see the child more frequently than any others, our research revealed some concerns

> *"I'm considered to be an efficient judge and I can't get to developmental issues. What's happening in other places?"*
>
> Judge

[10] Since data collection for this study was completed, Colorado has developed a statewide system of policies and procedures for complying with this amendment. Rules for implementing this requirement became effective on December 31, 2007.

about their capacity to monitor children's development effectively. Most *caseworkers* (both intake and service) described being comfortable identifying developmental issues. However, caseworker *supervisors* were less certain of caseworkers' abilities, stating that they had observed children deemed developmentally on-target by the caseworker who clearly should have been identified as "failure-to-thrive." In one county, a Judge told us that he was concerned that higher skilled caseworkers, who might be better equipped to identify developmental concerns, were largely "pushing paper" while less-skilled case aides and support staff were sent out to the foster homes to observe the child.

"Caseworkers have developmental issues on their radar screen. If they're aware that there is an issue, they make referrals, but the question is, do they notice it?"

- CASA worker

Similarly, there was a mixed perception among interviewees about the extent of knowledge and ability of *foster parents* in identifying potential developmental delays. While some caseworkers reported having complete confidence in foster parents' ability to identify developmental concerns, others felt that foster parents could use more training. Most foster parents in our statewide survey reported confidence in their *own* knowledge of developmental issues. On a scale of 1 to 10, with 1 being very little developmental knowledge and 10 being significant knowledge, foster parents rated themselves at a mean of 8.2. While this level of confidence was echoed by the foster parents we interviewed, there were a surprising number of foster parents who reported concerns that *other* foster parents were ill-equipped to identify and follow through with a referral for a developmental concern.

"They take these kids to homes with very well-meaning people who have no sophistication or knowledge of child development."

–Foster parent

Reliance on informal observation and personal knowledge of child development, rather than formal screening tools, to assess for delays is common among caseworkers and foster parents.

Although both caseworkers and foster parents reported assessing children in their care, almost all interviewed relied on their own knowledge of child development for this assessment. Many caseworkers interviewed were not aware of the formal assessment tools available. For those who were aware of these tools, most reported that they didn't have the time or the training in how to use them. Our survey of caseworkers corroborated this finding - while the majority (64.7%) reported automatically assessing children as they come onto their caseload, only 4.5% reported using a formal assessment tool and 68.0% reported relying on their own knowledge of child development.

Foster parents rely heavily on medical providers to help them assess the developmental progress of the children in their care and determine if there is a need for a referral for further evaluation and services. However, foster parents and others raised concerns about the thoroughness of the developmental assessments provided, a lack of continuity of care and issues of access to these providers.

As reported earlier, more than half (56.1%) of foster parents rely on medical providers to help them assess the developmental progress of the children in their care. Some of the EI/Preschool SPED case managers we interviewed were concerned about this reliance because they believe that the developmental assessments conducted by medical providers as a part of a regular health check-up, are often not thorough enough to pick up the subtle signs of developmental delay that might prompt a referral to EI/Preschool SPED. They attributed this, at least in part, to the fact that providers are paid by Medicaid and the low rates of Medicaid reimbursement prevent them from spending enough time with the child. Even when medical providers do identify a developmental delay, they often adopt a "wait and see" approach instead of referring the child for further evaluation, particularly when they have never seen the child before and have no information on the child's developmental history.

> *"It's hard enough to find a provider [who accepts Medicaid] It's even harder to find a good provider. I can't wait until the whole adoption goes through when I can take my boy to my own doctor."*
>
> - Foster Parent

Adding to these concerns is the issue of access. Our survey of foster parents indicate that almost half (43.0%) found the lack of providers accepting Medicaid to be one of the greatest barriers in addressing the developmental needs of their children. Interviews with medical providers indicated that some refuse to take any patients on Medicaid, some will only take a foster child if the foster parents' biological children are already in the medical practice and some have a quota system and only accept a limited number of children in foster care, as a percentage of their patient caseload.

> *"Child welfare does a pretty good job. The problem is Medicaid doesn't reimburse well enough. We take a loss on every visit. It doesn't cover our expenses.*
>
> - Medical Provider

As a consequence, foster parents interviewed described traveling long distances to reach providers who would accept Medicaid and unfortunately, they did not always feel that these providers were of high quality. One parent shared that she had to drive her foster child almost an hour for routine medical checkups that were otherwise available within a five minute drive for her own children because there were no providers nearby who would accept Medicaid. Foster parents related stories of calling long lists of providers and being turned away as soon as the office learned that funding would be through Medicaid.

Referrals

Once developmental concerns are identified, are the key players able to make informed decisions about where to refer children for further evaluation and services? Are those sources of referral accessible and responsive to the needs of this population?

Referrals of children were sometimes hampered by caseworker confusion over how the referral system operated in their community.

In several counties, caseworkers seemed confused about the referral process. A number of them did not recognize the name "Child Find" or the name of the local Part C-funded entity in their locality and instead automatically referred children on their caseload to the child development clinic at the local hospital. They seemed unaware of the services and protections offered under Part C of IDEA such as the required timelines for processing referrals and conducting evaluations, the case management services available (to help families with paperwork and arrange and coordinate services)[11] and the requirement that services be delivered in the child's "natural environment" rather than the specialist's office.[12] These benefits are generally not available when a child is referred to a source outside of the Part C system.

Even when caseworkers knew about Child Find some were under the impression that it was only for school-aged children or children ages 3 and up, or they believed that the only way into the system was to be identified and referred when the child was an infant in a Neonatal Intensive Care Unit. Among caseworkers who did refer children to Child Find, many felt that the most complex cases should still be handled by the local child development clinics. [13]

In contrast, the referral system for assessments of developmental problems in the rural areas included in our field study seemed to be better understood by key players. Without exception, interviewees knew where to refer a child for an assessment. This appeared to result in a better understanding of roles, increased communication among the players involved, and more automatic sharing of information about evaluation results and services. Interviewees pointed to the importance of having a simple, single-point-of-entry that was clearly communicated to everyone. It may also be that the smaller size of the communities involved and the lack of nearby alternative sources for assessments contributed to a greater clarity about roles and responsibilities and more uniformity in addressing developmental needs.

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[11] EI/Preschool SPED case managers voiced concern that families involved in the child welfare system were too stressed to be able to navigate the system without the help of a case manager. The child development clinics will provide families with large packets of paperwork to fill out and a list of specialists to call but a lack of follow up by parents often delays services for children.

[12] Providing services in the child's "natural environment" means delivering the services where the child is normally, alongside his or her non-disabled peers whether that is at home, in the community or at a child care site. Interviewees told us that when services instead are delivered in a specialists' office, often the interventions are not as effective, the child has to experience more transitions, transportation issues are created for the parents, and the caregiver and/or child care provider miss opportunities to learn strategies from the specialist to make therapies consistent across all settings.

[13] Toward the end of our study, responsibility at the state level for the Early Intervention Program under Part C of IDEA shifted from the CO. Department of Education to the Division of Developmental Disabilities within the CO. Department of Human Services. Since then this shift has resulted in the Community Centered Boards throughout the state being given the responsibility for accepting referrals, ensuring that evaluations are done by the appropriate Child Find offices within the school districts, determining eligibility and providing case management services. While this is a change in the structure and oversight of the program, at the local level, the system for referrals and evaluations of children between the Part C-funded entity and Child Find has remained generally the same.

Some caseworkers were reluctant to refer to Child Find because they were concerned about the thoroughness of the assessments provided and/or the limited hours of operation of some of the offices. Others said referrals were sometimes hampered by difficulties convincing biological parents to give permission for their child to be evaluated.

> *"From my perspective there needs to be a single point of entry for kids where their developmental concerns are identified. My sense is that kids are not being identified."*
>
> – DHS caseworker supervisor

Some caseworkers and foster parents encountered problems accessing EI/Preschool SPED for assessments because of a lack of capacity to process referrals for evaluations in a timely fashion, despite the timeframes mandated under IDEA. In our foster parent survey, one in four (25.0%) reported that it took too long to get screenings and 26.1% cited waiting lists as a challenge. In our interviews, some caseworkers and foster parents pointed to the limited hours of some of the Child Find offices run by the local school districts, which are only open during school hours and are closed, or operate for very limited hours, during school vacations and summers. Caseworkers worried that if they referred a child toward the end of the school year, that could cause lengthy delays before the child was evaluated and services initiated. Some caseworkers were also concerned that because the Child Find offices were run by the school districts, delays would occur when a child who had been referred for evaluation had his or her child welfare placement changed to a different school district. Others, however, felt that these transitions had gone quite smoothly.

Another reason given by caseworkers for referring children to sources other than Child Find was a concern that the evaluations provided by Child Find sometimes were not as thorough as those conducted by the child development clinics. This view was not shared by the medical providers we interviewed, however. All reported being very satisfied with the quality of the evaluations conducted by Child Find and the efficiency of the process when they referred children. Like many of the caseworkers, they did report that they referred children with the most complex needs to the child development clinic instead of Child Find.

> *"You run blocks all the time because you're just the foster parent – you don't get to make the big decisions."*
>
> Foster Parent

Lastly, caseworkers raised the issue of legal authority for consenting to evaluations. While some caseworkers told us they had encountered little difficulty obtaining the permission of a child's biological parents before referring the child for an assessment, others cited this as a barrier to getting children the help they needed. Some parents were reluctant to give their permission for fear that if a developmental problem was found, that would reflect badly on their parenting and they would be less likely to regain custody of their child. There was also confusion over who had the legal authority to provide permission, with some interviewees telling us that foster parents and caseworkers had

been allowed to sign when they were not legally authorized to do so. Several foster parents we interviewed expressed frustration at having no power to make decisions for the child and cited instances in which the biological parents were either living in another state or were incarcerated and assessments and services were delayed while caseworkers attempted to locate them to obtain permission.

"I have to push somebody to do something. It's really hard because they look at me and say, 'Well, she's just the foster parent'"

– Foster Parent

Access to EI/Preschool SPED Services and ECE Programs

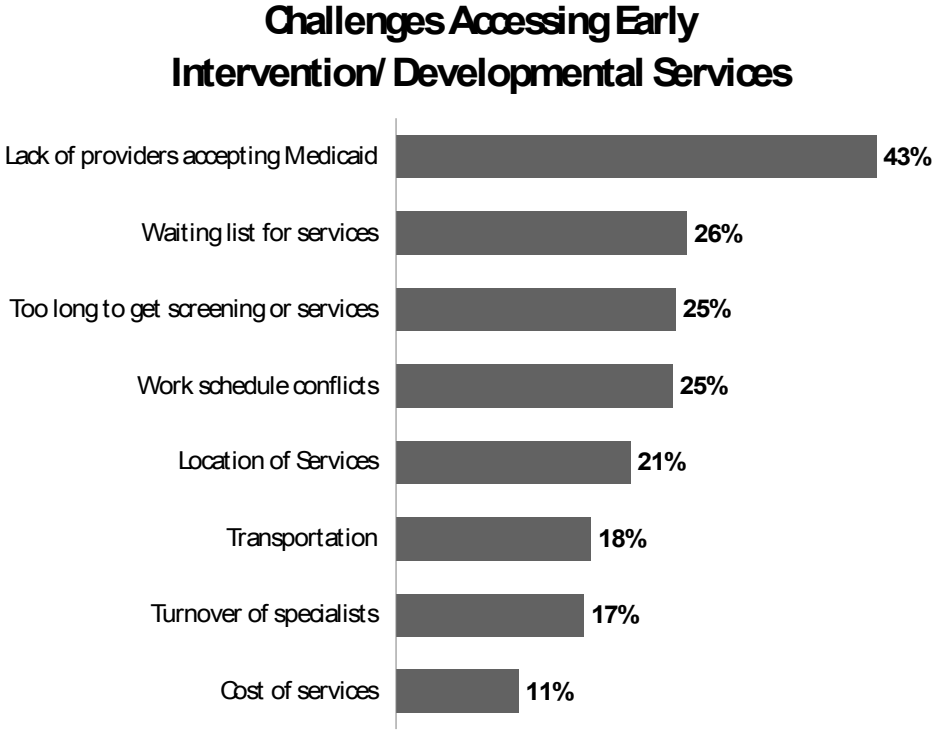
Given the high prevalence of developmental problems among young children in the child welfare system, do children have adequate access to EI/Preschool SPED services and quality ECE programs?

Once a child is referred and found eligible for EI/Preschool SPED services, foster parents and caseworkers reported several barriers to *accessing* those services, although in general, satisfaction with the *quality* of the services received was high.

In general, the caseworkers and foster parents we interviewed raised few concerns about accessing early intervention services once a child was identified as having a developmental delay. They seemed much more concerned about whether children were being identified and referred in the first place. In our *survey* of foster parents, however, some barriers to accessing services were identified. Foster parents were asked to rate the severity of different barriers on a scale of 1 to 10 with 1 being "No Problem" and 10 being a "Serious Problem." Almost half of foster parents (43.0%) gave a score higher than 5 for "Lack of Providers who accept Medicaid," an issue discussed earlier with regard to access to medical providers for health check-ups. The next most frequent barriers receiving a score above 5 were "Waiting Lists" (26.1%); "Work Schedule Conflicts with Scheduled Appointments" (24.8%); "Takes Too Long to get Services" (25.0%) and "Location of Services/Transportation Issues" (20.9%).

"Kids that are identified as having special needs get good services once they are identified, but kids who aren't identified – those kids are in trouble."

- Foster Parent



In general, once children were able to access services such as speech or occupational therapy, foster parents seemed satisfied with the quality of these services. Almost two-thirds (63.4%) of foster parents said they were "Very Satisfied" and another one-quarter (26.9%) said they were "Somewhat Satisfied" with these services.

Policies regarding eligibility for child care assistance may be hampering access to ECE programs because they focus more on the parents' needs (for work, respite, etc.) than on enrolling children in the child welfare system purely for developmental reasons.

Policies regarding child care assistance can create barriers to access for children in the child welfare system for those foster parents who are not working and/or who have incomes too high to qualify. The Colorado Child Care Assistance Program (CCCAP), which provides child care subsidies for families under the federal Child Care Development Fund, requires that foster parents meet the same requirements for eligibility as other parents – they must

> *"Many parents need and would greatly benefit from childcare assistance programs, but make too much money to get financial help. So they leave kids with "in home" sitters when the kids could get better socialization by being in a preschool program. This bothers me that we aren't able to help more working class families with childcare."*
>
> -DHS caseworker

be employed and have incomes low enough to qualify.[14] According to a number of caseworkers we interviewed, when foster parents are employed, the foster payments they receive almost always make their income too high to qualify for CCCAP. And, if they aren't employed, then they are ineligible for that reason.

While "special circumstances" child welfare funding under Title IV-E is available to qualifying *biological* parents of children in the child welfare system to cover child care costs, this funding normally lasts for only three months and is intended more to cover the need for respite for parents or for the safety of the child, rather than to support any longer-term enrollment of the child. Caseworkers cited the short duration of this child care funding as a barrier for biological families retaining custody of their children and receiving child welfare services. Furthermore, in most counties, foster parents are ineligible for these funds – it is expected that foster parents would pay for child care out of the payments provided by the child welfare agency to support the child; again, an assumption many foster parents said was unrealistic.

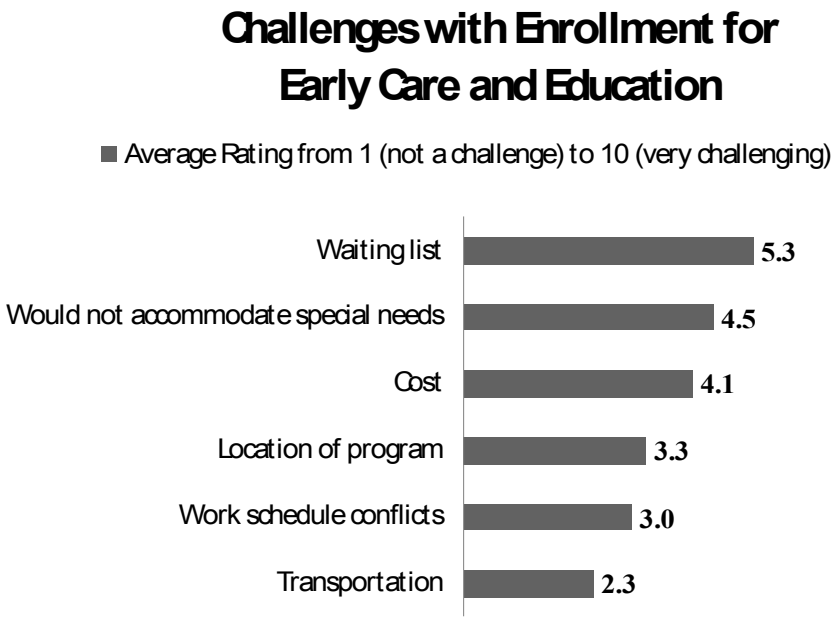
> *"Day care is non-existent. Nobody can afford it and there's no money for childcare. Young, unwed couples struggle – they can't afford anything. Three months special circumstances funding [under child welfare] is nothing!"*
>
> - CASA worker

A number of caseworkers reported that the children they had enrolled in ECE programs were only there because they had diagnosed special needs and the EI/Preschool SPED programs under IDEA had placed them there as a part of the services they were receiving to address their disability. In fact, one caseworker thought that the *only* way children in the child welfare system could be enrolled in an ECE Program was through being placed there by EI/Preschool SPED.

Lack of capacity of ECE Programs, quality concerns and other barriers can also limit access.

Beyond the question of child care assistance, both foster parents and caseworkers described other challenges enrolling children in ECE programs. More than one third (38.1%) of caseworkers and 26.2% of foster parents reported having problems accessing care. One of the main reasons cited was "limited space, waiting lists."

[14] Under the federal Child Care Development Fund, states are given the option of extending child care assistance to foster children without foster parents having to meet the same eligibility requirements as other families do. Colorado has not adopted that option, however.



We learned from our interviews with child care providers, child care R&Rs and child welfare caseworkers that many public preschools, including Head Start, grant priority to enrolling children in the child welfare system, particularly if they are in foster care. Unfortunately, our survey also found that three-quarters of foster parents (74.1%) were not aware of this policy. This could be remedied with appropriate training and outreach to foster parents.

Other issues of access cited included the time-consuming challenge of obtaining necessary immunization records, which may not have followed the child, the difficulty finding an ECE program that would accept children with special needs, the cost of care and work schedules that conflict with hours of operation of the ECE program. Almost one-third (30.3%) of caseworkers surveyed felt that the children who could most benefit from quality ECE programs did not have access to them.

Finally, a number of caseworkers expressed concern about the quality of the ECE programs available to children in the child welfare system. One caseworker said that in her area, with the exception of Head Start, most of the ECE programs serving low-income children were deemed to be of low quality under Colorado's Qualistar Quality Rating System. As a result, she believed that if she couldn't enroll children in Head Start, they would be better off at home.

> *"Early Head Start and Head Start would be good for all of the young children we serve so why aren't we getting more kids into them?"*
>
> DSS Supervisor

Collaboration/Coordination/Communication

Are the child welfare, EI/Preschool SPED and ECE systems collaborating at the agency and practice level to create a seamless system that connects young children to the early interventions they need?

***Agency-level* collaboration between child welfare and EI/Preschool SPED was evident, although the extent varied from county to county. However, ECE programs (with the exception of Early Head Start/Head Start) often were not included.**

As explained earlier, Colorado has a county-based system where each county determines the financing and provision of services in accordance with state and federal policy. As a result, each county differs in their approach and the extent to which systems collaborate to address the developmental needs of young children in the child welfare system. Coincidentally, three of the five counties involved in our field study had formal assistance in setting up collaborations among child welfare, Part C, Early Head Start, and public health agencies for children ages 0 to 3.[15] In those counties, collaborations, at least with regard to the youngest children, appeared to be stronger and in some, players continue to meet monthly to discuss current practice and/or establish formal Memoranda of Understanding.

> *"I would like to see more community meetings with all of the agencies at the table so everyone knows what's going on"*
>
> Privately contracted child welfare caseworker

> *"I have seen cases where [collaboration] is successful and cases where it is not. There needs to be more coordination. Sometimes early childhood feels like the least significant part of the team. Early childhood people have a lot to give – they know a lot about the child."*
>
> - ECE provider

However, ECE providers said they were infrequently included in these efforts and even where formal collaborations were established, their inclusion usually did not extend beyond Early Head Start/Head Start. Our interviews uncovered little or no collaboration with Child Care R & R networks or with other types of child care settings (child care centers, family child care, etc). One R&R staff person remarked that when ECE or EI/Preschool Special Education receive a grant they are usually required to have child welfare at the table but that the reverse is rarely true. This is unfortunate as our survey data reveal that 26.0% of foster parents rely on their child care provider to identify developmental needs.

Practice-level collaboration, communication and information sharing was uneven between the child welfare, EI/Preschool SPED and ECE systems.

[15] Alamosa, Arapahoe, and El Paso counties were involved in a project conducted by JFK Partners of the University of Denver to increase referrals of children ages 0 to 3 from child welfare to Part C. Researchers provided training and facilitated meetings with county-level child welfare and Part C staff to increase collaboration.

In order to monitor the developmental progress of children in the child welfare system and refer children for needed interventions in a timely fashion, key players need to communicate with each other on a regular basis and share pertinent information about the child. The results of our interviews and survey data indicate that this is not happening with regularity across the systems involved. As a measure of the degree of information sharing between child welfare and the EI/Preschool SPED system we asked caseworkers if they regularly receive copies of reports of evaluations for children on their caseloads. Less than half reported that they *automatically* (without having to request it) receive that information from Child Find (40.5%) and only a little over one-third automatically receive results from the Part C entity (37.8%). One in five reported never receiving a report from the ECE entity (20.3%) and 19% reported never receiving results from Child Find.

> *"We see ourselves as silos but what we need to be doing is working together to make sure we get to the neediest kids."*
>
> Early Intervention Director

When asked which professionals caseworkers communicated with, and how frequently, a little over one in four reported communicating monthly (28.6%) and over one-third (39.4%) reported communicating less than monthly with EI/Preschool SPED case managers. More than one quarter (26.1%), however, reported no interaction. Communication with ECE providers was somewhat more frequent - almost half (46.7%) reported monthly communication, 29.0% reported less than monthly contact and 12.9% reported no interaction at all. In our interviews, caseworkers expressed regret that their caseloads were too high to enable them to communicate with these professionals more frequently. Foster parents interviewed understood the time constraints caseworkers were under but they also expressed frustration about the high turnover of caseworkers which in their view disrupted the process of assessing development and referring children for services.

We asked the few biological parents we were able to interview about their perspectives on the degree of communication and information sharing they saw happening between the key players in their child's life.[16] Their impression was that for the most part, they were the nexus for that communication, relaying information between the key players rather than the key players speaking with each other. Yet, they remained very pleased with the early intervention services their children were receiving although one felt it had taken too long for her caseworker to refer her child for an initial evaluation to determine eligibility for these services. The others, however, were very praising of their caseworkers and grateful to them for connecting their children to services they saw as having a very positive impact on their child's development.

[16] In addition to foster parents, we had intended to include interviews with biological parents retaining custody of their children and receiving child welfare services in our study. Unfortunately, this population proved very difficult to reach and in the end, we only were able to recruit and interview three biological parents in the five counties included in our field study compared with sixteen foster parents.

There was evidence in our interviews that courts can play an important role in prompting more communication and information sharing across the three systems. Caseworkers told us that the fact that they have to report about a child to the court every sixty to ninety days often prompts them to call the child's EI/Preschool SPED case manager or specialist *if* they expect that the developmental needs of the child will be raised in the court hearing. This suggests that it may be particularly important for judicial personnel, whether in specialized courts or not, to regularly request information about the developmental needs of every child whose case comes before the court.

Our findings indicated that sometimes, because of confidentiality issues, key players in a child's life aren't even aware that the child is involved in the child welfare system. For example, ECE providers told us they had little interaction with caseworkers and often didn't know about a child's involvement in the child welfare system, particularly if that child was still in the custody of his or her biological parents and receiving child welfare services, which is common. While they understood that confidentiality is a major factor, they still felt that the child's safety might be at risk if they were not at least informed about custody issues. They also felt that an awareness of the child's situation would assist them in handling situations that might arise and in recognizing any signs of developmental concerns.

Similarly, early intervention *case managers* interviewed were consistently informed of a child's involvement with the child welfare system when the child was in foster care and consent from the biological parent was needed for services to take place. However, they had very little awareness in those cases where the child was still in the custody of his or her biological parents. Early intervention *therapists* (speech, physical, and occupational therapists), on the other hand, seemed more likely to learn of the child's involvement even when the child is still with the biological parents, as they provide early intervention services primarily in the child's home.

While child welfare caseworkers consider foster parents as primarily responsible for meeting the child's developmental needs, often not enough information is shared with them to support their being effective in that role.

As reported previously, survey and field study results revealed that most caseworkers expect foster parents to be primarily responsible for identifying and referring children to services. In spite of this expectation, however, foster parents often lack the information about the child that would help them monitor the child's development effectively. Less than half (41.9%) of foster parents surveyed reported "always" receiving medical records, leaving well over half (58.2%) potentially lacking that basic information on a child placed in their care. Only a little over half (57.6%) always receive information on special services or therapies currently being received, and less than half (42.5%) always receive information about the child's family history.

Foster parents recognize that this information is often unavailable even to caseworkers, because biological parents may be unwilling or unable to share it. However, this still makes it difficult for them to address a child's needs in a timely and appropriate manner. Some foster parents we spoke with reported receiving only a bag of medications or a first name when a child was initially placed in their care. "Medical passports," created on entry to the system and intended to contain all relevant medical information, including developmental assessments and interventions, were often not received by foster parents. Those who did receive them reported that they were often blank. On the positive side, more than three quarters of foster parents (75.7%) surveyed reported receiving at least *some* health or developmental information upon placement, or within two weeks of the child's placement.

> *"I don't know anything about this two-week-old I have. I have to ask. I don't know how long he's supposed to stay, even. These children are supposed to come with some information. We want to do the best we can – we can't do that if we don't know anything."*
>
> - Foster parent

As discussed earlier, medical providers also expressed concern about a lack of information about the medical and developmental history of the children they see and how that affects the thoroughness of the assessments they are able to conduct. They often "work in the dark" because the knowledge foster parents have of a child's medical history is usually so poor. When they work in a medical practice that has a social worker, the social worker is assigned the task of trying to find the information if the foster parent doesn't have it. These providers reported rarely, if ever, having contact with child welfare caseworkers unless there is a question of legal action being needed.

> *"We don't get anything. If we're lucky, we get a piece of paper with a name and a Medicaid number on it."*
>
> - Foster parent

Lastly, medical providers raised a concern about their own ability to share information with key players in the child welfare system because of confidentiality constraints imposed by the Health Insurance Portability and Accountability Act (HIPAA). Indeed, only 16.6% of caseworkers surveyed said they *automatically* receive reports from health providers. This underscores the need for agency collaboration to establish procedures and protocols for addressing cross-systems confidentiality issues.

> *"Sometimes we just have a Ziploc baggie full of medications and getting immunization records is nearly impossible."*
>
> - Medical provider

Conclusion

In our report, we have identified the very real challenges Colorado faces in ensuring that very young children in the child welfare system are connected with the early interventions so necessary to their healthy development. We want to be sure, however, to

emphasize that Colorado is not unique in this regard and we also want to point to the many positive signs of effective collaboration that emerged from our study.

Because, ultimately, foster parents are the "24/7" caregivers for many children in the child welfare system, we included in our survey a question to gauge the level of satisfaction they felt with the services provided by the various professionals involved in addressing the developmental needs of the children in their care. Despite the various challenges identified in our findings, the survey results for this question were relatively positive. Almost three-quarters (74.7%) of foster parents were "very satisfied" with the services provided by medical providers and almost two thirds (63.4%) were "very satisfied" with the services provided by EI/Preschool SPED specialists (e.g. OTs, Speech Therapists). The percentage for ECE providers was 55.7%; Child Find, 50.0%; and child welfare caseworkers, 47.8%. The percentages for being "somewhat satisfied" with those professionals were an additional 19.0%, 26.9%, 34.1%, 38.0% and 32.1% respectively.

In addition, there have been several public and private initiatives in Colorado which have worked to address many of the issues we have raised in this report. A number of entities (including JFK Partners[17], the Kempe Center[18], the ABCD Project[19] and Project BLOOM[20]) have worked to foster collaboration between systems at the state and local level in order to better address the developmental needs of young, at-risk children, including those in the child welfare system. The Colorado Department of Human Services (CO. DHS) and the Colorado Department of Education (CDE) have also spearheaded cross-agency efforts to develop Memoranda of Understanding to clarify roles and responsibilities and have held five state-wide, cross-systems forums on advocating for the educational needs of children in the child welfare system that included workshops and speakers on the developmental needs of children ages 0 to 5. Colorado

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[17] See Footnote #15

[18] The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect provides and improves direct clinical services, improves clinical service delivery systems, and provides training, education and consultation programs to prevent and treat child abuse and neglect in Colorado and throughout the nation. http://www.kempe.org/

[19] The ABCD Project, "Assuring Better Child Health and Development Through the Use of Improved Screening Tools", is a collaborative effort to help primary care providers improve identification of developmental delay by using standardized testing. Despite the recommendation to use a standardized tool there are perceived barriers to screening in practice including time, staff needed, and inadequate reimbursement. The ABCD Project began three years ago, with a pilot in several primary care sites in Arapahoe, Douglas and Denver counties, to address these barriers. http://www.abcdresources.org/

[20] Project Bloom focuses primarily on young children from birth to five years old with serious emotional disturbances (SED) in El Paso, Fremont, and Mesa counties and the city of Aurora. The project provides enhanced training, integrated delivery of supports and services, statewide working groups focusing on system improvements, and ultimately, sustainable statewide resources for addressing children's mental health. Project Bloom builds on the seeds for improving mental health in the four communities, including working with each county's Consolidated Child Care Pilot program to further improve the quality of early care and education (ECE). Project BLOOM works with diverse partners, including early childhood leaders and educators, mental health centers, departments of human services, employment and training programs and others. http://www.projectbloom.org/

has developed a Caseworker Manual and Curriculum on the educational needs of children and youth in the child welfare system that includes discussion of issues unique to children ages 0 to 5. These materials have been adapted for use with foster parents. Lastly, CO. DHS has asked for assistance from our project staff to produce a DVD on this topic for use in cross-disciplinary training for the key players in all three systems.

Like other states, Colorado is struggling to develop and implement a seamless system of referral, and EI/Preschool SPED and ECE interventions, for children in the child welfare system, recognizing that if early interventions are provided to enhance the learning of these children, they will be more likely to overcome early trauma and neglect and attain the skills needed to be successful in school. The challenges we report from our case study in Colorado are illustrative of those faced by all states in ensuring that children receive ongoing and effective developmental assessments, enhanced, high quality early learning environments and timely referrals for specific, targeted interventions when concerns are identified.

Colorado has set an example in this regard and we hope our findings and suggested strategies will be helpful to policymakers and practitioners in Colorado, and in other states, who are working to address the developmental needs and enhance the school readiness skills of this vulnerable population of children.

Suggested Strategies

Based on our findings, and with the assistance of our advisory committee, we have developed a number of suggested strategies for strengthening collaboration in Colorado and in other states to better address the developmental needs of young children in the child welfare system.

IDEA Part C and B Policy

Goal: *Increase capacity for regular, ongoing developmental assessments of children ages 0 to 5 in the child welfare system:*

National and state-level data indicate that many children at-risk for developmental problems are not being identified and referred consistently for EI/Preschool SPED services. To address this problem, we offer the following strategies:

- **Extending the CAPTA requirement for children so that all children ages 0 to 5 in the child welfare system are automatically referred for a developmental assessment and appropriating the necessary funding to expand capacity to meet that need.** CAPTA and IDEA now require that all children ages 0 to 3 who are the subject of substantiated cases of abuse or neglect be automatically referred for a developmental assessment. In addition to full implementation of this

requirement, the state should also consider extending that requirement to preschool children so that all children ages 0 to 5 in the child welfare system are screened for potential developmental problems.

- **Establishing a training and certification program for medical providers** in order to address the capacity of the system to handle the increased volume of referrals and to expand the number of medical providers who are willing to accept Medicaid and serve these children. These providers would be required to follow a more exhaustive protocol for assessing the development of children in the child welfare system, would receive training and certification for serving these children and would be reimbursed at a higher rate under Medicaid to compensate them for the additional time involved. Medical providers who were certified under the program would need to comply with the same timelines required under IDEA for conducting evaluations and would need to ensure that information regarding the evaluation of the child is shared in a timely fashion with caseworkers and biological/foster parents.
- **Requiring all sources used to assess the development of children in the child welfare system to meet the same timelines required of Child Find under IDEA.** If new sources for assessment are used to expand capacity to handle the increased referrals outlined above, they should be required to meet the same timelines required under IDEA. This would allow for expansion of capacity to handle the increased referrals outlined above without compromising children's progress with delays in the processing of referrals and determinations of eligibility for services.
- **Ensuring expanded hours for Child Find offices** which might otherwise be open for reduced hours, if at all, during school vacations. Delays of several months in processing requests for evaluations for infants and toddlers in particular, can undermine the effectiveness of early intervention.
- **Providing training to caseworkers and foster parents on the use of a formal assessment tool** so that once the initial evaluation referred to above is conducted, the child's progress can continue to be monitored. Signs of developmental delays or disabilities may not be evident when a child first enters the child welfare system and that child may be considered to be meeting developmental milestones. Without ongoing monitoring, the child who later shows signs of problems may be missed, particularly if he or she has to change placements.
- **Supplying court personnel with a checklist of questions about the child's developmental needs** to use in court hearings to insure that young children's development is monitored on an ongoing basis and early interventions, including ECE programs, are considered as part of the service planning for each child. Knowing that questions will be asked in court regarding a child's developmental status might help to elevate the importance of monitoring the child's development among the key players in the child welfare system.

Early Care and Education Policy

Goal: *Expand access to quality ECE programs for children in the child welfare system*.

As described earlier, quality early care and education can enhance the development of young children in the child welfare system. However, our interviews and survey data indicated significant barriers to access and affordability issues for children in the child welfare system. Based on these findings, we offer the following suggested strategies:

- **Expanding the capacity of quality ECE programs to enroll at risk children** in the child welfare system who need quality early learning environments by increasing funding for Early Head Start/Head Start and other public ECE programs.
- **Ensuring that all publicly-funded ECE programs (e.g. Early Head Start/Head Public Preschool and Pre-K Programs, contracted programs) give priority to enrolling children in the child welfare system.** In Colorado, the Colorado Preschool Program and most Head Start Programs do this already. Outreach efforts to inform key players of this policy should be conducted.
- **Adopting the existing federal option available to allow parents in the Child Protection System, as well as foster parents, to qualify for child care subsidies** even when they don't meet the work and income eligibility requirements other parents must meet to qualify. This would further expand access to ECE programs for children in the child welfare system.
- **Giving priority to biological parents and foster parents of children in the child welfare system in providing child care subsidies** where there is a waiting list for child care assistance.

Record Keeping and Sharing of Information

Goal: *Improve information sharing among the key players in the lives of young children in the child welfare system and strengthen administrative record keeping on the degree to which developmental needs are being addressed so that this information is available to policymakers for planning and evaluation purposes.*

Our findings indicate that many of the key players in the lives of young children in the child welfare system are frustrated by the lack of information they are given with which to address the developmental needs of this population. There is also a lack of reliable administrative data to permit policymakers to determine the degree to which efforts to collaborate between systems are, in fact, leading to more children receiving the early interventions they need. Based on our findings we suggest the following strategies:

- **In order to adequately address the developmental needs of young children all key players need access to complete and up-to-date information on each child,** including the results of developmental assessments, receipt of EI/Preschool SPED services, enrollment in ECE programs, etc. This information can be included on health and education "passports" which should accompany each child and protocols and procedures should be developed to clarify roles and responsibilities for keeping this information up-to-date. This data also needs to be recorded in a manner that allows state policymakers to determine, in the aggregate, the extent to which children's development is being assessed and children referred for EI/Preschool SPED and ECE interventions.
- **Interagency MOUs outlining protocols and procedures should be developed at the state and county levels to address issues of confidentiality** raised by the various laws governing the education, child welfare and health care systems so that information relevant to a child's development can be shared on a "need to know" basis between the key players in a child's life.

Training

Goal: *Expand and strengthen multi-disciplinary training opportunities across the systems examined in this study.*

Colorado already offers opportunities for training to caseworkers on a number of the key topics, including developmental milestones, specific developmental disabilities and the effects of maltreatment on child development. However, our research indicates that 1.) caseworkers and foster parents would like some of the content to be at a higher level, and/or that they be trained more frequently; 2.) some of the topics below are not covered by existing training, particularly the content related to the ECE system and 3.) some of the stakeholder groups other than child welfare listed below also do not have opportunities for this training in order to learn about the other systems involved in effective collaboration to address the developmental needs of young children in the child welfare system.

We list here key components of a comprehensive training system to strengthen collaboration across these sectors. We propose that in an approach similar to the efforts of the JFK Partners Early Identification Project, each county undertake an effort to look across systems and develop an approach to training that reflects the resources, structures and needs of that locality. In carrying out that planning, communities should consider ideas like the one suggested by a Qualistar staff person to open up *existing* training for one sector, such as foster parents, to include another, such as ECE providers.

Based on our findings, key components of a local training system should include the following:

Subject*:* *Child development and early intervention*

Audience: All players in the child welfare system including caseworkers, foster parents, court personnel

- Developmental milestones
- Early warning signs of developmental disabilities
- Importance of early intervention
- Importance of establishing a lead person to be primarily responsible for monitoring the development of the child and raising concerns
- Use of a formal screening tool to assess development
- How to refer children for early intervention or preschool special education
- Parental consent issues
- Integration of planning for an individual child and family across systems (e.g. IFSP and family service plan under child welfare)
- IFSP and IEP process and role of caseworker and foster parent in IFSP/IEP meetings

Subject: *Understanding the Early Care and Education System*
Audience: All players in the child welfare system including caseworkers, foster parents, court personnel

- What is quality ECE and how high quality care enhances child development
- Resources for enrolling children in ECE programs and assistance in paying for child care and how to access these
- Priority enrollment policies in ECE programs

Subject: *Communication and Collaboration*
Audience: All players in the child welfare system including caseworkers, foster parents, court personnel

- How to address confidentiality issues with other players in child's life (foster parents, ECE providers, medical providers, EI/Preschool SPED case managers and specialists)
- How ECE providers and EI/Preschool Special Education specialists and case managers can act as vital sources of information on the child and family
- How to involve the courts in addressing the developmental needs of children

Subject: *Addressing the needs of young children in the child welfare system in the early intervention and ECE settings*
Audience: ECE providers and EI/Preschool special education case managers and specialists

- Impact of early trauma on child development
- Understanding the child welfare system, including mandated reporter provisions, confidentiality, etc.

- Help with specific situations that might occur in the child care or early intervention setting
- Effective ways of communicating with parents involved in the child welfare system
- Acting as a source for information about the child's and family's well-being for caseworkers
- Integration of planning for children and families across systems (e.g. the Iindividual Family Service Plan under IDEA Part C and the family service plan under child welfare)

Interagency Planning and Collaboration

Goal: *Strengthen interagency planning and collaboration between child welfare, EI/Preschool SPED and ECE systems in order to better meet the developmental needs of young children in the child welfare system.*

As described earlier, in those counties where there has been a concerted local effort to plan across systems, such as the planning process facilitated by the JFK Partners Early Identification Project, we found that stakeholders in each system were better informed about the other systems, understood the role they played in addressing the developmental needs of the children they served and had developed formal and informal agreements/ MOUs that enhanced collaboration. As a result, we offer the following strategies:

- In order to improve collaboration at the local level, the early childhood councils, which now exist in almost all counties in Colorado, should consider initiating inter-agency planning efforts to address barriers to effective collaboration. The councils should develop MOUs regarding the roles and responsibilities the various agencies should take on to ensure that children in the child welfare system are linked to the services they need, what protocols should be established for information sharing across systems, and what training each sector would need to play their roles effectively. These early childhood councils should include representative foster parents.

- At the state level, interagency efforts to resolve issues that may be hindering collaboration at the local level should continue in order to address such issues as parental consent, information sharing and confidentiality, timely provision of information to foster parents and caseworkers, lack of providers accepting Medicaid, policies regarding eligibility for child care assistance, training priorities, etc.

Description of Relevant Programs and Policies

The following are brief descriptions of the key programs and systems that are the subject of this study *as they existed and were structured during the time that we collected our data for our case study.*

The Child Welfare System

The Adoption and Safe Families Act (ASFA) is the federal law that sets standards and provides funding for the states' child welfare programs. While administration and services are centralized in the state agency in some states (with services delivered through regional offices), in others, services are delivered through county-level, quasi-independent agencies which operate under varying degrees of state agency oversight.

Colorado's child welfare program is a state supervised, county administered system. As a result, there is variation in how services are structured and delivered across the state. Depending on the needs of the population served, some counties have specialized units to focus on a particular population such as families with substance abuse issues, infants and toddlers or adolescents. Some counties contract with private, non-profit agencies for some of their services to children and families and, as a result, some foster parents are part of the state system and some are overseen by these private agencies.

Similarly, there is variation in how the judicial system operates in each county. Depending on the size of the county, some courts are specialized courts which only adjudicate child welfare cases, while in other counties, child welfare cases are handled with other kinds of cases. Guardians ad litem (GALs) are lawyers appointed by the court to represent the interests of the child in custody actions where there are allegations of abuse or neglect, or in protective order proceedings. In some courts, Court-Appointed Special Advocates (CASAs) assist the GALs. CASAs are volunteers who are members of the community and work with a guardian ad litem to represent the best interests of a child whose case is before the court by getting to know the child and gathering relevant information about the child and the family. Due to the limited number of volunteers, they are usually assigned to only the most complex cases.

In Colorado, the state agency which provides oversight to the county level child welfare programs is the Colorado Department of Human Services (CDHS). In addition to setting policy and monitoring the operation of child welfare programs throughout the state, the state agency also collaborates with other relevant early childhood systems and programs. For example, a staff person from CDHS is designated as the liaison to the Early Intervention Program under Part C of IDEA within the Division of Developmental Disabilities. The Part C Program and Child Welfare have entered into Memoranda of Understanding to clarify policy on such issues as who can act as an Educational Surrogate for young children in the child welfare system who receive services under IDEA.

IDEA Early Intervention and Preschool Special Education

The federal Individuals with Disabilities Education Act (IDEA) governs the provision of early intervention and special education services to children with disabilities. Part C of the Act governs early intervention services to children from birth to age three. Section 619 of Part B of IDEA governs special education services for preschoolers aged three through five. While services to preschoolers under Part B are paid through special education, direct services under Part C are paid through a hierarchy of funding sources, including private health insurance, Medicaid and Title V of the Social Security Act (Maternal and Child Health Block Grant).

Part C Early Intervention for Children ages 0 to 3

When our study began in 2004, Part C was under the Colorado Department of Education. In 2006, however, that function was given to the Division of Developmental Disabilities under the Colorado Department of Human Services (CDHS). It is now the lead agency for implementing Part C, which is called Early Childhood Connections (ECC) in Colorado. An advisory group called the Colorado Interagency Coordinating Council, required under Part C of IDEA, includes representatives from child welfare and helps set policy and advises CDHS on implementation issues for the Part C Early Intervention Program.

At the county level, Part C of IDEA is implemented by local agencies which provide a single point of entry covering a single county or, in some cases, multiple counties. These agencies, which can include Early Childhood Connections offices, Community Centered Boards[21] or County Departments of Public Health, work closely with the Child Find agencies (through school districts) which identify and evaluate children who are potentially eligible for Part C.[22] Typically, referrals to the Part C Program for assessments are made either to these Part-C funded entities or directly to Child Find. The Child Find offices, run by local school districts, are responsible for screening and evaluations for all potentially eligible infants and toddlers referred to the program, and they also conduct evaluations for older children.

The Part C agencies are responsible for providing case management services and arranging for therapeutic services to eligible families and their children. In addition to case management provided by the Part C agencies, direct services coordinated under IDEA but funded through other sources (e.g. Medicaid, Title V Maternal and Child Health) include parent education, health and nutrition services, speech therapy, physical

[21] Community Centered Boards are responsible for community services for children with delays in their development and developmental disabilities and adults with developmental disabilities. Currently, there are twenty Community Centered Boards across the state.
[22] See footnote #11.

and occupational therapy, mental health services, vision and audiology services, transportation to specialist appointments, etc.

Under Part C, IDEA services must be provided in the child's "natural environment" (e.g. the home, the community, play groups, child care programs) in order to integrate services into the every day routines of the child and reach the child in settings where children without disabilities participate. This is required unless it is determined that functional goals (milestones in basic skills set for the child) cannot be achieved satisfactorily in a "natural environment."

For children birth to three a multi-disciplinary team determines eligibility, develops the Individualized Family Service Plan (IFSP) and conducts reviews of the child's progress. Typically, the IFSP team includes parents or guardians, evaluators, child care providers, family advocates, the Part C service coordinator, professionals providing early intervention services, and any other relevant people knowledgeable about the child, at the discretion of the parents. The IFSP for infants and toddlers revolves around the involvement of the family and the attention paid to the family's needs as well as the child's.

Preschool Special Education for Children Ages 3 through 5:

Section 619 of Part B of IDEA governs special education services to children with disabilities ages three through five. While the Colorado Department of Education provides state-level oversight, the program is operated through the local school districts just like special education for school aged children. School systems provide evaluations through Child Find as well as provide case management and services for children found eligible.

Preschoolers found eligible for special education must receive services in the "least restrictive environment" which for this age group means providing services in a continuum from least to most restrictive as follows: by an itinerant teacher or specialist coming to the child's home or child care setting; the school system providing services in settings such as a play group, home or child care program; a classroom in an integrated preschool program with non-disabled peers; or a classroom in a special preschool program exclusively for children with disabilities.

Like Part C, Part B requires a multi-disciplinary team that includes the parents or guardian to determine eligibility and services and conduct annual reviews for children found eligible. The plan the team develops for a preschooler is called the Individualized Education Plan (IEP) and the meetings of this multi-disciplinary team are called IEP meetings.

The Issue of Parental Consent

Before a child can be screened under Part C or B of IDEA, and before services can be initiated for those found eligible, the child's parent or legal guardian must provide written consent. Where parental rights have been terminated, an educational surrogate can be appointed or, under certain conditions, the foster parent may provide consent.

The Early Care and Education System

The third system that is the subject of this study is Early Care and Education (ECE). The ECE system is not really a system per se, but a patchwork of public, private non-profit and private for-profit ECE programs including Early Head Start/Head Start, public preschools and pre-K programs, private non-profit and for-profit child care centers and family child care homes. For infants and toddlers, there are also a number of home-based programs that emphasize family support and parent education as well as case management to enrich the early learning environments of children.

There is also a system of child care resource and referral offices to help families judge the quality of an ECE setting and locate an ECE program that can meet their needs. In Colorado, local resource and referral agencies are organized under an umbrella organization called Qualistar Early Learning and are a resource for caseworkers and foster parents in finding appropriate child care providers for a child in the child welfare system.

In Colorado, there are a number of potential sources of support for enrolling children in ECE programs including:

Child Care Development Fund: The CCDF is the primary source of federal funding to assist working parents in paying for child care for their children. Assistance is provided in the form of child care subsidies based on family income. Colorado's program is called the Colorado Child Care Assistance Program (CCCAP). In order to qualify in Colorado, biological and foster parents must be employed and have an income low enough to meet the guidelines. Colorado has not adopted the option available to states to automatically cover children in foster care where the foster parents do not meet these requirements. Furthermore, funding is not sufficient to serve all eligible families in Colorado and the state does not give priority to foster children (whose foster parents do meet those requirements) in providing subsidies. Colorado also funds a comparatively small number of slots in ECE programs for families eligible for assistance through contracts with child care centers.

Child Welfare Funds: Some county child welfare agencies use "Special Circumstance" Title IV E funding to pay for the cost of a child enrolled in an ECE program. However, these funds are quite limited. There are a number of circumstances under which these subsidies are typically granted. For example, they might be used to enable a mother in a family preservation program to attend counseling sessions or to look for employment. Because funding is so limited, it is typically not used as a source for the ongoing

enrollment of a child in an ECE program for the primary purpose of enhancing the child's development.

Colorado Preschool Program: This publicly funded program is operated in 171 out of a total of 178 school districts in the state. Some use the funding to contract with Head Start or other preschool programs in the community. About two thirds of the children served are in programs operated directly by the local public school system. The programs are part-day unless other funding is used to cover additional hours. The purpose of the program is to address the developmental needs of at-risk four year olds. During the enrollment period, children in the child welfare system are given priority for the limited number of slots available.

Early Head Start/Head Start Programs: Early Head Start and Head Start are comprehensive, federally-funded child development programs that serve children from birth to age five, pregnant women, and their families. Early Head Start provides individualized child development and parent education services to infants and toddlers up to age three from low-income families through a mix of home visits, experiences at an Early Head Start center, and experiences in other settings such as family or center-based child care. Head Start programs are comprehensive, preschool programs for low income children age three through five and include enriched learning activities, developmental and health assessments and family support services. These programs are funded and operated through regional federal Head Start offices. Most of these programs give priority to children in the child welfare system during their enrollment periods.

SECTION TWO

National Survey of Child and Adolescent Wellbeing (NSCAW)

The NSCAW is the first national study of child welfare to collect data from children and families and the first to relate child and family well-being to family characteristics, experience with the child welfare system, community environment, and other factors. As described in Section I, we analyzed the NSCAW data to set a framework for our case study in Colorado by examining the prevalence of developmental problems among children ages 0 to 5 in the child welfare system nationally and the degree to which these problems are being identified and children referred for evaluations and services under IDEA. We also examined the degree to which these children were enrolled in ECE programs.

Unlike our research for our case study in Colorado, the NSCAW data is child-specific, meaning that the questions asked of caregivers and caseworkers were about a specific child who was followed over a period of time. Our research in Colorado focused on the experiences caseworkers, caregivers and service providers have had with collaboration *in general* – none of our questions were about a *specific* child in their care or on their caseload.

The NSCAW permitted us to look at two subgroups of the child welfare population over time: those children who had entered the child welfare system at the time of sampling and were receiving child welfare services (the CPS sample)[23] and those who had been in foster care for approximately one year when the sample was drawn (the LTFC sample). By analyzing this data, collected over time, caseworker practice among *investigative* intake caseworkers (those who do the initial investigation of allegations of child abuse and neglect when a child is first referred to child welfare) can be compared with that of *service* caseworkers who serve children and families after charges of abuse and/or neglect are substantiated. Given the critical importance of intervening as early as possible to address developmental concerns, looking at this data over time permitted us to get a sense of the points at which developmental needs are or are not identified after the child first enters the child welfare system.

[23] This group included children who were still in the custody of their biological parents and were receiving child welfare services and those who were placed in foster care.

We report major findings from our analysis of the NSCAW in this section and include frequencies in the Appendices.

Research Questions

Using the NSCAW, we examined the following questions:

- To what extent do children aged 0-5 in the child welfare system have developmental delays or behavioral issues?
- To what extent have children aged 0 to 5 been referred by caseworkers for assessments to identify a learning problem or developmental disability?
- To what extent have children aged 0-5 in the child welfare system been tested for learning problems, special needs, or developmental disabilities by an education or health professional?
- To what extent do caregivers feel that the child *needs* to be tested for identification of developmental concerns?
- To what degree have children been referred by caseworkers to child care programs including a Head Start program, nursery school, or early childhood development program?
- To what extent have children aged 0-5 in the child welfare system been enrolled in a child care program, including a Head Start program, nursery school, or early childhood development program?

Description of Full NSCAW Sample

The NSCAW was based on a sample of 6,228 children, ages birth to 14 (at the time of sampling), who had contact with the child welfare system. It included:

1.) 5,501 children selected from those who were the subject of child abuse or neglect investigations conducted by Child Protective Services (the CPS Sample)

2.) 727 children selected from those who had been in out-of-home placement for about 12 months at the time of sampling, referred to as the longer-term foster care (LTFC) sample.

The sample design is a stratified cluster sample of all children in the target population, with oversampling of infants, sexual abuse cases, and cases receiving ongoing services after investigation (Dowd, Kinsey, Wheeless, Thissen, Richardson, Mierzwa, and Biemer, 2002).

The NSCAW obtained information from assessments of the children and face-to-face interviews with current caregivers as well as child welfare caseworkers, children, and teachers, if the child was school-aged. The questions asked in the NSCAW focused on the characteristics, needs, experiences, and outcomes for children and families involved in the child welfare system (Chapman, Gibbons, Barth, McCrae, and the NSCAW Research Group, 2003). The data were collected about the selected children over a fifteen month period beginning in October, 1999. The follow-up data were collected from caregivers and caseworkers at 12 months and from all respondents at 18 months and 36 months.

Description of Subgroups that were the Subject of our Analysis:

For our analysis we chose to examine two subgroups of very young children drawn from the CPS and LTFC samples in the NSCAW:

1.) **From the CPS Sample:** 2,102 children ages 0 to 5 who had just entered the child welfare system when the sample was drawn and were receiving CPS services.[24] We analyzed data collected from assessing these children and interviewing their investigative caseworkers and caregivers at Wave I and data collected from their service caseworkers at Wave II, approximately one year later. This allowed us to compare caseworker practice in addressing developmental needs at different points in the adjudication of a case.

2.) **From the LTFC Sample:** 268 children ages 1 to 5 who had been in foster care approximately one year at the time of sampling. We analyzed data collected from assessing these children and interviewing their service caseworkers and caregivers only at Wave I. Including this subgroup provided us with additional information on developmental concerns, caregiver perspectives and caseworker practice for those children who had been in foster care for at least one year.

The chart below provides a summary of these subgroups and the data points and data sources that were included in our analysis.

[24] In order to compare caregiver perceptions and services provided, data collected from interviews with caregivers regarding 1,403 children in the CPS sample who were in "in-home placements," (meaning children who remained with their biological families and were receiving CPS services), were reported separately from data collected from caregivers regarding 699 children in "out-of-home placements" (meaning that they had been removed from their homes and placed with foster parents or relatives).

Subgroups and Sources of NSCAW Data Analyzed in our Study

Subgroups drawn from full NSCAW Sample	**Wave I** (Wave I data collected when sample was drawn)	**Wave II** (Wave II data collected approximately one year later)
CPS Sample: Children ages 0 to 5 who had just entered the child welfare system when the sample was drawn (N-2,102)	• Developmental Assessments (reported for whole CPS sample) • Investigative caseworker Interviews (reported for whole CPS sample) • Caregiver interviews (reported separately for in-home and out-of-home to compare perspectives of two types of caregivers – biological parent/relative and foster parent. See footnote #22)	Service caseworker interviews[25](reported for whole CPS sample.)
LTFC Sample: Children ages 1-5 who had been in foster care approximately one year when sample was drawn (N-268) [26]	• Developmental Assessments • Service caseworker interviews • Caregiver interviews	We did not analyze data from Wave II for the LTFC sample.

Measurement of Variables

Child Developmental Assessment Measures[27]

Child developmental assessment measures were used to examine the rates of developmental problems for children aged 0 to 5 in the child welfare system.

Child's cognitive skills. Children's cognitive skills were measured with the Battelle Developmental Inventory – Cognitive subscale (BDI; Newborg, Stock, Wnek, Guidubaldi, & Svinicki, 1984) for children aged 0 to 3 and Kaufman Brief Intelligence Test – Composite Score (K-BIT; Kaufman and Kaufman, 1990) for children aged 4 to 5. Cognitive skills for children aged 0 to 5 were computed by using standardized scores for BDI and K-BIT.

[25] Of the 2,102 baseline interviews at Wave I, 1,425 caseworkers (63%) completed an interview at Wave II.
[26] Of the 339 LTFC children aged 1-5 at Wave I, 71 children (21%) were excluded from the analysis because interviews did not occur or they went home after construction of the sampling frame but before interviews could be conducted because of timely one-year case review hearings followed by reunification.
[27] Child's cognitive and language scores were obtained by administering assessment tools to children and child's behavior scores were acquired by asking current caregivers.

Child's communication skills. Children's communication skills were measured with the Preschool Language Scale-3 – Total Score (PLS-3; Zimmerman, Steiner, & Pond, 1991).

Child's behavior problem. Children's behavior problems were measured with the Vineland Adaptive Behavior Screener – Daily Living Skills domain (Sparrow, Carter, & Cicchetti, 1993).

Caregiver Measures[28]

Current caregiver reports were used to construct measures of child health, assessment and identification of developmental needs, and access to services and early care and education programs.

Child's overall health. Caregivers were asked by NSCAW interviewers whether their child has any health problems that last or reoccur and whether their child has been up-to-date with his/her immunizations or shots.

Assessment and identification of developmental needs. Assessment and identification of developmental needs were measured using the following questions that asked caregivers: (1) whether their child has been tested for learning problems, special needs, or developmental disabilities by an education or health professional; (2) whether caregivers think that their child needs to be tested for learning problems, special needs, or developmental disabilities; (3) whether they have been told by an education or health professional that their child has learning problems, special needs, or developmental disabilities; and (4) whether their child has been provided with an Individualized Family Service Plan (I.F.S.P.) under Part C of IDEA or an Individualized Education Plan (I.E.P.) under Part B Section 619 of IDEA.

Early care and education programs. The NSCAW interviewers asked caregivers whether their child is in any type of center-based child care program including a Head Start program, nursery school, or early childhood development program. If caregivers responded "yes" to this question, they were asked whether it was a Head Start program.[29]

Caseworker Measures

Caseworker reports were used to construct measures of recognition of developmental problems, service needs, and referrals to services.

Recognition of developmental problems. The NSCAW interviewers asked *investigative* caseworkers whether, at the time of the investigation, the child had major developmental disabilities or behavior problems.

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[28] The caregiver measures were administered separately to the child's permanent or non-permanent caregivers.

[29] Caregivers were not asked about home-based babysitting or child care; only whether the child was enrolled in any type of center-based child care programs..

Perceived need for/referrals to services by caseworker. Service caseworkers were first asked about services the child may have *needed* in five areas: (1) learning problems or developmental disabilities; (2) special education classes or services; (3) emotional, behavioral, or attention problems; (4) health problems; and (5) routine check-ups or immunizations.

Next, *referrals* to services were measured by asking caseworkers whether they referred children to services in each of the five areas listed above.

Analyses

For the description of the sample, frequency and percentage distributions are used. Weighted analyses are conducted to produce national estimates.[30] As a result of the weighting strategies, these analyses are representative of the nation's child welfare population.

Major Findings

Child, Caregiver, and Caseworker Characteristics

CPS Sample:

- Three quarters of children (75.0%) were home with their parents; 10.5% were in foster homes; and 9.2% were in kin care settings.
- Almost one fifth (18.6%) of children in the CPS sample were less than 1 year old. 17.6% were 1 year old; 14.7% were 2 years old; 16.3% were 3 years old; 17.0% were 4 years old; and 16.3% were 5 years old. About half of children were white (44.8%); 35.7% were black; and 13.4% were Hispanic.
- 60.8% of caregivers completed high school or high school equivalent. About half of caregivers (44.7%) did not work and 39.9% worked full-time.
- 11.7% of caseworkers have been on the job for less than one year. 44.6% of caseworkers have been a caseworker for 1-5 years; 20.5% for 6-10 years; and 17.5% for more than 10 years.

LTFC Sample:

- More than half of children in the LTFC sample were in foster homes (67.4%); 30.0% in kin care settings; and 2.6% in other out-of-home care arrangements

[30] Weighted analyses are conducted using the Complex Samples Analysis in SPSS to take into account the NSCAW stratification plan and the probability of PSU (Primary Sampling Unit) selection.

(e.g., group home, residential program). More than one third of children (35.2%) were 1 year old; 29.7% were 2 years old; 10.2% were 3 years old; 14.2% were 4 years old; and 10.7% were 5 years old. About half of children were black (50.3%); 30.3% were white; and 12.8% were Hispanic.

- About 58.7% of non-permanent caregivers completed high school or a high school equivalent. More than one third of non-permanent caregivers (38.6%) did not work and 37.2% worked full-time.
- 5.3% of caseworkers have been on the job for less than one year. Half of caseworkers (50.0%) have been a child welfare caseworker for 1-5 years; 25.3% for 6-10 years; and 15.9% for more than 10 years.

Occurrence of Developmental Delays

This population of children showed a high prevalence of developmental problems. Based on the criteria commonly used to determine if a child has developmental delays (Rosenberg, Smith, Levinson, 2006), children were considered to have developmental problems if their score was less than or equal to one standard deviation below the mean.

CPS Sample:

- 44.0% of children in the CPS sample had developmental delays on cognitive skills; 41.3% had language delays; and 36.7% had behavioral problems.
- About half of children (47.3%) in the CPS sample showed developmental problems on one or more of these three measures of developmental assessments[31]

LTFC Sample:

- 47.1% of children aged 1-5 had developmental delays on cognitive skills; 48.9% had language delays; and 51.9% had behavioral problems.
- Overall, more than half of children (57.3%) aged 1 to 5 in the LTFC sample showed developmental problems on one or more of these three measures of developmental assessments.[31]

Assessment of Developmental Needs by Investigative Caseworkers and Caregivers

In general, despite the high prevalence of developmental problems revealed by assessments of the children, developmental concerns were often missed by caregivers and

[31] For the purposes of this analysis we included children whose scores were 1.5 standard deviations below the mean on one of the three developmental measures or children whose scores were one standard deviation below the mean on two or more developmental measures.

investigative caseworkers who were much more likely to recognize the need for, and refer children for, health check-ups and immunizations than for assessments to identify a developmental or learning problem.

CPS Sample:

- Intake (investigative) caseworkers, at the time of investigation, were only able to identify 22.0% of those children found through assessments to have significant developmental or behavior problems.
- Children were far more likely to receive their immunizations on-time than to receive assessments for developmental problems. The vast majority of children in in-home placements (93.2%) and children in out-of-home placements (91.5%) were reported by their caregiver as being up-to-date with their immunizations or shots, but according to these caregivers, most children who are in in-home placements (78.6%) and out-of-home placements (62.8%) have never been tested for learning problems, special needs, or developmental disabilities by an education or health professional.
- Caregivers often didn't recognize the need for children to receive these assessments. Among children who have never been tested, the majority of those in in-home placements (77.7%) and out-of-home placements (67.3%) have caregivers who think that their child does not need to be tested at all for learning problems, special needs, or developmental disabilities.
- Compared to the high prevalence rates for developmental problems revealed earlier, only a comparatively small proportion of children had been reported to their caregivers as having a developmental or learning problem by a professional and not all of these children had an IEP/IFSP developed for them. Only one in ten children (10.4%) in in-home placements and one in five (20.4%) children in out-of-home placements had caregivers who report being told by an education or health professional that their child has learning problems, special needs, or developmental disabilities. According to these caregivers, only a little over half of these children in in-home placements (51.6%) and a little less than half of these children in out-of-home placements (43.4%) have been given an Individualized Family Service Plan (I.F.S.P.) or an Individualized Education Plan (I.E.P.) to address their developmental problems.

LTFC Sample:

In general, the results for the LTFC sample were similar to those of the CPS sample, although the proportion of children whose caregivers and caseworkers recognized the need, and referred the child, for developmental assessments was somewhat higher suggesting that the longer a child is in the child welfare system, the more likely that developmental concerns are identified. Nevertheless, there was still a significant gap between the proportion of children found to have developmental problems based on the assessment results reported earlier and the proportion whose developmental needs were recognized and addressed by caseworkers and caregivers.

- Nearly all of the children (99.3%) were reported by their caregivers to be up-to-date with his/her immunizations or shots, but more than half of children (56.5%) were reported to have never been tested for learning problems, special needs, or developmental disabilities by an education or health professional.
- Among children who have never been tested, the majority (79.2%) had caregivers who thought their child does not need to be tested at all for learning problems, special needs, or developmental disabilities.
- Almost one quarter (22.5%) of the children in the LTFC sample had caregivers who reported that they had been told by an education or health professional that their child has learning problems, special needs, or developmental disabilities. Among these children, only about half (51.2%) were reported by their caregiver to have been given an Individualized Family Service Plan (I.F.S.P.) or an Individualized Education Plan (I.E.P.) to address their developmental problems.

Perceived Need for/Referrals to Services by Service Caseworkers

Similarly, despite the high prevalence of developmental problems revealed by assessments of the children reported earlier, developmental concerns were often missed by *service* caseworkers as well. They were much more likely to recognize the need for, and refer children for health check-ups and immunizations than for assessments to identify a developmental or learning problem.

CPS Sample:

- A higher proportion of service caseworkers recognized the need for children to obtain regular health checkups and immunizations than the need for developmental assessments. Almost two-thirds (65.6%) of the children had caseworkers who indicated that the child needed routine check-ups or immunizations. However, less than one quarter of the children (23.2%) had caseworkers who responded that the child needed an assessment to identify a learning problem or developmental disability. Almost one quarter of the children (22.3%) had caseworkers who believed the child needed services for health problems and a little over one in ten (13.4%) for an emotional, behavioral or attention problem.
- Caseworkers were less likely to refer children for a developmental assessment than they were to refer a child for a health checkup and immunizations. A little more than half of the children (52.1%) had caseworkers who recommended that the child receive routine check-ups or immunizations, but only 14.3% had caseworkers who indicated that they had referred the child to an assessment to identify a learning problem or developmental disability.

LTFC Sample:

The results for the LTFC sample were similar although again, the rates for referral for developmental assessments were higher suggesting that the longer a child is in the child welfare system, the more likely that the child will have been referred for a developmental assessment.

- The majority of children in the LTFC sample (92.6%) had caseworkers who indicated that the child needed routine check-ups or immunizations, although only 39.2% had caseworkers who responded that the child needed an assessment to identify a learning problem or developmental disability. Over one third (37.5%) reported that the child needed services for health problems and 22.3% indicated that the child needed services for an emotional, behavioral or attention problem.
- The majority of children (82.7%) had caseworkers who had recommended that the child receive routine check-ups or immunizations, but only 34.9% had been referred for an assessment to identify a learning problem or developmental disability.

Early Care and Education Programs

CPS Sample:

The NSCAW also asked caregivers about whether or not children were enrolled in center-based child care programs. [32] Despite the positive impact of ECE on the development of at-risk children and the high rates of developmental problems in this population, enrollment was comparatively low, particularly in Head Start.

- Only a little more than one quarter of children aged 0-2 in in-home (26.4%) and out-of-home (29.7%) placements were reported by their caregivers to be in any type of center-based child care program including a Head Start, nursery school, or early childhood development program. About half of children aged 3-5 in in-home (45.1%) and out-of-home (54.8%) placements were in any type of center-based child care program.
- For children ages 3 to 5 in the CPS sample who are in in-home placements, only 14.9% had caregivers who reported that their child was enrolled in Head Start, and for children in out-of-home placements, that percentage was only 17.4%.

LTFC Sample:

Rates of enrollment were comparable for the LTFC although rates for preschoolers were somewhat higher for the LTFC sample than for the CPS sample suggesting again, that the

[32] See footnote #29.

longer a child is in the child welfare system, the more likely that the caregiver or caseworker will enroll the child.

- About one quarter of children aged 0-2 (25.8%) were reported by their caregivers to be in any type of center-based child care program including Head Start, nursery school, or early childhood development program. A little more than half of children aged 3-5 (59.4%) were reported to be in any type of center-based child care program.
- Only about one out of five of children ages 3 to 5 in the LTFC sample (19.0%) were reported by their caregivers to be enrolled in Head Start.

SECTION THREE

Case Study in Colorado: Surveys of Foster Parents and Caseworkers

We conducted a case study in Colorado, using a combination of qualitative and quantitative methods, to examine what issues of collaboration across the child welfare, EI/Preschool SPED and ECE systems might help explain the gaps between actual need and perceived need for referrals to services revealed by our analysis of the NSCAW data. The first phase of this case study involved in-depth interviews with stakeholders in these three systems and the findings from these interviews are included in the analysis in Section I. Informed by this qualitative research, we designed statewide surveys of caseworkers and foster parents which we conducted in 2005 and 2006. The Table below lists our research questions for the interviews and the surveys. Following the table we present our findings from the survey data. (See Appendices 2 and 3 for the survey instruments and frequencies.)

Table 1. Research Questions for our Case Study in Colorado

Conceptual Framework	Research Questions	Interviews	Surveys
Overarching Policies/Systems Management	***ECE, IDEA and Child Welfare*** What are the laws, regulations, policies and protocols relevant to collaboration between IDEA, ECE and child welfare systems?	**X**	
	What are the issues facing states in implementing the new requirement under CAPTA that states refer all children under three who are the subject of substantiated reports of child abuse and neglect to the early intervention system under Part C of IDEA?	**X**	
	How does the state agency view the ASFA requirement to address the educational well being indicator in child welfare as it applies to young children age 0 to 5?	**X**	
	What array of services do they consider relevant to the educational needs of very young children? Does that service array include ECE settings?	**X**	

Conceptual Framework	Research Questions	Interviews	Surveys
	Does policy dictate that all children entering the child welfare system be provided with a developmental assessment or is this only done if a judgment is made that the child is showing signs of a developmental delay?	X	
	Does public policy and funding support providing access to these IDEA and ECE programs for young children in the child welfare system?	X	
	To what degree do public policies and agency missions support effective collaboration between the ECE, IDEA and child welfare systems?	X	
	Training of Child Welfare Key Players What training is provided, if any, to child welfare key players about the brain research and the links between early learning environments and school readiness?	X	X
	What training is provided, if any, regarding the interpretation of the educational well being indicator under ASFA as it applies to children age 0 to 5?	X	X
	What training is provided, if any, about the early signs of developmental delay? About the importance of early intervention for children at risk?	X	X
	To what degree does the training provided to these groups promote effective collaboration with players in the ECE and EI/Preschool SPED systems?	X	X
	What training is given to these groups to allow them to be effective advocates for very young children in the EI/Preschool SPED system?	X	X
Systems Entry/Assessment/ Planning	**Level of Awareness** To what degree do the key players in the child welfare system view the requirement under ASFA for addressing the educational needs of children as applying to children ages 0 to 5?	X	X
	What is the level of awareness among these key players about the role of quality ECE programs/IDEA in the school readiness of children in the child welfare system?	X	X
	What is the level of awareness of these key players about the early signs of developmental delay? About the importance of early intervention for children at risk?	X	X
	Screening and Initial Assessment What is the process followed when families of children age 0 to 5 enter the child welfare system?	X	
	To what extent, if any, are the education needs of children 0 to 5 considered in the initial assessment of the family and child(ren)?	X	X
	What is the screening process used to assess the developmental/educational needs of children? What questions are asked to assess educational needs?	X	X
	Service Plan Development and Implementation Is IDEA and/or ECE considered as a part of the service plan for that child?	X	X
	To what extent are children in the child welfare system being referred to/enrolled in IDEA and/or ECE programs and for ECE, what types of settings are they enrolled in?	X	X
	What triggers consideration of an ECE setting? The needs of the child or the needs of the foster parent/biological parent to work?	X	X

Conceptual Framework	Research Questions	Interviews	Surveys
	Is there clarity about who handles enrolling children in these programs: the foster parent or the case worker?	X	X
Reassessment & Evaluation	**Monitoring and Reassessment** To what degree are the educational needs of children 0 to 5 revisited throughout the monitoring and reassessment process and how is this done?	X	X
	Once the service plan is implemented who makes the judgment about whether educational needs are being addressed adequately? Who are the key informants the case worker relies on to monitor the progress of the child?	X	X
	For children eligible for and receiving services under IDEA, is there clarity among the key players in the child welfare system about who plays what role in developing and monitoring an Individual Family Service Plan (IFSP)/Individual Education Plan (IEP) for a child found eligible under Part C or Part B of IDEA?	X	X
Care Management or Care Coordination	**Collaboration among the Key Players** To what degree do the players in the ECE, IDEA and child welfare systems collaborate at the state level? At the local level?	X	X
	What are the barriers to effective collaboration?	X	X
	To what extent is information shared between the players involved in addressing the educational needs of very young children regarding the family background/needs and progress of the child? What confidentiality constraints affect the sharing of this information?	X	X

Foster Parent Survey Results

We were interested in the perceptions of foster parents about whether young children in their care are receiving the ECE and early intervention services they need. We were also interested in the level and substance of training received by foster parents, their level of knowledge about the EI/Preschool SPED and ECE systems and their experiences with negotiating those systems. As explained earlier, unlike the NSCAW, our survey was not child-specific. None of our questions focused on any particular child but rather on the experiences of foster parents generally in addressing the developmental needs of their foster children.

Methodology

We received a list of foster care administrators in each of Colorado's 64 counties from the Child Welfare Division of the Colorado Department of Human Services. Letters and emails were sent to each of the administrators telling them about this project and requesting their assistance in getting contact information for foster parents. This was followed up with multiple phone calls to obtain the information requested. We received

names of foster parents from 31 counties. Two counties refused and four counties did not have any foster parents. The remaining 27 counties did not answer our request. We also obtained the names of the private foster care agencies. There were 25 private agencies contacted. We received information from seven of these agencies. The names we received from these seven counties extended over 14 counties. Six of the counties with private foster parent agencies were counties from which we did not have any public foster parent names. In total, 707 Foster Parent Surveys were sent out to foster parents in 37 counties (57.8% of all Colorado counties).

We administered the survey through multiple methods. Our first approach was a mailing to foster parents containing a cover letter explaining the project and the contents of the survey. Participants were also invited to fill out the survey online. An incentive was offered for completing the survey; participants could enter their name in a lottery for one of five $100 American Express gift cards. We also explained in the cover letter that this was voluntary and completely confidential. Foster parents who had not returned their survey were then called by USM's Survey Research Center to complete the surveys. This survey was completed by foster parents who foster or have fostered children ages 0-5 in the last 12 months.

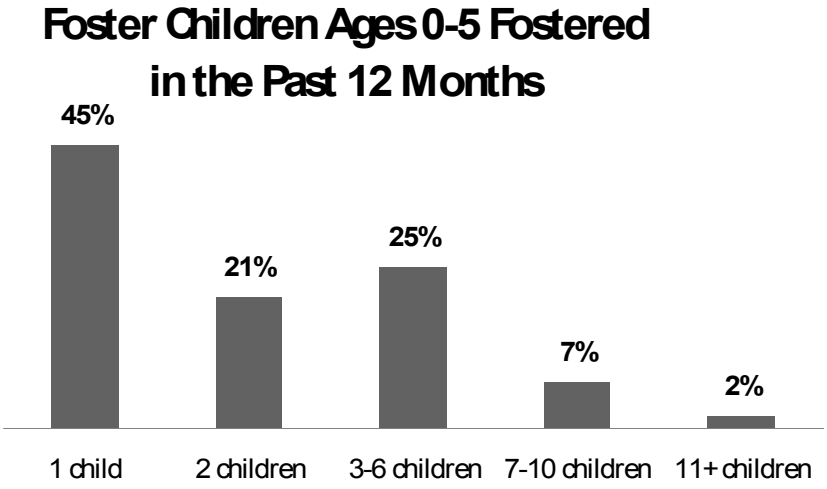
Our Sample

Two hundred and sixty six foster parents from 34 counties responded to the survey and were currently or in the last 12 months fostering children between the ages of 0 and 5. This represents a 38% response rate and a confidence interval of +/- 4.8 percentage points. Specifically, the results are 95% accurate to +/- 5 percentage points. For example, the percentage of foster parents with children who are receiving early intervention services is 67%. The "true" percentage for this statistic is somewhere between 62% and 72%. See Appendix 2 for frequencies of all survey results.

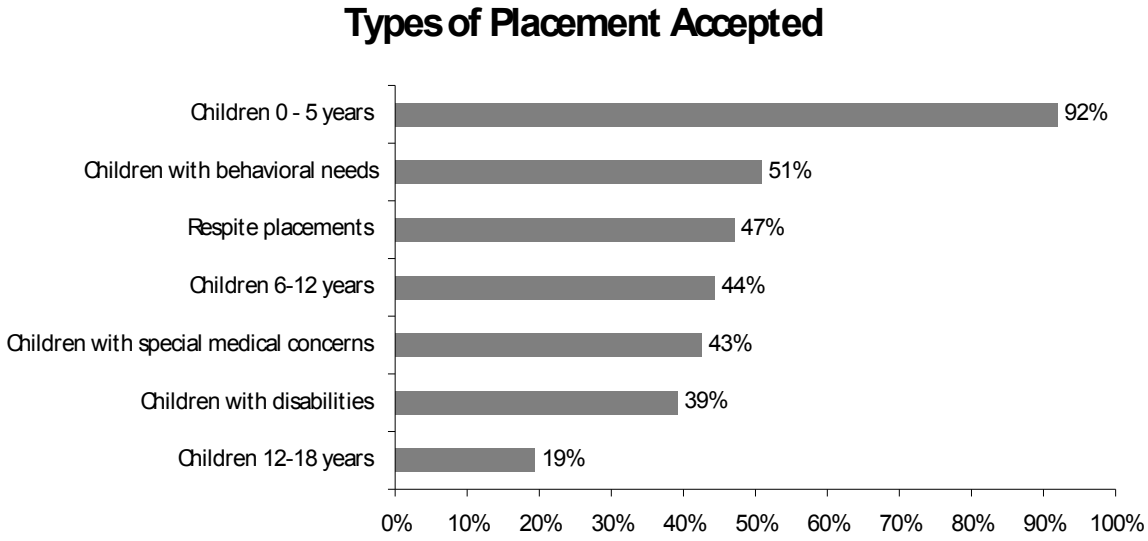
Characteristics of Foster Parents

Of the foster parents responding to the survey, 92.0% reported accepting placements of young children (0-5 years of age). In addition, respondents were able to select all that applied of the following; 44.4% accept children 6-12 years of age and 19.4% accept children 12-18 years of age. Thirty-nine percent accept children with disabilities, 50.9% accept children with behavioral concerns, 42.6% accept children with special medical concerns and 47.1% accept respite placements.

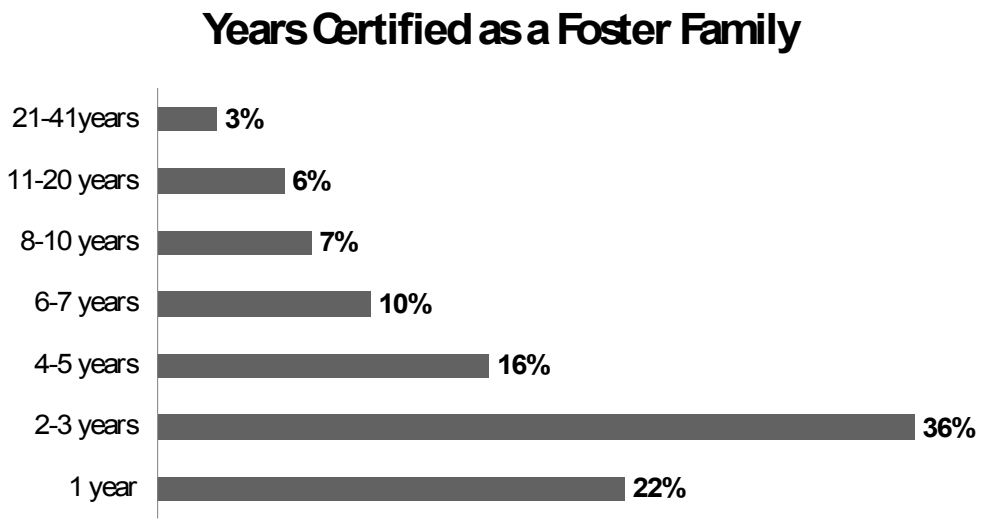
Survey Results



Foster parents were currently caring for a single child on average (mean = .97) but had cared for an average of three children over the past 12 months (mean = 2.79). More than one-third (39.1%) of the respondents did not currently have a child in their care but did have a young child in their care during the past 12 months. Four out of ten (42.9%) foster parents generally have a single child placed in their care at a time. Almost a third (29.9%) of foster parents have two children placed in their care at a time.

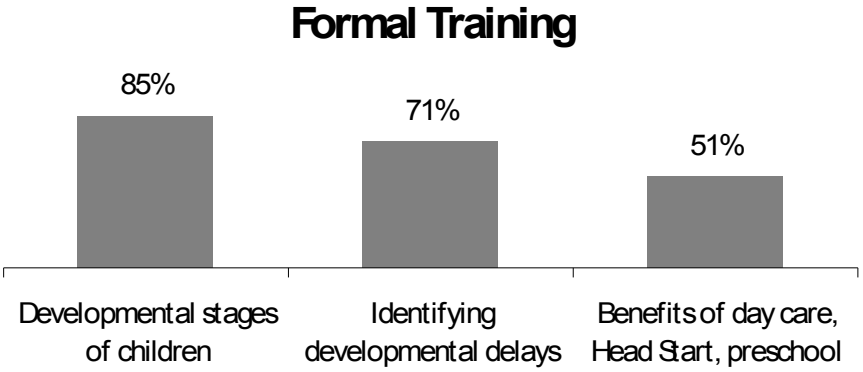


Years of certification, a proxy for experience of foster parents ranged from 1 year to more than 40 years. On average, foster parents have been certified as a foster family for about 5 years (mean = 4.74). More than a quarter of foster parents (26.2%) have been certified for more than 5 years and a little less than a quarter of foster parents (22.2%) have been certified just a year.



Training on Child Development, Early Intervention and Early Care and Education

Formal Training
The majority (85.3%) of foster parents have received training on developmental stages of children. Almost three-quarters (70.9%) have received training on the early warning signs of childhood disabilities. However, only half (51.0%) have received training on the benefits of child care, Head Start and/or preschool settings.

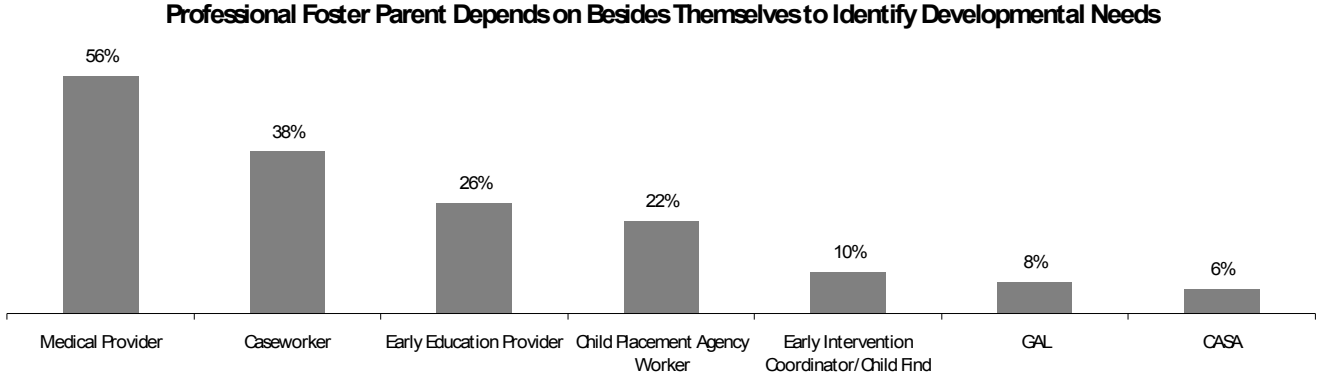


Assessment and Referral for Developmental Problems

We were interested in whether children in the child welfare system who had developmental problems were being identified, referred to and provided with appropriate services.

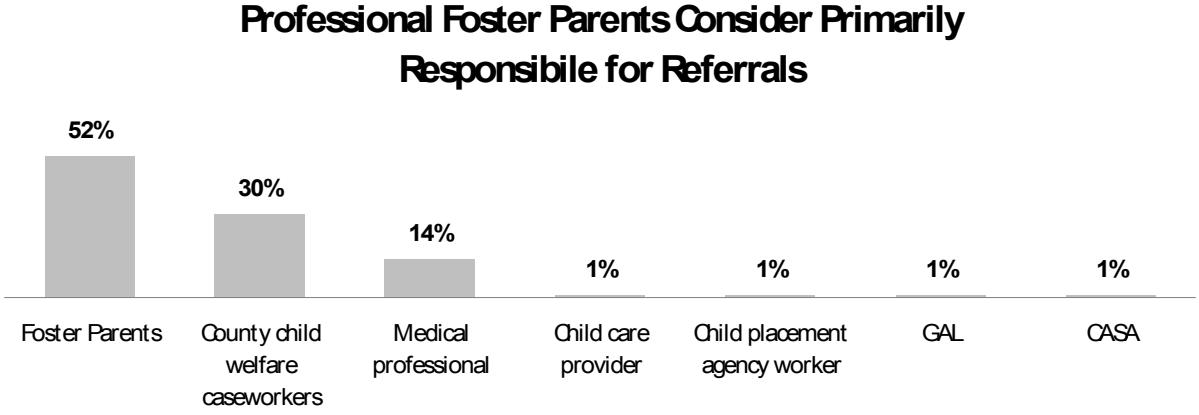
Number of Children Receiving Early Intervention Services
Of the foster parents surveyed, 67.1% had a foster child who was receiving early intervention services.

Primary Responsibility for Identifying the Developmental Needs of Children
We asked foster parents who, besides themselves, they depend on to identify the child's developmental needs; they were asked to check all that apply. More than half of foster parents (56.1%) depend on medical providers to identify the child's developmental needs. A third (38.2%) depend on their caseworkers, 26.0% depend on the child care or Head Start provider, 21.9% depend on a child placement agency worker, 9.8% on Child Find, 7.5% on their Guardian ad Litem, 6.9% on other parents and foster parents, and 5.8% on their Court Appointed Special Advocate (CASA).



Referral for Services
From the foster parent's perspective, we asked them who they would talk to if they identified a child as potentially having a delay. More than half of foster parents (52.9%) would first talk to their caseworker. More than one-third (39.1%) would talk to their medical provider; 5.2% would talk to the Child Find office and 1.1% would talk to their child care provider.

We also asked foster parents who they think has primary responsibility for making a referral for the child. Half of the foster parents (51.5%) felt they had primary responsibility. Almost one- third (30.4%) felt the county child welfare caseworker had primary responsibility; 14.0% thought the medical professional should be referring the child and 1% or less thought the child care provider, child placement agency worker, GAL or CASA should have primary responsibility for referring the child for services.



Length of Time for Referral Source to Assess
From the foster parent's perspective, once the child is referred the assessment is completed on average within 3.5 weeks. Specifically, 27% of assessments were completed within 1-2 weeks, 45% within 4-5 weeks, 18% within 1.5 - 2 months, 9% within 3-6 months, and 1% within 6 months or more.

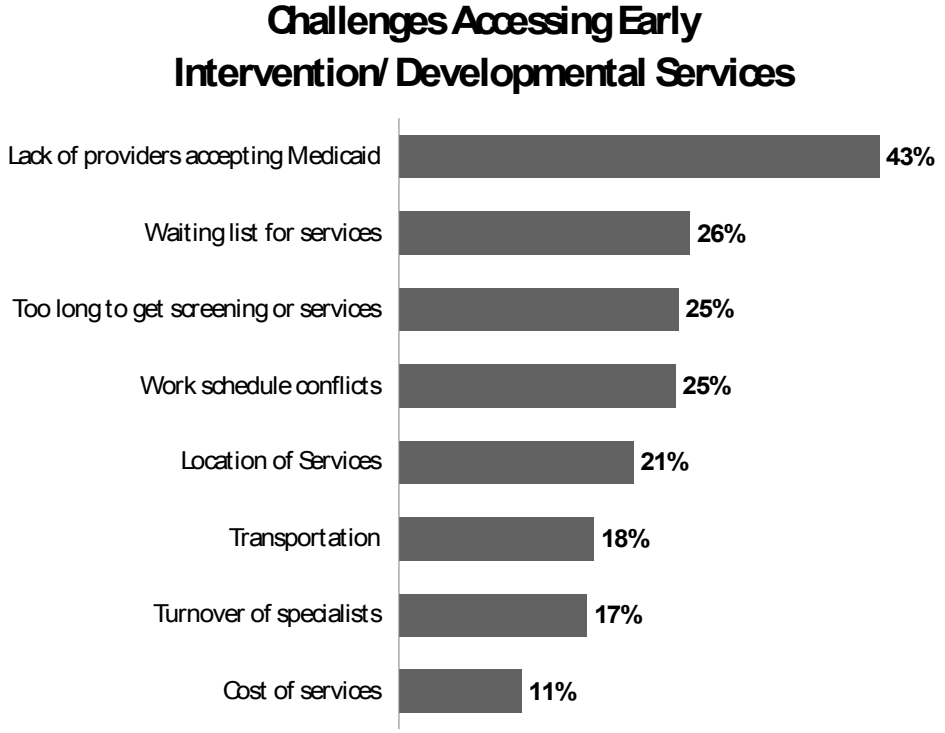
Rescreening
We also asked foster parents whether a child in their home who was screened for developmental needs and found not to need services would be screened again at a later time. Eighty-eight percent of foster parents thought their child would be re-screened. However, only 26.1% thought the child would be automatically re-screened. Almost three-quarters (73.9%) of foster parents stated that the child would only be re-screened if they requested it.

Receipt of Early Intervention Services

We were interested in the foster parents' experiences with having children in their care receive early intervention services. Almost two-thirds of foster parents (64.8%) have had a child who needed special services such as speech or occupational therapy.

Challenges Accessing Services
Foster parents were asked if they had experienced challenges in accessing early intervention services. The largest problem was the lack of providers that accepted Medicaid services (43.0% of foster parents rated this a problem).[33] A quarter (25.0%) of foster parents also found that it takes too long to get screening or services, the waiting list is too long (26.1%), and it is difficult to schedule services due to work schedule conflicts (24.8%).

[33] *Issues rated above 5 on a scale of 1 to 10 were categorized as "a problem"*



Knowledge of Early Childhood Development

We asked foster parents to rate their knowledge of child development. On a scale of 1 to 10 where "10" indicates that the foster parent is very confident about their knowledge of child development, foster parents rated themselves an 8.2 out of 10 indicating a high level of confidence.

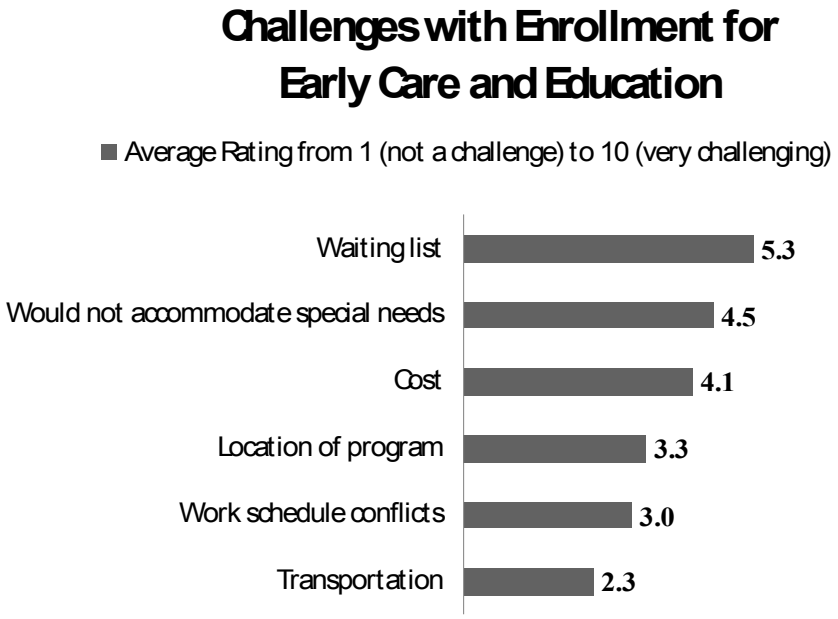
When we asked foster parents about the ways they learned about child development, 87.6% of them indicated they had been to training on child development and 72.6% responded that they had learned about child development through having children of their own. 52.5% have had professional experience with children and 49.8% have had formal education on child development lending to their knowledge.

Use of Early Care and Education

Information on Early Care and Education
Among the foster parents surveyed, 60.3% reported having at least one of their foster children enrolled in child care, preschool or Head Start. Of those, 75.8% had had one of their foster children enrolled in daycare, preschool or Head Start *in the last 12 months*. Of the children enrolled in the last 12 months, the greatest number, 67.2% were enrolled in a child care center/preschool program. Almost one in five (19.5%) were enrolled in a

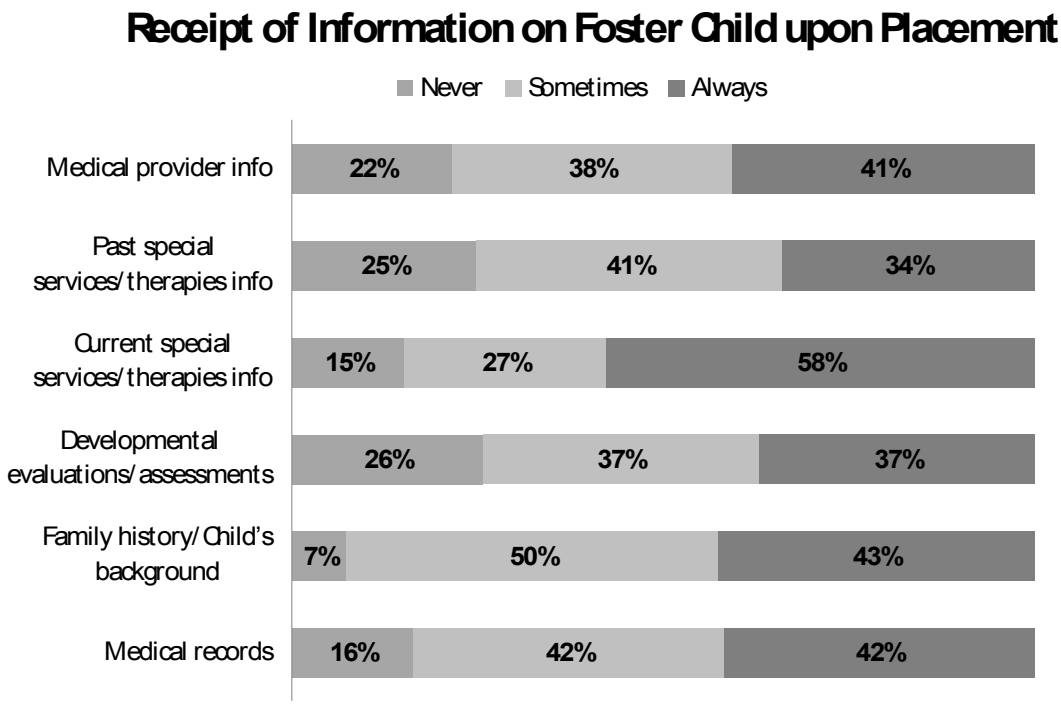
family child care home (day care in someone else's home), 17.6% in a Head Start program and 9.7% in a preschool that specifically provides special education services.

Problems with Enrollment
A little over one quarter (26.2%) of foster parents stated that they had problems accessing ECE programs for their foster children. We asked foster parents to rate problems they had with access to ECE programs. The highest rated problem was the waiting list or lack of space in programs. Another significant challenge was that programs would not accommodate children with special needs.



Coordination between Early Care and Education, Early Intervention and Child Welfare System

An important aspect of coordinating early intervention services is ensuring that foster parents have the information they need to continue services, start services or provide supplemental services at home for the child. We asked foster parents to what degree they are informed about the child's health, development and special services when the child is first placed in their home. Two thirds (66.0%) of foster parents indicate that when a child is first placed with them they never or only sometimes receive information regarding early intervention services their child has received in the past. About four in ten (42.4%) say the same for services the child is *currently* receiving. Over half report that they never or only sometimes receive information on the child's developmental evaluations (63.0%), current medical provider (59.2%), medical record (58.2%), or family history (57.5%).



Subgroup Analysis of Foster Parent Survey

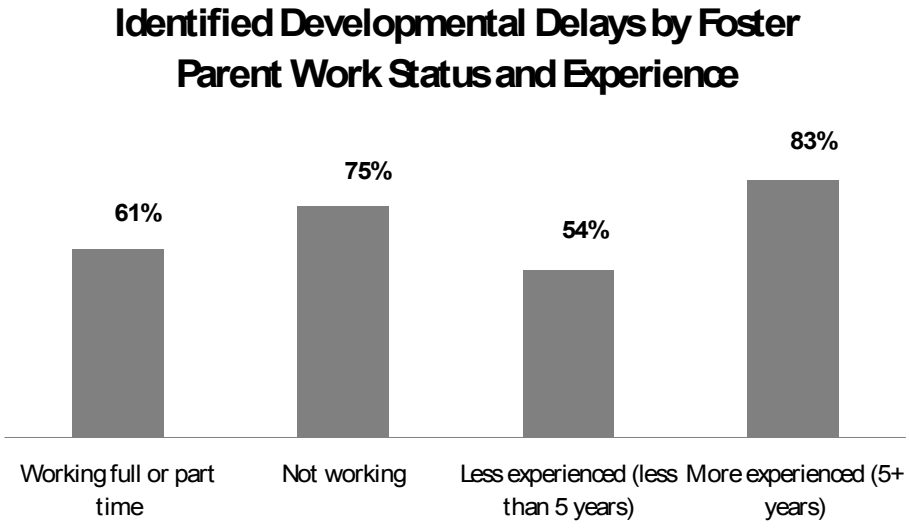
We were interested in examining the data by certain subgroups of foster parents: foster parents working full or part time or not working, foster parents who had a higher or lower income ($50,000/year or less than $50,000 per year), foster parents with 5 or more years of experience and foster parents with a bachelor's degree or with less than a bachelor's degree.

Subgroup Analysis Groupings		
	Group 1	Group 2
Employment	Working full or part time (n = 160)	Not working in or out of the home (n = 99)
Income	Annual income of $50,000 (n = 153)	Annual income of less than $50,000 (n = 99)
Experience	5 or more years experience (n = 144)	Less than 5 years experience (n = 102)
Degree	Bachelor's Degree (n = 93)	Less than Bachelor's Degree (n = 163)

Identification of Developmental Delays
Having known or identified a child with developmental delays in their care differed by the foster parent's work status and experience as a foster parent.

Foster parents who were not working were more likely to have a child who had been identified as developmentally delayed. It is possible that parents who are not working are more likely to be assigned a child who has developmental delays.

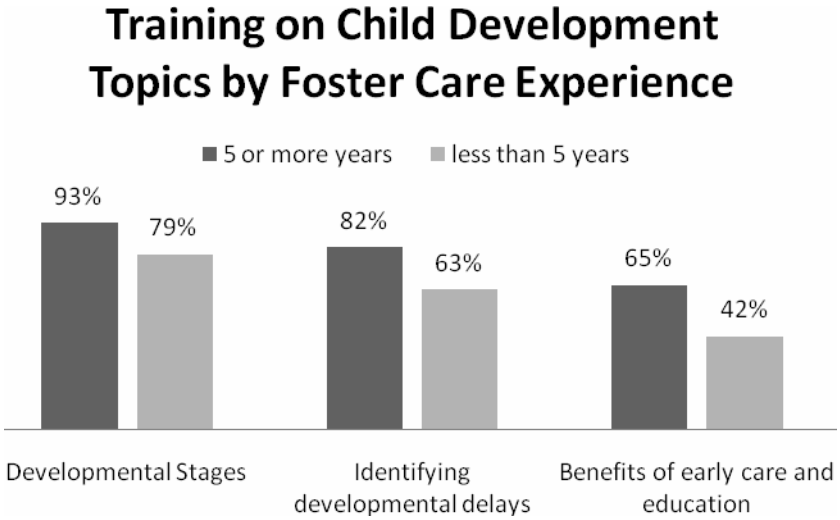
Foster parents who are more experienced are more likely to have a child who has been identified as developmentally delayed. Again, more experienced foster parents may be more likely to be assigned developmentally delayed children.



*$x^2 = 5.19, p < .05$ *$x^2 = 21.94, p < .001$

Training on Child Development
Having training in specific areas differed by how long they had been a foster parent.

Foster parents with more than five years experience were more likely to have training on developmental stages, on identifying developmental delays and on the benefits of ECE.

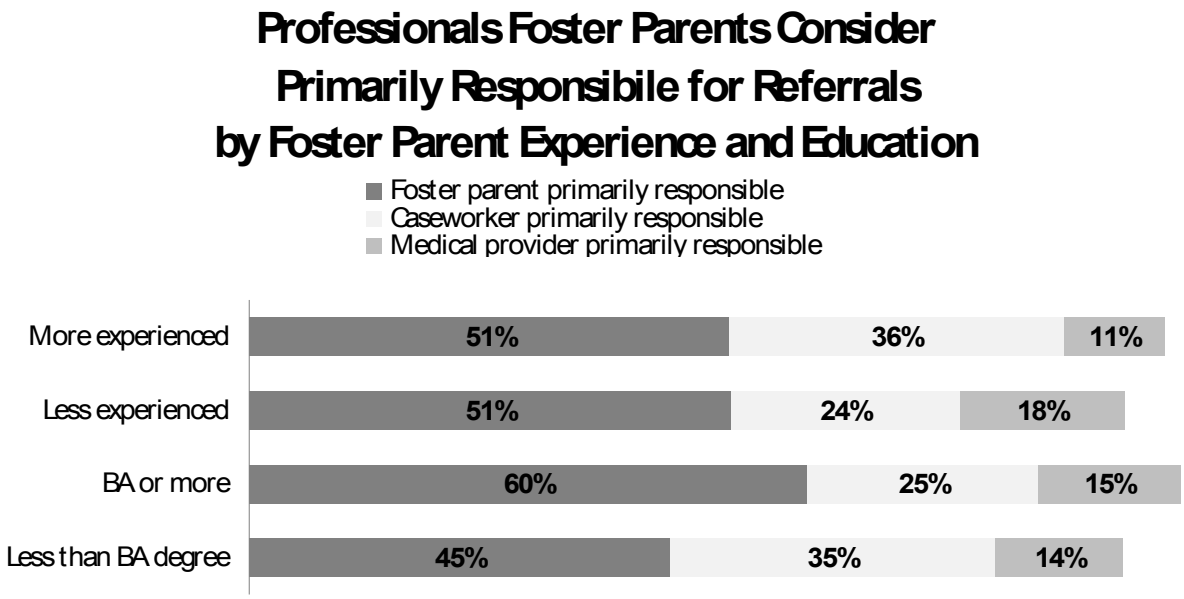


*$t = 2.98, p < .05$ *$t = 3.31, p < .05$ *$t = 3.55, p < .05$

Primary Responsibility for Making Referrals
The perception of who is responsible for referring a child differed by the educational level of the foster parent (this was not tested statistically).

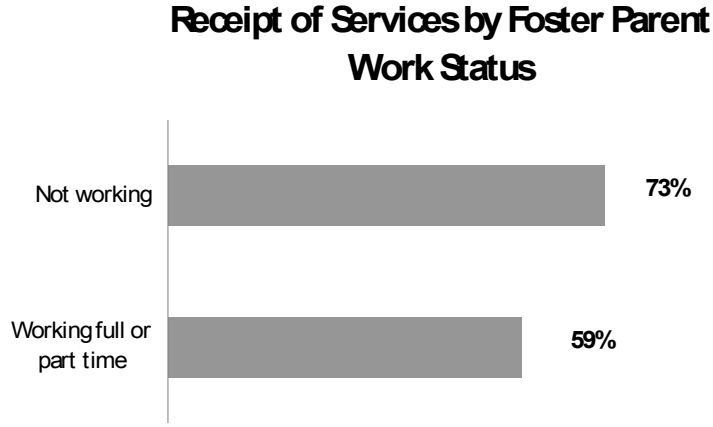
A higher percentage of foster parents with at least a bachelor's degree reported that the foster parent has primary responsibility for making referrals; a smaller percentage of foster parents with at least a bachelor's degree reported that the caseworker has the primary responsibility for making referrals.

A higher percentage of foster parents with less experience reported that the medical provider is responsible for making referrals while a smaller percentage of foster parents with less experience thought the caseworker has responsibility for referring children for special services.



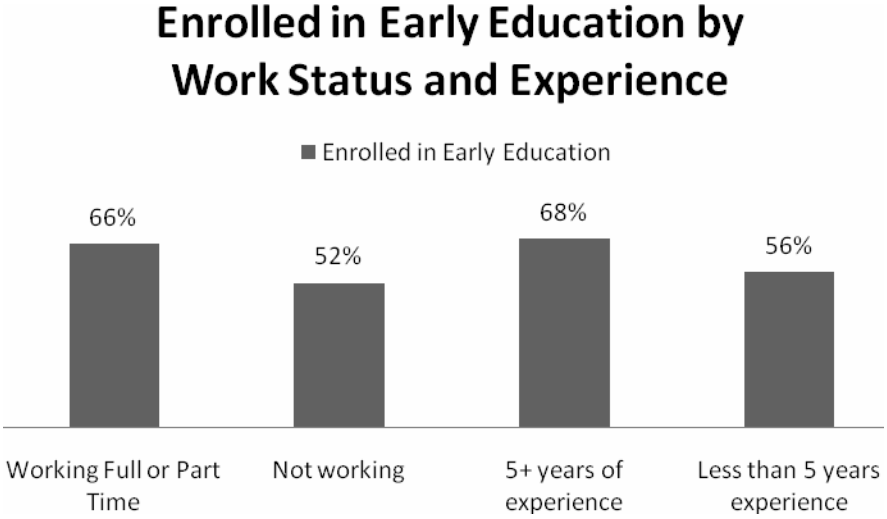
Receipt of Services
Having a child who has needed special services differed by the foster parent's work status

Foster parents who are not working are more likely to have a child who needs special services *(*t = 2.26, p < .05*). Again, it may be that agencies are more likely to place children with special needs with foster parents who are not working, or that foster parents who are not working are more likely to accept these placements.



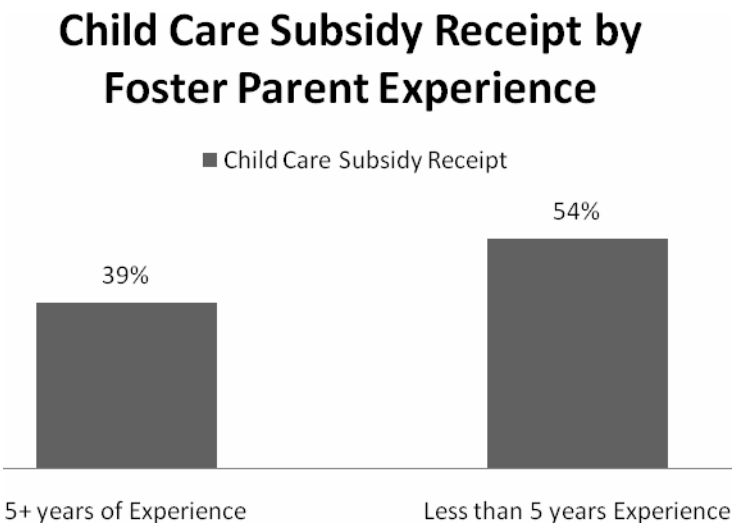
Enrollment in Early Care and Education
Having a child enrolled in ECE is related to the foster parent's work status and years experience as a foster parent.

Foster Parents who are working full or part time and foster parents with more experience are more likely to have a foster child enrolled in ECE.



** t = 2.32, p < .05* ** t = 1.78, p < .10*

Receipt of State Subsidies for Early Care and Education
Foster parents who are less experienced are more likely to have received subsidies for ECE services.



$t = 1.66, p < .10$

Challenges with Early Intervention Services

- Challenges related to **level of income**: The schedule of early intervention services was rated as more challenging by lower income foster parents ($t = 2.12$, $p < .05$). It may be that lower-income foster parents are more likely to work in jobs with less workplace flexibility so that transporting children to early intervention services may present a greater challenge.
- Challenges related to **experience as a foster parent**: foster parents with more experience rated the turnover of the early intervention specialist as a bigger challenge than foster parents with less experience ($t = 1.92$, $p < .10$). It may be that foster parents with more experience may have had more exposure to the EI/Preschool SPED system and therefore have had more experience with specialist turnover.

Challenges with Early Care and Education Programs

- Challenges related to **level of education**: Foster parents with at least a bachelor's degree rated the location of early education programs as more challenging ($t = .72$, $p < .10$). Those same parents rated transportation to early education programs as more challenging ($t = 1.69$, $p < .10$).
- Challenges related to **level of income**: Work schedule conflicts were rated as more challenging by lower income foster parents ($t = 1.66$, $p < .10$). It may be that lower-income foster parents are more likely to work in jobs with non-traditional hours and/or jobs with less workplace flexibility so that a mismatch of work hours with child care hours would present a greater challenge.

Child Welfare Caseworker Survey Results

We were interested in the perceptions of child welfare caseworkers about whether young children in the child welfare system are getting the ECE and early intervention services they need. We were also interested in the level and substance of training received by caseworkers, their level of knowledge of how to negotiate the early intervention and ECE systems and their experiences with negotiating those systems. As explained earlier, unlike the NSCAW, our survey was not child specific. None of our survey questions focused on any particular child but rather on the experiences of caseworkers in general in serving the developmental needs of this population of children.

Methodology

Because the child welfare division of each county in Colorado is run separately, we contacted the directors of each county's child welfare division to develop a mailing list. We received the list of state/county names of county child welfare directors with the assistance of Ted Trujillo, Director of the Division of Child Welfare within the CO. DHS. Letters and emails were sent to each of the directors telling them about this project and requesting their assistance in gathering contact information for child welfare caseworkers. Multiple phone calls were also made to obtain the information requested. We received information from 54 counties out of 64 counties. 53 counties provided us with lists of child care welfare caseworkers within their counties; one county refused and 10 counties did not answer our request. We also contacted 25 private child welfare agencies. We received information from 7 of these agencies. The names we received extended over 14 counties. 1,053 Caseworker Surveys were sent out to caseworkers across 53 counties (83% of all CO counties).

We administered the survey through multiple methods. Our first approach was a mailing to both caseworkers containing a cover letter explaining the project and the actual survey. Caseworkers were given the option of filling out the survey online. An incentive was offered for completing the survey; respondents could enter their name in a lottery for one of five $100 American Express gift cards. The cover letter detailed the voluntary and confidential nature of the survey. A second survey was sent to increase the response rate approximately three weeks after the first survey. Only those caseworkers serving children ages 0-5 in the last 12 months were asked to respond to the survey.

Our Sample

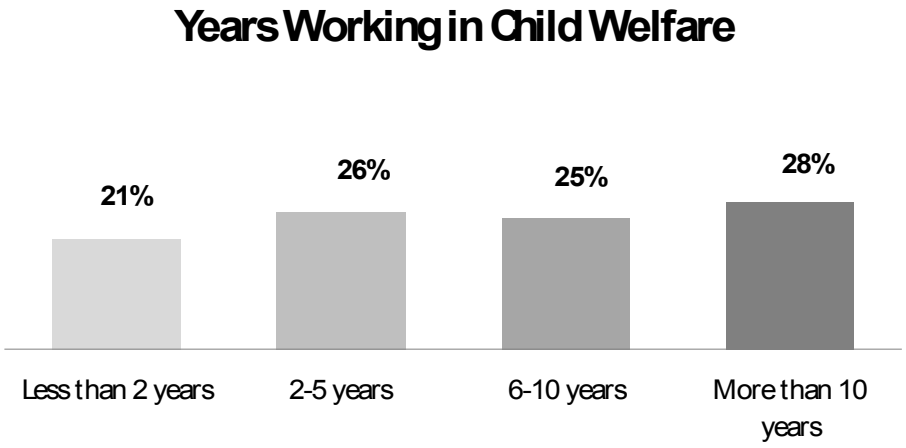
We received 339 completed surveys from 52 counties representing a 32% response rate and a confidence interval of +/- 4.4 percentage points. Specifically, the results are 95% accurate to +/- 4 percentage points. For example, the percentage of caseworkers with children that are receiving early intervention services is 82%. The "true" percentage for this statistic is somewhere between 78% and 86%.

Characteristics of Child Welfare Caseworkers

Job Description
Of the 339 people who responded to the survey, 12.1% were supervisors and 87.9% were caseworkers. Since supervisors have substantially different job responsibilities than caseworkers and are less likely to interact directly with the families, we focus the rest of this report only on the experiences of caseworkers.

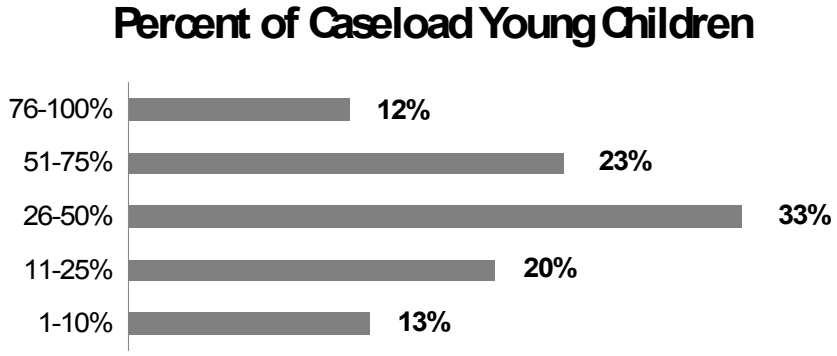
Public vs. Private Caseworkers
The majority of those who responded to the survey worked for a public child welfare agency (96.0%). While 11% of the surveys were sent to caseworkers at private agencies, only 4.0% of those who responded worked for a private agency.

Experience in the Child Welfare Field
More than four out of ten respondents (47.5%) have been working in the child welfare field for five or fewer years. More than half (52.5%) have been working in the child welfare field for more than five years.



Caseloads
The majority of caseworkers (85.0%) had caseloads between 1 and 20 families; 2.6% of caseworkers didn't have a caseload, 11.2% had a caseload between 21 and 40 families and 1.1% had a caseload of more than 40 families.

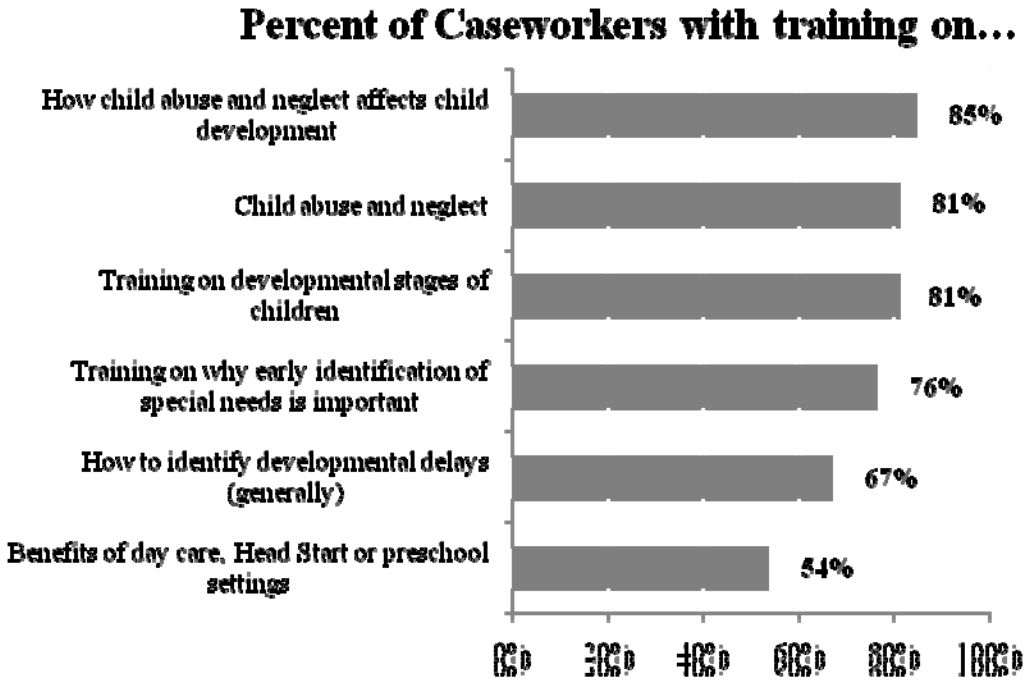
A third (35.0%) of the caseworkers responding to the survey had young children (children ages 0-5) as more than half of their caseload. Almost 13% of caseworkers (12.9%) had only 1% to 10% of their caseload comprised of young children, 19.5% of caseworkers had 11-25% of their caseloads comprised of young children and 32.7% of caseworkers had 26-50% of their caseload comprised of young children.



Survey Results

Training on Child Development, Early Intervention and Early Care and Education

Formal Training
We asked caseworkers about ongoing training as well as the training they received when they started their job. These numbers reflect any training in the particular area *regardless* of when it was received. A majority (81.2%) of child welfare workers have been trained on the developmental stages of children. 76.4% have been trained on why early identification of a child's special needs is important and 67.0% have been trained on how to identify a child's developmental delays or special needs. More than three-quarters (81.2%) have been trained on child abuse and neglect and 84.8% have been trained on how child abuse and neglect affects a child's development. Only 53.6% have been trained on the role that child care/Head Start can play in a child's development.



Timing of Training and Training Requirements

We also asked about the timing of receipt of training and whether it was mandatory or not. Looking at whether caseworkers received training when they first started the job and/or whether they received training since starting their job, we see that training on child abuse and neglect happens routinely when caseworkers enter their job and is likely to be mandatory. Training on the "role that child care can play in a child's development", "why early identification of a child's special needs is important" and especially "how to identify a child's developmental delay" happen for more caseworkers after they start their job and are not as likely to be mandatory. In fact, training on the "role that child care can play in a child's development" and "how to identify a child's developmental delay" is mandatory for only about a third of the caseworkers.

We asked caseworkers what additional training they would want. Many caseworkers commented that they took training when they found a need for it (e.g. had a child with fetal alcohol syndrome come onto their caseload). However, caseworkers expressed that it would be more helpful to get relevant training when they start their job so they are more informed for all their clients. The most common request was for additional training on developmental milestones of children and how to identify developmental delays.

Training Requested by Caseworkers

- Developmental milestones of children
- How to identify developmental delays
- Available resources in the community for children with developmental concerns
- Effects and benefits of child care and ECE
- Effects of early drug exposure
- Parenting a child with special needs
- Detailed instructions on how to refer a child for services
- How to communicate with parents about developmental delay
- Infant mental health

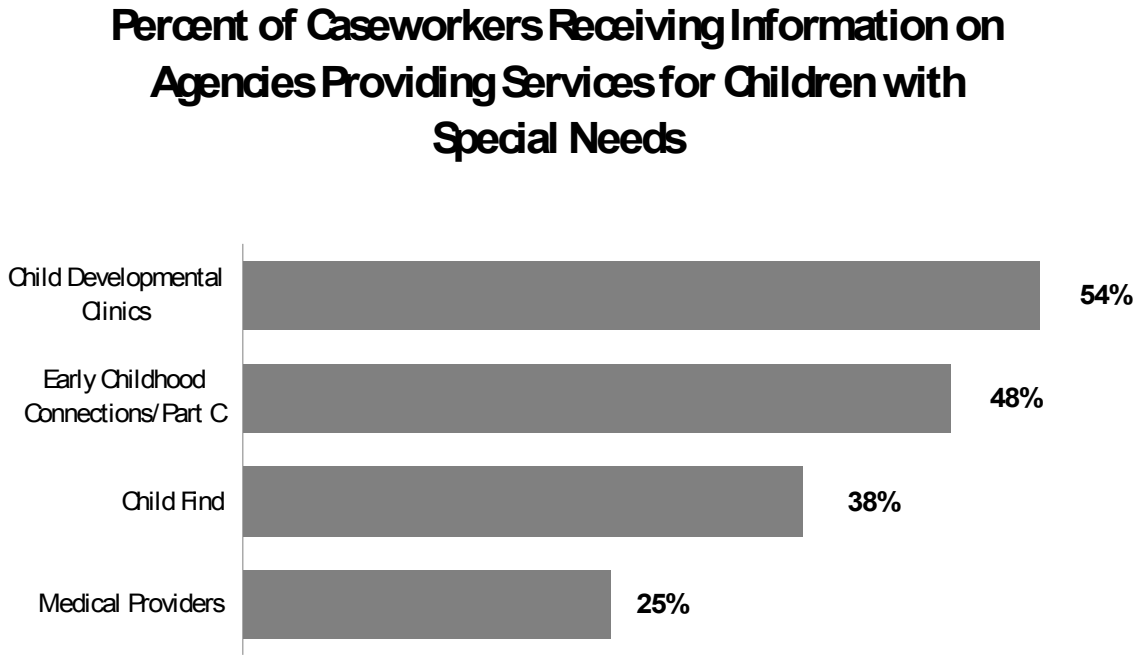
Assessment and Referral for Developmental Problems

We were interested in whether children in the child welfare system who had developmental problems were being identified, referred and provided with appropriate services. We asked caseworkers a series of questions to gather information on our research questions.

Knowledge of Agencies that Provide Services for Children with Developmental Problems

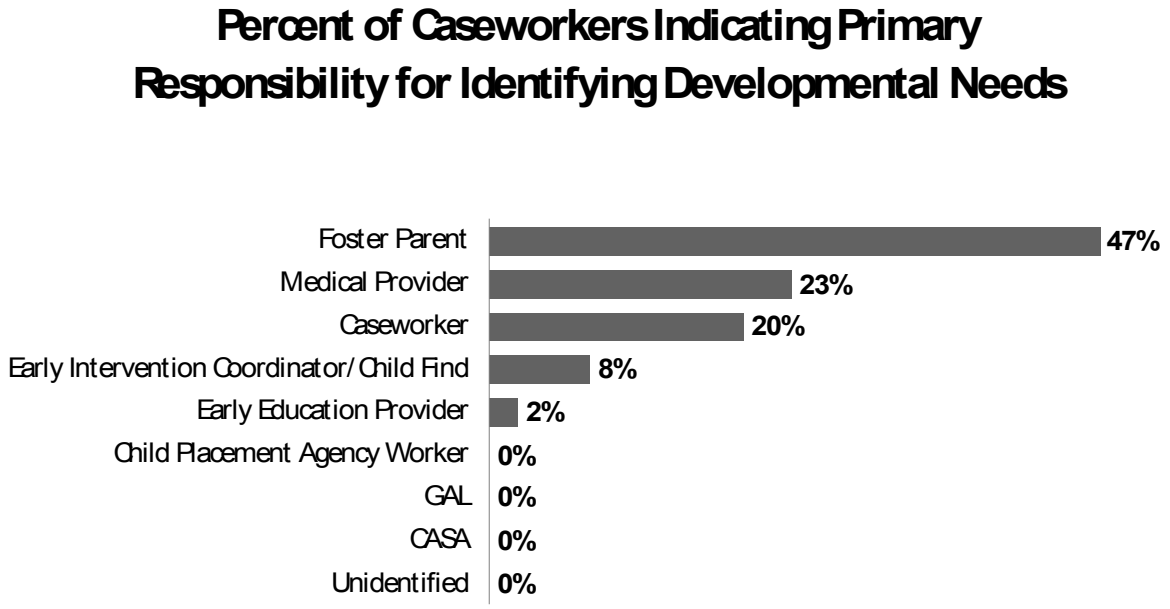
We were interested in whether caseworkers had knowledge of the four primary ways of obtaining services for children with developmental problems. We asked caseworkers about their knowledge of Early Childhood Connections, Child Find, local child development clinics and medical providers.

Caseworkers were most likely to know about local child development clinics – 54.1% of caseworkers had received information on them. Almost half (48.2%) of caseworkers were provided information on Early Childhood Connections/Part C services; 37.7% were provided information on Child Find and 25.3% were provided information on medical providers.



Primary Responsibility for Identifying the Developmental Needs of Children
We asked caseworkers who they thought has primary responsibility for identifying the developmental needs of children. Almost half of caseworkers (47.0%) thought the foster parent or biological parent has primary responsibility. Almost one-quarter (23.3%) of caseworkers thought the medical provider has primary responsibility, 19.6% thought the

caseworker has primary responsibility, 7.8% thought the early intervention coordinator has primary responsibility and 2.2% thought the child care or Head Start provider has primary responsibility.



Initial Child Development Assessment

We were interested in when and how the initial assessment of a child's development occurred. We asked caseworkers "When do you assess the development of a child on your caseload?" Respondents selected all that applied, resulting in totals in excess of 100%. Almost two-thirds of caseworkers (67.4%) state that they automatically assess a child's development when the child comes onto their caseload; 39.4% of caseworkers assess a child's development when they notice something is wrong or some skills are delayed; 17.1% of caseworkers assess a child's development when the foster parent or guardian requests an assessment; 10.0% assess when there is a court order to do so; 2.6% state that they don't assess a child's development and 5.2% state that assessing a child's development is not part of their job.

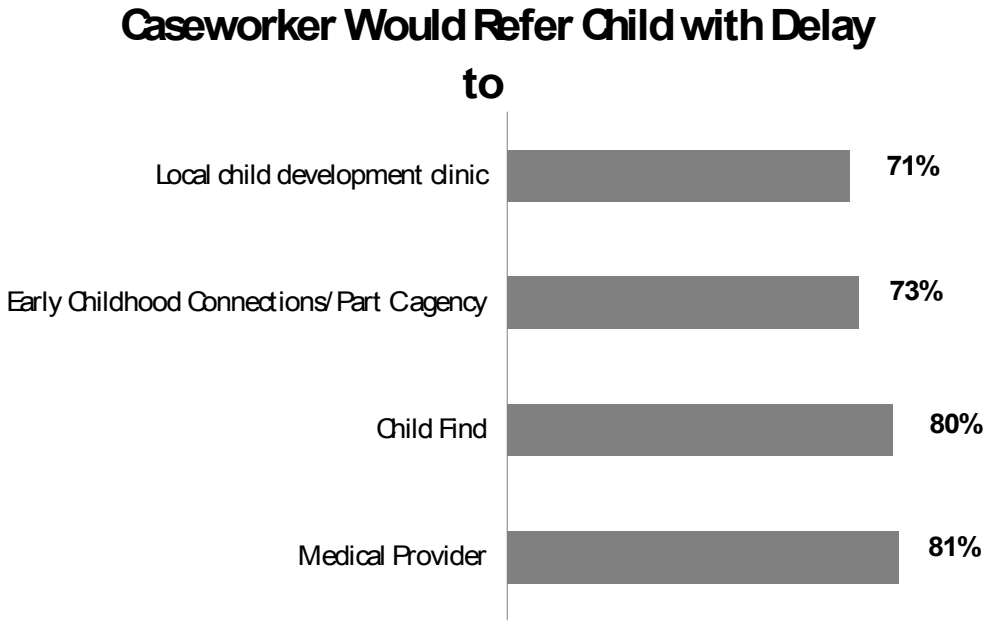
We asked caseworkers "How do you *initially* assess the development of a child who comes onto your caseload?" The majority (68.0%) rely on their personal knowledge of child development. Only 4.5% of caseworkers use a formal screening tool. Almost one-quarter (22.3%) of caseworkers refer the child to a professional that routinely conducts child assessments (3.0% of those caseworkers refer due to agency policy).

When asked about *ongoing* assessment of the children on their caseload not found eligible for early intervention services at the initial assessment, a lower percentage rely on their personal knowledge (45.0%) and a higher percentage rely on referral to a professional (38.0% - 1.9% of those due to agency policy). Only 2.6% use a formal

assessment tool; 2.6% state that they don't assess children on an ongoing basis and 10.8% state that ongoing assessment is not part of their job description. The issue of ongoing assessment is important because some developmental problems may not emerge until later in a child's development.

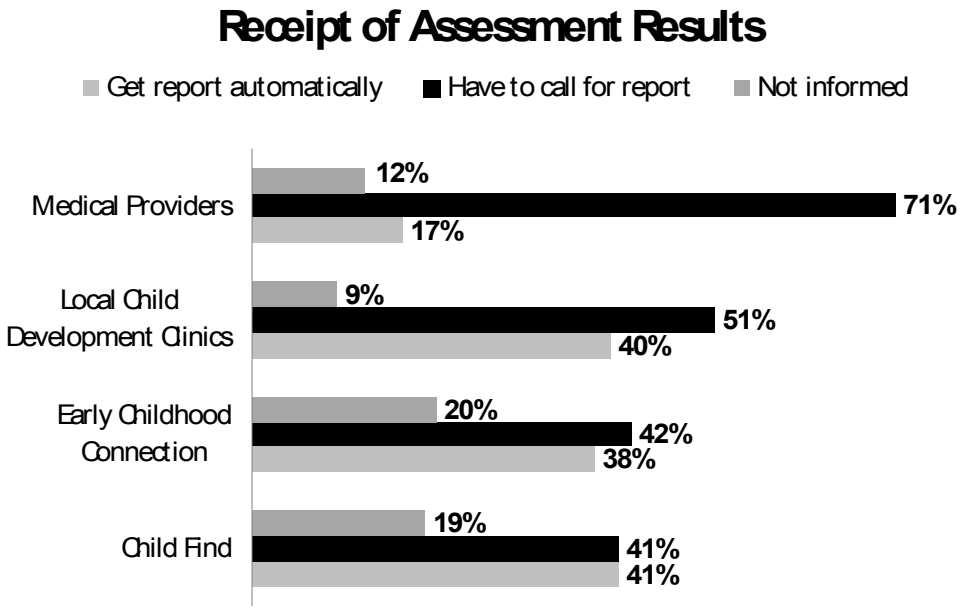
Referral for Services

Next, we were interested in how and to whom children are referred for evaluation and, if found eligible, for special services. A majority (81.2%) of caseworkers refer a child to a medical provider; 79.7% refer to Child Find; 72.8% refer a child to Early Childhood Connections/Part C and 70.7% refer to a local child development clinic. Due to Colorado's county-based system, decisions about where to refer children may vary not only by level of awareness of resources by caseworkers, but also by local agency policy and/or variations in the availability of resources for referrals. Therefore, while these numbers are important for giving an impression of where caseworkers are referring children with special needs, it may also be a reflection of how services are structured and delivered in each county.



Receipt of Results of Assessment

We asked caseworkers how they receive assessment results from the agency/provider who assessed the child. Only about 4 out of 10 caseworkers receive a report automatically from Early Childhood Connections, Child Find and local child development clinics. Only 16.6% of caseworkers receive reports automatically from medical providers. About one in five (20.3%) are not informed at all of the results from Early Childhood Connections and Child Find. Confidentiality laws, confusion over the role of caseworkers and lack of awareness of the child's involvement in the child welfare system may be acting as barriers to the sharing of this information.



Receipt of Early Intervention Services

We asked caseworkers whether any of the children on their caseload were receiving early intervention services. Among caseworkers who responded, 82.4% stated that at least one of the children on their caseload was receiving services.

Individualized Family Service Plans/Individualized Education Plans
Individualized Family Service Plan (IFSP) for children ages 0 to 3 and or Individualized Education Plan (IEP) meetings for children ages 3 to 5 are held to coordinate services for children receiving EI/Preschool SPED services. We asked caseworkers about their involvement in these meetings. 71.7% of caseworkers received notice of the IFSP or IEP meeting. 75.0% of caseworkers state that they attend the IFSP or IEP meetings. 4.9% state that they would like to attend the meetings but don't have time. 11.6% said they are not told about the meeting and therefore can't attend. 8.5% of caseworkers state that attending IFSP or IEP meetings is not in their job description. We also asked caseworkers how often they attend the IFSP or IEP meetings. 18.5% of caseworkers state that they attend the meetings "every time", 57.8% state that they attend "almost every time" and 23.7% state that they attend "sometimes."

We asked caseworkers how they perceived their role on the IEP or IFSP team. Responses ranged from a very peripheral role to an essential advocacy role. These are the range of responses.

Caseworker's Perceived Role on IFSP/IEP Team

- To make referrals based on information
- To be an advocate for the child and the family
- To monitor services that are being delivered to the child
- To give the history, family background and family dynamics as they might affect services
- To be a resource for the parent
- To gain knowledge about the child and the services they are receiving
- To coordinate services: "My presence makes sure we are collaborating to accomplish the same goal"
- "Only have a role if the foster parent feels I need to be there"
- "Depends on custody arrangement"
- "Don't get informed enough to have a defined role"

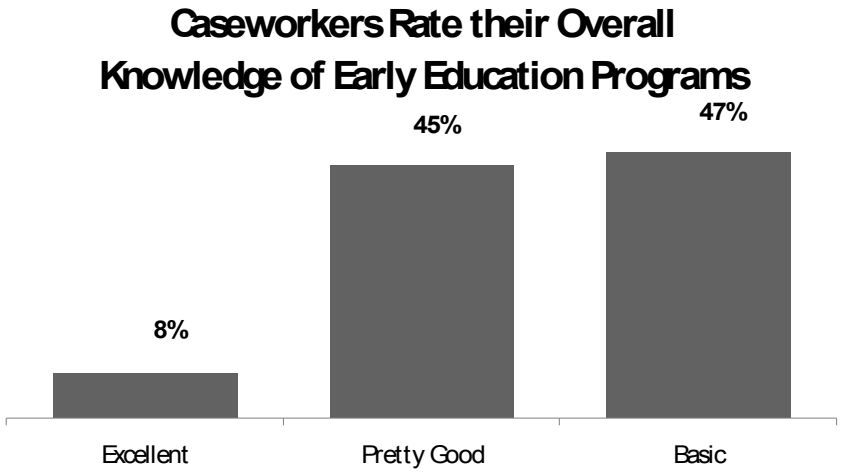
Sharing Knowledge of Early Childhood Development with Foster Parents

The great majority (92.8%) of caseworkers report that foster parents are given some type of information about child development. Almost half (45.1%) report that foster parents are given a brochure or handout on child development and 31.0% of caseworkers report that they talk to foster parents about child development.

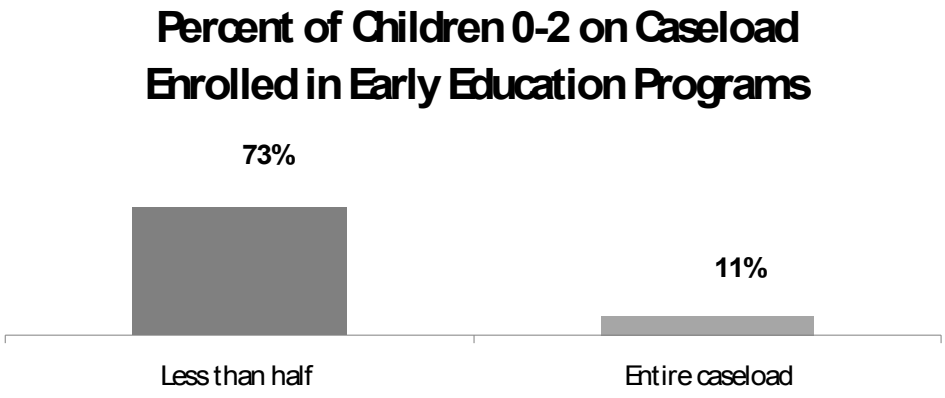
Use of Early Care and Education

Information on Early Care and Education
We were interested in knowing whether caseworkers were provided with information on ECE options for children. Two-thirds of caseworkers (67.2%) were provided with information on child care in general. More than half of caseworkers (57.2%) were provided information on Head Start. Slightly more than a third (38.9%) of caseworkers were provided information on Early Head Start, which serves children aged 0-2. Less than a third of caseworkers (27.6%) were provided information on the Colorado Preschool Program. However, in some Colorado communities, the Colorado Preschool Program is used as a funding stream to support preschool programs, rather than a stand-alone program (i.e. Head Start programs use these funds to add hours or expand capacity). As a result, caseworkers in those communities may not recognize the name of the program.

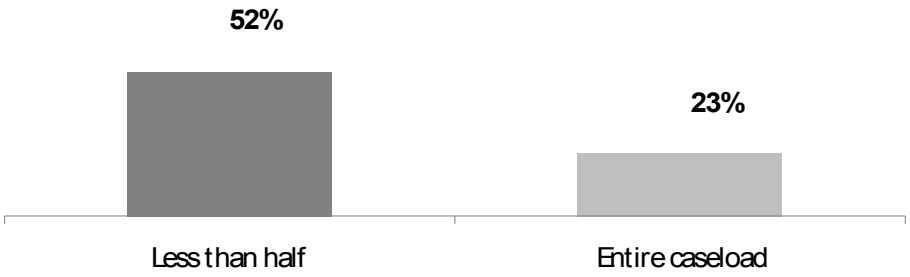
Rating their overall knowledge of ECE programs, only 8.1% of caseworkers rated their knowledge as "excellent", 44.9% rated their knowledge as "pretty good" and 47.1% rated their knowledge as only "basic".



In terms of actually enrolling children on their caseload in ECE programs, the majority (72.7%) of caseworkers had less than half of their children 0-2 enrolled in ECE programs. Just 10.9% of caseworkers had their entire 0-2 caseload enrolled in ECE. More of the caseworkers had enrolled children 3-5 in an ECE program. About half (52.2%) of the caseworkers had less than half of their children 3-5 enrolled in ECE programs. 23.1% of caseworkers had 100% of their 3-5 caseload enrolled in ECE programs.

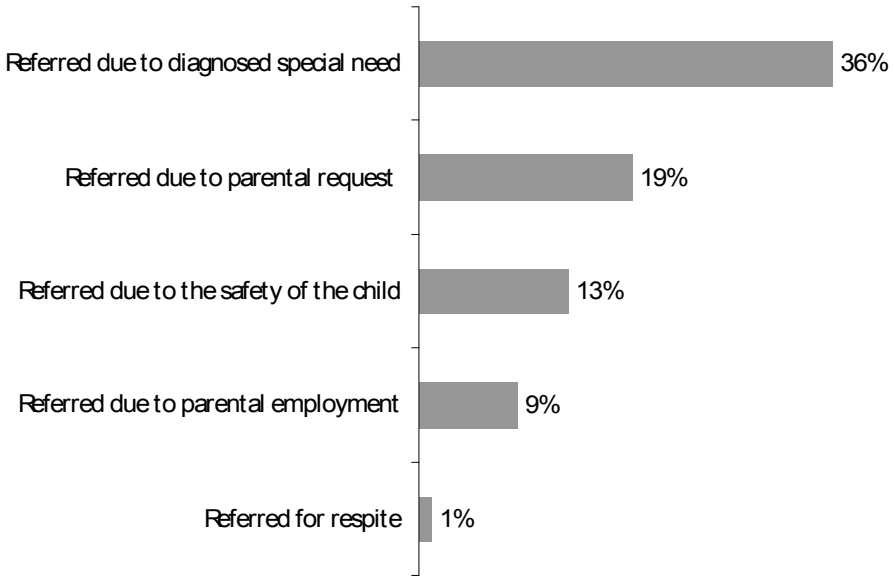


Percent of Children 3-5 on Caseload Enrolled in Early Education Programs



Caseworkers stated their reasons for referring children to ECE programs. The most common reason was a diagnosed special need (35.9% of caseworkers referred children for this reason). Almost one in five (18.5%) referred children because of a parental request; 13.0% referred children due to the safety of the child (generally getting the child out of the household during the day); 8.5% of caseworkers commonly refer due to parental employment and 1.1% refer for respite – to give the caregiver a break during the day. Only 5.6% of caseworkers stated that they do not refer children to ECE programs.

Reasons for Referring Children to Early Education Programs

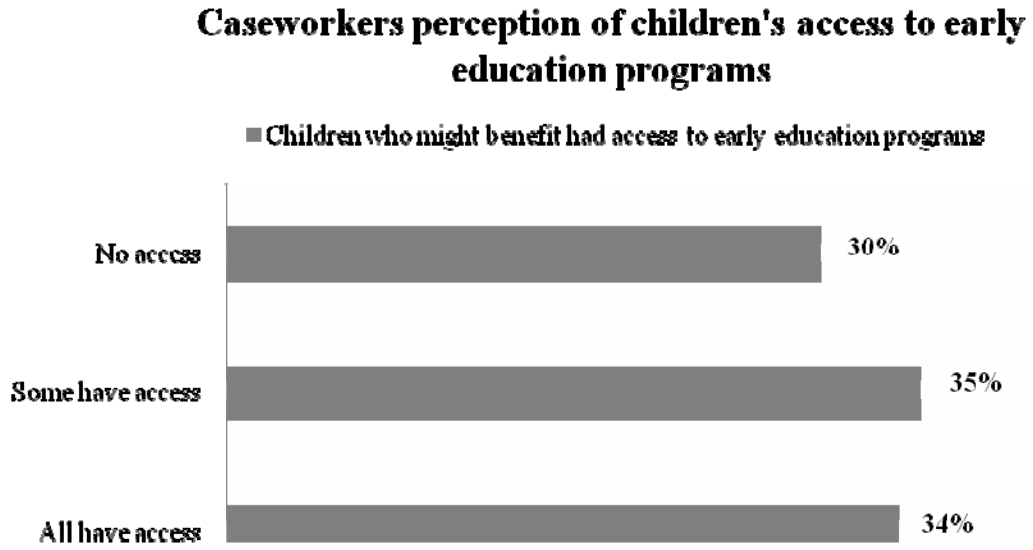


Problems with Enrollment
38.1% of caseworkers stated they had problems with enrolling children in ECE programs. We asked caseworkers to describe the nature of the problems with enrolling a child; common responses include:

Problems with Enrolling Children in Early Care and Education

- Enrollment documentation hard to get (from parents/guardians)
- Child not eligible
- Program full/waiting list
- Parent doesn't follow through on referral/enrollment
- Paperwork from child welfare end takes too long
- Program wouldn't take child with significant behavioral or medical needs
- Hours of program don't match parent/guardian's employment
- Caseworker doesn't know how to apply

Access to Early Care and Education
The caseworkers were asked whether they thought all the children in the child welfare system who might benefit from ECE programs have access to those programs. Only a third of caseworkers (34.3%) felt all children who might benefit had access to ECE programs. Another third of caseworkers (35.4%) thought children who might benefit had "some" access to ECE programs and 30.3% of caseworkers thought children who might benefit do not have any access.

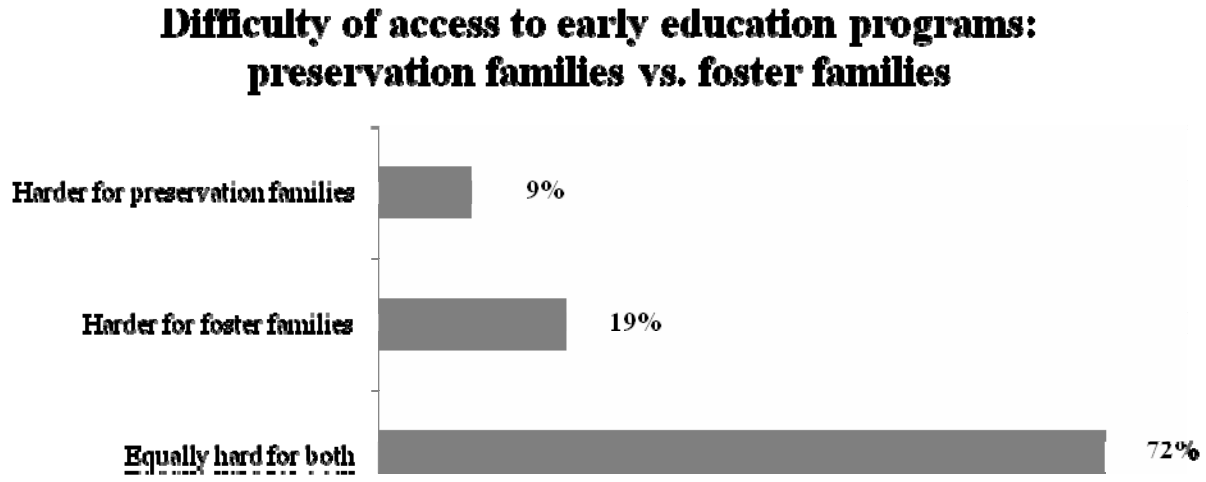


Specifically, caseworkers stated the following reasons why all children who might benefit do not have access to early childhood programs.

Why Access to Early Care and Education Programs is Limited

- Lack of knowledge about available programs on caseworker and parent's part
- Lack of funding
- Lack of space available in ECE programs
- Lack of programs in rural areas and particular counties
- Lack of communication between caseworkers and foster parents
- Lack of comprehensive planning
- Lack of transportation
- Lengthy enrollment process
- Difficulty in getting all necessary paperwork from parents/guardians
- Referrals not made early enough
- Parents/guardians distrustful of child care

We also asked caseworkers whether they thought it was harder for children living at home in family preservation programs or children living in foster homes to access ECE programs. Almost three-quarters (72.0%) of caseworkers felt it was equally hard for both groups to access ECE; 18.7% of caseworkers felt it was harder for children living with foster parent to access ECE programs and 9.3% felt it was harder for children living at home in a family preservation program.



Coordination between Early Care and Education, Early Intervention and Child Welfare System

We asked caseworkers to tell us how often they communicate with various key players regarding meeting the developmental needs of young children in the child welfare system. Caseworkers reported having the most communication with biological parents (68.2% report at least weekly communication) and foster parents (63.8% report at least weekly communication). Almost one in three (30.4%) caseworkers speak at least weekly with mental health specialists, 23.5% with Guardians ad Litem, 11.6% with medical providers, 11.0% with the ECE teachers, and 8.8% with CASA's.

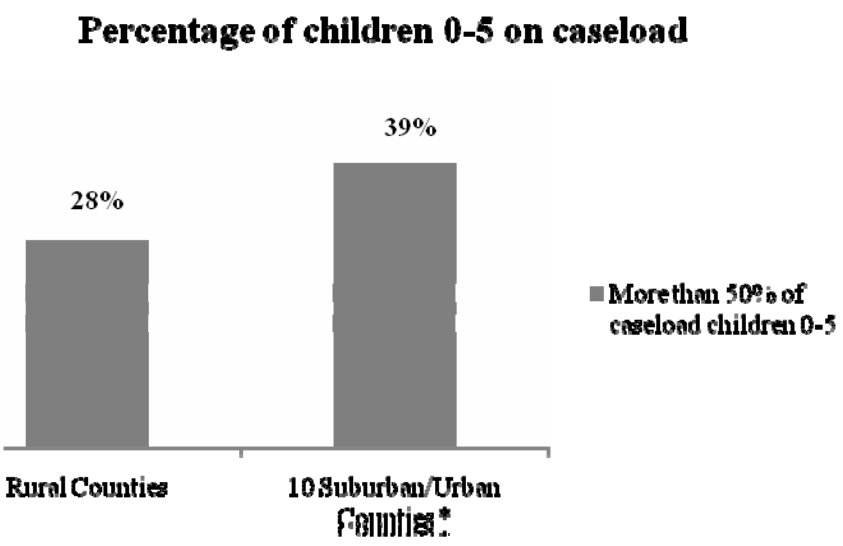
Subgroup Analysis

Below, we examine the survey data by certain subgroups. We are interested in whether there are differences by the size of the county the caseworker is in, the caseworkers' experience in the field, the caseworkers' percentage of young children on their caseload, and the type of training the caseworker has received.

Small versus Large Counties

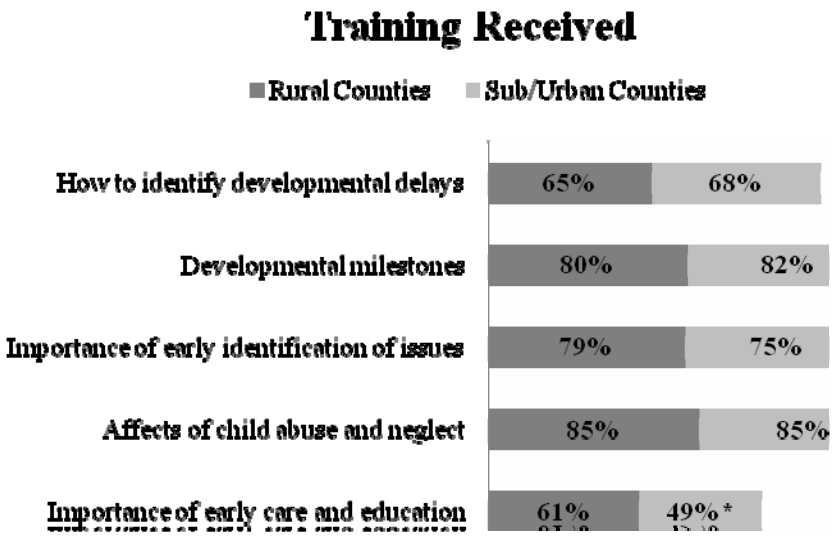
We were interested in examining the data by size of county. We differentiated counties by the federal definition of rural areas which is having a population density of less than 40 people per square mile. Ten counties would be considered suburban or urban by the definition: Adams, Arapahoe, Boulder, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo and Weld. The rest of the counties are considered rural counties. This designation also coincides with population size. All of the suburban/urban counties also have populations above 150,000 people. In the analyses below, we look at whether the difference between rural and suburban/urban counties is statistically significant. A '*' indicates that a significant difference was found using a Chi-square test.

Analyses revealed that caseworkers in suburban/urban counties have a higher percentage of 0-5 year old children on their caseload.



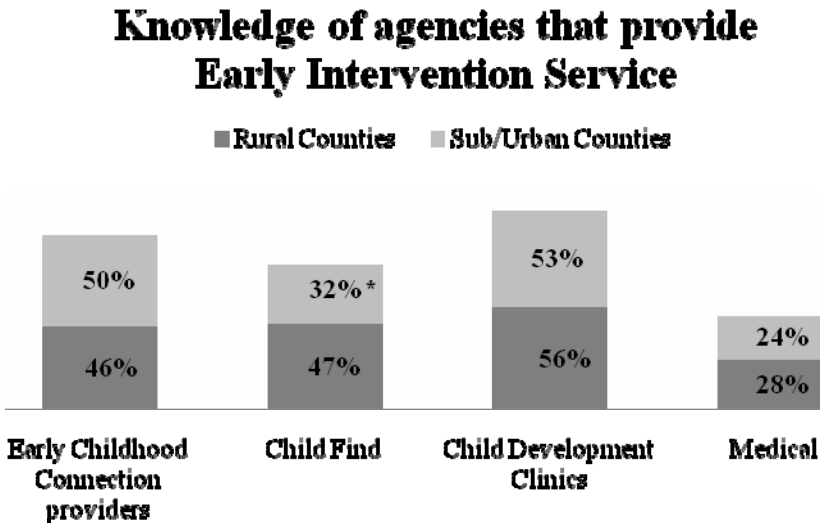
* $x^2=3.03,\ p < .10$

A smaller percentage of caseworkers in suburban/urban counties have had training on the importance of ECE. We didn't find differences in whether sub/urban caseworkers or rural caseworkers received other types of training.



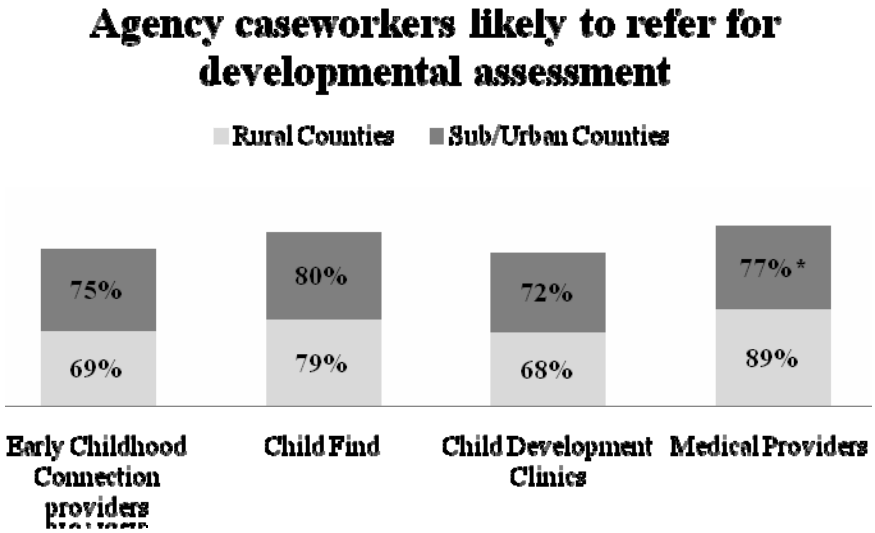
* $x^2=3.25,\ p < .10$

Caseworkers in rural counties are more likely to be aware that Child Find provides early intervention services. There were no differences in awareness of other types of agencies.



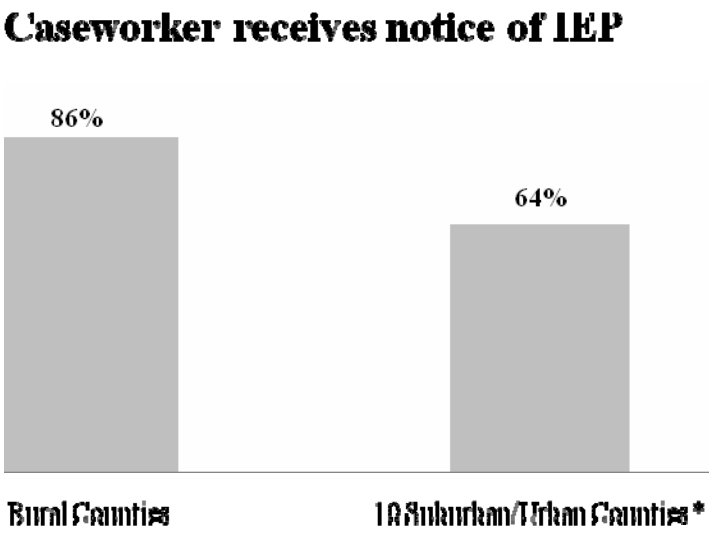
* $x^2=5.70,\ p < .05$

Caseworkers in rural counties are more likely to refer children to medical providers for early intervention services but not to other types of providers.



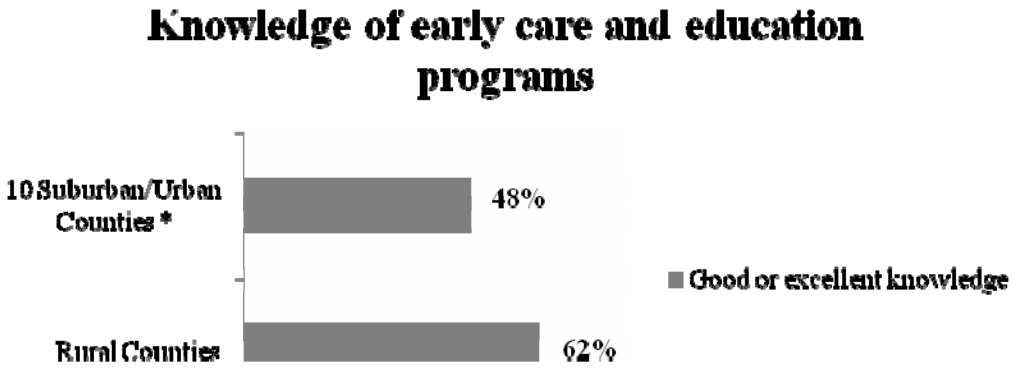
* $x^2=5.03,\ p < .05$

Caseworkers in suburban/urban counties are less likely to receive notice of IEP meetings. In rural counties, we found better avenues of communication perhaps in part due to the fewer number of people involved.



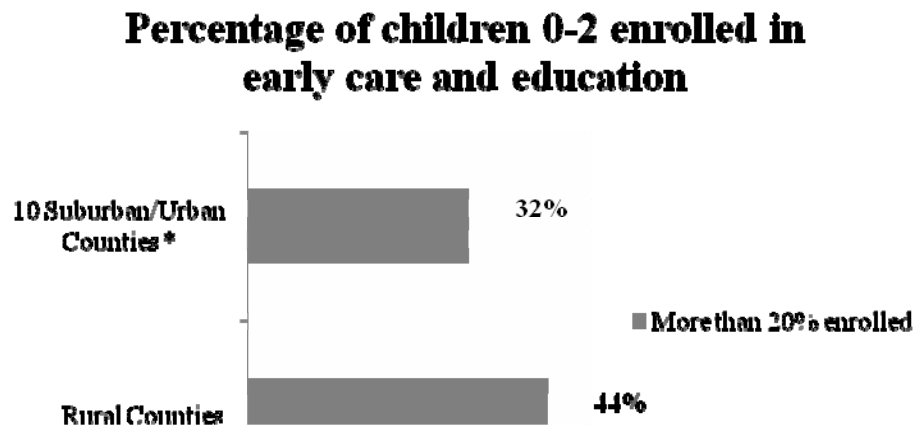
* $x^2=13.05,\ p < .001$

Caseworkers in suburban/urban counties rate their knowledge of ECE programs lower.

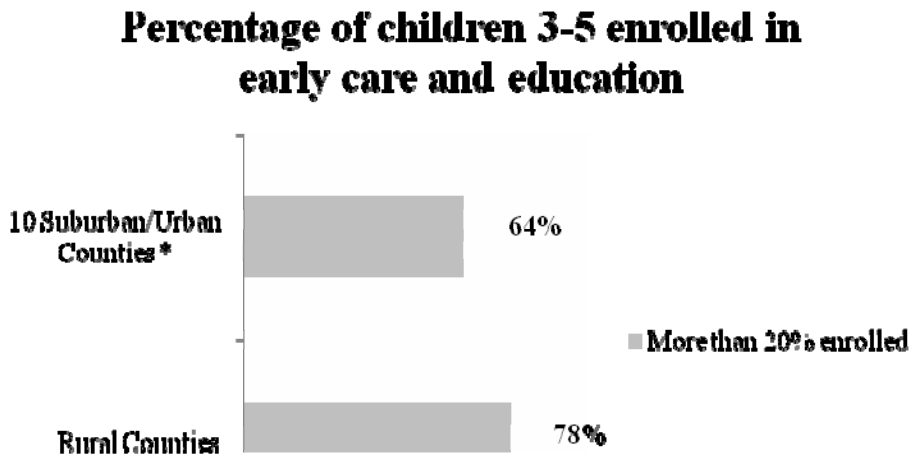


* $x^2=5.10,\ p < .05$

Caseworkers in rural counties have a greater proportion of their children age 0-2 and 3-5 enrolled in ECE programs than do caseworkers in suburban/urban counties.



* $x^2=3.47,\ p < .10$

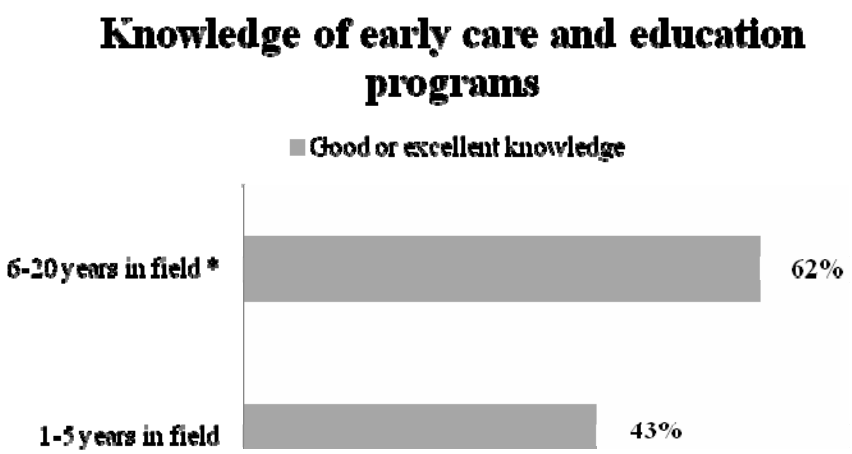


* $x^2=5.40,\ p < .05$

Experience in the Field

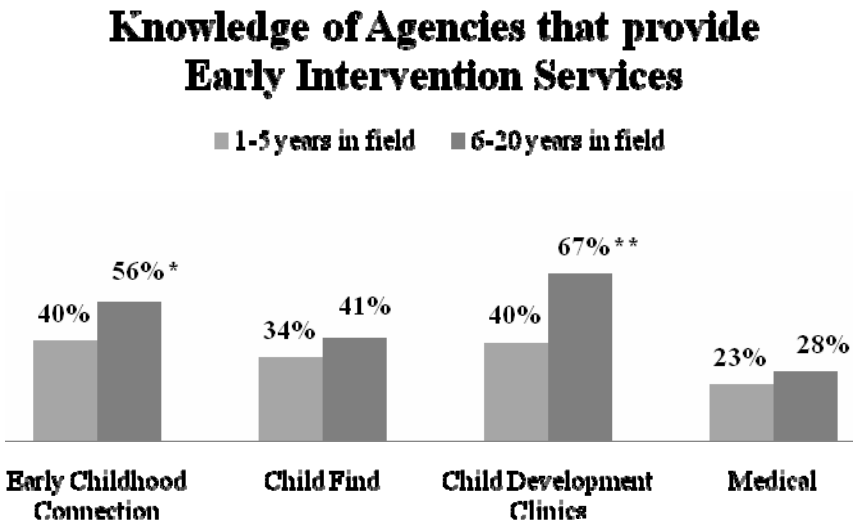
We divided the sample into caseworkers who had 5 or less years of experience in the field (42% of sample) and caseworkers who had more than five years experience in the field (53% of sample). Again, a '*' indicates a statistically significant difference using a Chi-square test of significance.

Caseworkers with more experience rate their knowledge of ECE programs as higher. This makes sense as they are likely to have been exposed to more training and been exposed to a wider diversity of services available for children.



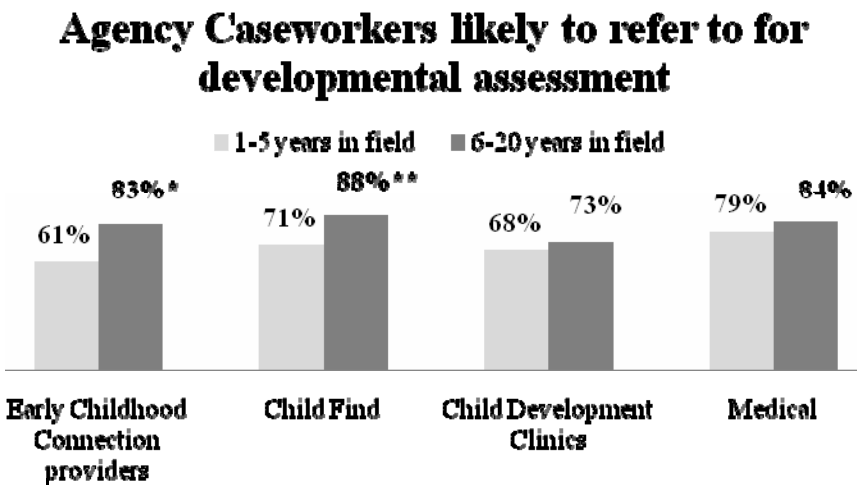
** $x^2=10.58,\ p < .001$*

Caseworkers with more experience are more likely to know that Early Childhood Connections and child development clinics provide services to children with early intervention needs. Again, caseworkers in the field for longer would have more exposure to a variety of services for children.



** $x^2=6.14,\ p < .01$; ** $x^2=19.21,\ p < .000$*

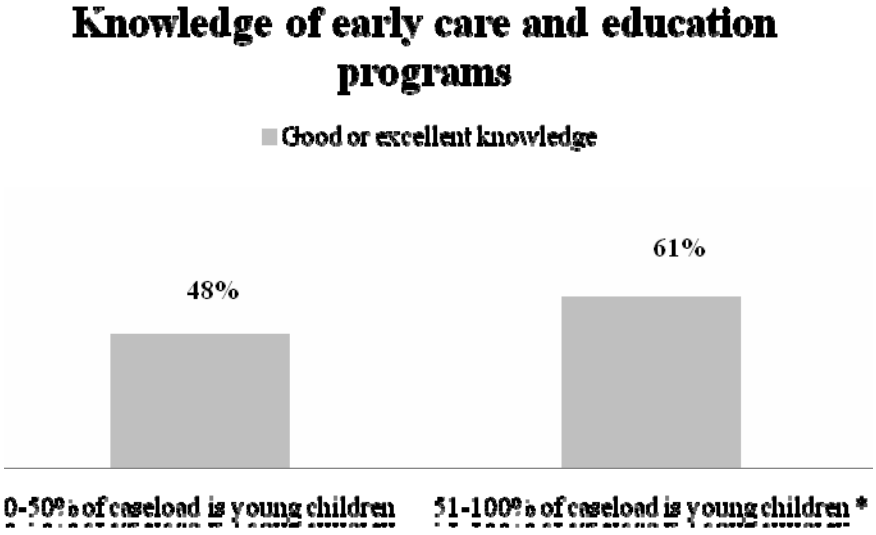
Caseworkers with more experience are more likely to refer children with early intervention needs to Early Childhood Connections and Child Find. These are programs set up specifically to serve children in need of developmental services.



** x^2=11.98, p < .001;** x^2=9.28, p < .01*

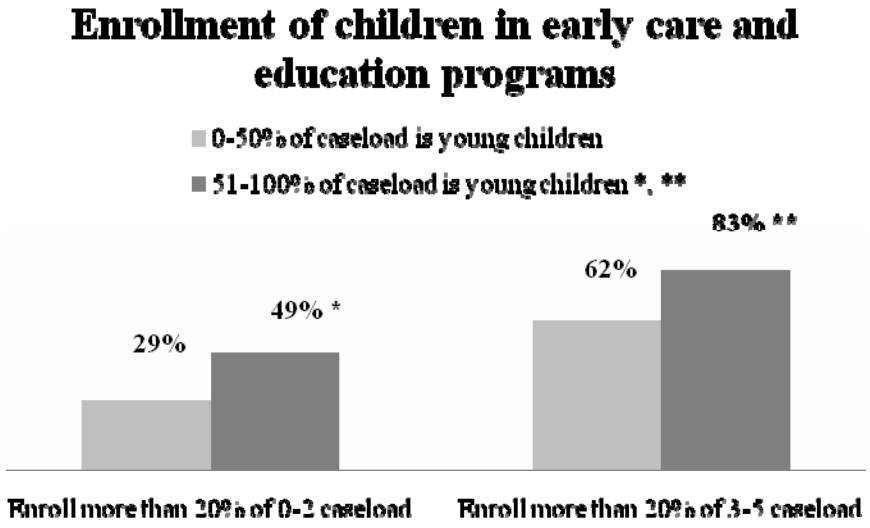
Proportion of Young Children on Caseload
We divided the sample into caseworkers with 0-50% of their caseload as young children (66% of sample) and caseworkers with more than 50% of their caseload as young children (34% of sample). Again, a '*' indicates a statistically significant difference using a Chi-square test of significance.

Caseworkers with more children age 0-5 on their caseload rate their knowledge of ECE programs higher. This makes sense as their exposure to the developmental needs of young children and availability of resources for addressing them is likely to be greater.



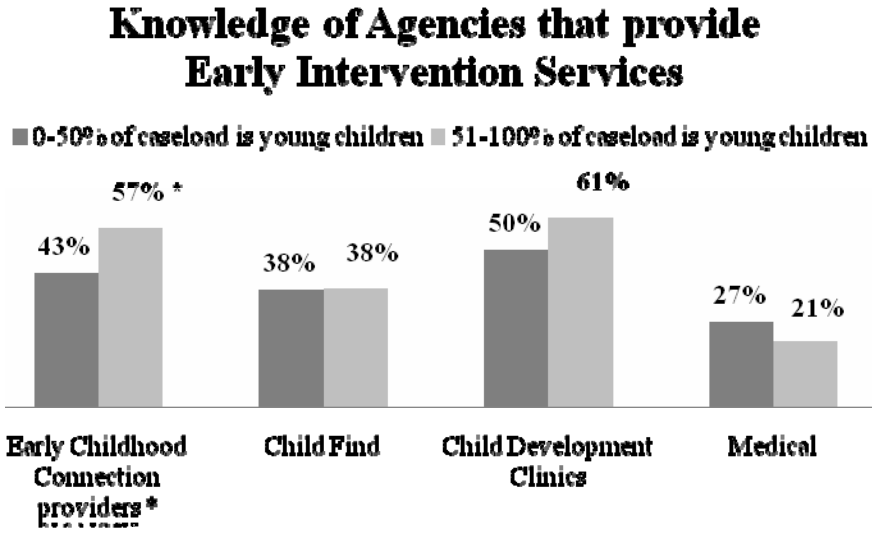
** x^2=4.21, p < .05*

Caseworkers with more children age 0-5 on their caseload have enrolled a greater percentage of their 0-2 year old clients and their 3-5 year old clients in ECE programs. Caseworkers solely or more focused on the needs of younger children may be more likely to recognize the utility and need for ECE programs.



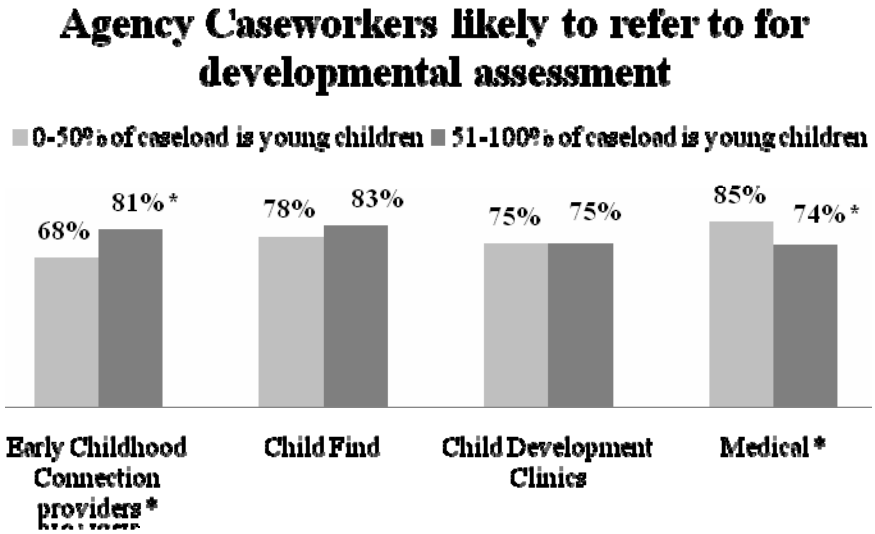
* $x^2=9.48$, $p < .01$; ** $x^2=11.77$, $p < .001$

Caseworkers with more children age 0-5 on their caseload are more likely to know that Early Childhood Connections provides services to children needing early intervention. Again, more exposure to younger children may give them more information on services available for young children.



* $x^2=4.72$, $p < .05$

Caseworkers with more children age 0-5 on their caseload are more likely to refer to Early Childhood Connections and less likely to refer to medical providers, an important finding given the likelihood that the evaluations received through Early Childhood Connections may be more comprehensive and that a determination of eligibility for, and initiation of, early intervention services is made through that agency.



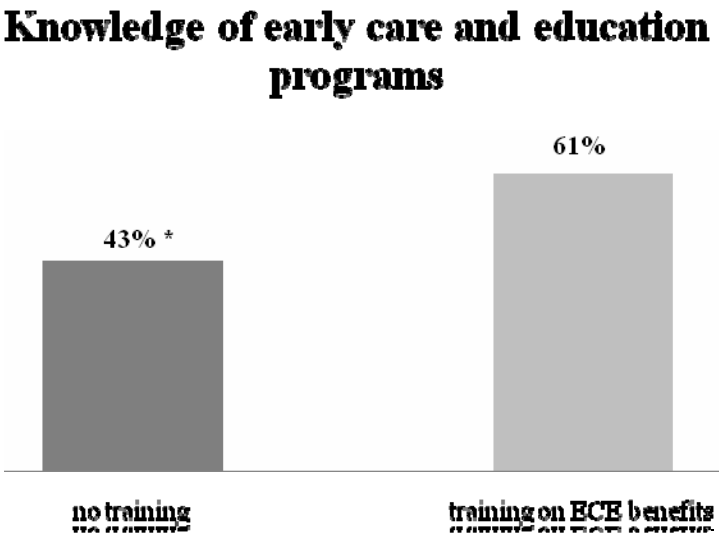
* $x^2=4.17$, $p < .05$;** $x^2=3.33$, $p < .10$

Type of Training

We examined whether specific types of training given to caseworkers made a difference in terms of key outcomes. A '*' indicates a statistically significant difference using a Chi-square test of significance. In general, our findings suggest that training does make a difference in caseworkers' perceptions of their own level of knowledge and, more importantly, on their practice in connecting children with ECE programs and sources of assessment for EI/Preschool SPED services.

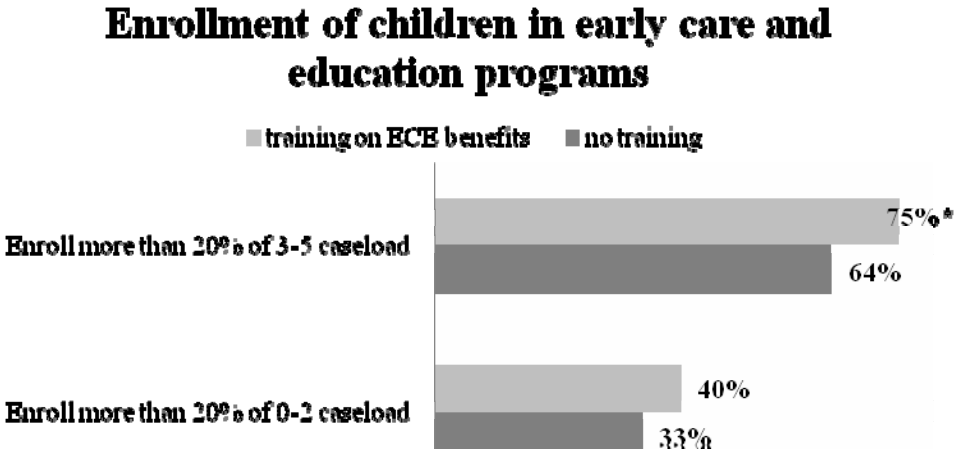
Did training on the benefits of early care and education make a difference?

Caseworkers with training on the benefits of ECE programs rated their knowledge of ECE programs higher. Presumably, the training is having an impact of caseworkers' perceptions of their level of knowledge.



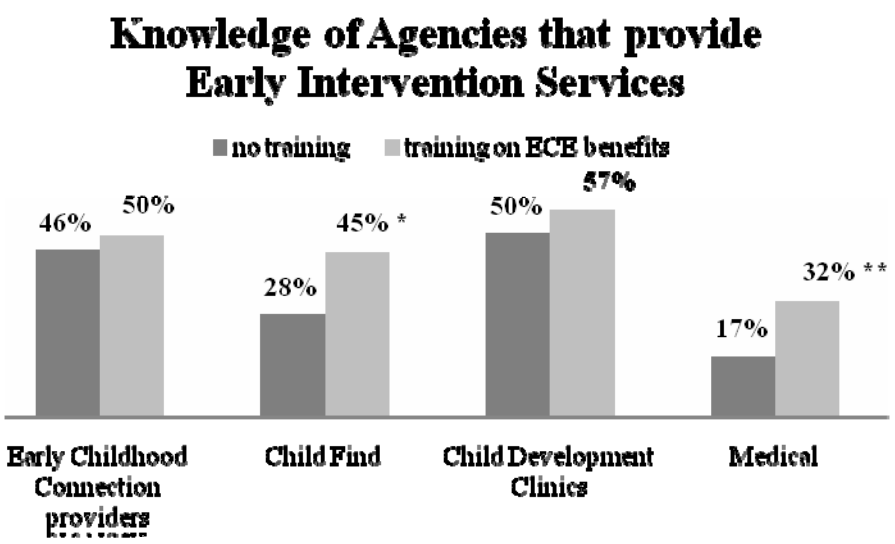
* $x^2=8.81, p < .01$

Caseworkers with training on the benefits of ECE programs enrolled a greater percentage of their 3-5 year old caseload in ECE programs. Thus, having knowledge about the importance of ECE programs is impacting the behavior of caseworkers, specifically their seeking out and enrolling children in ECE programs.



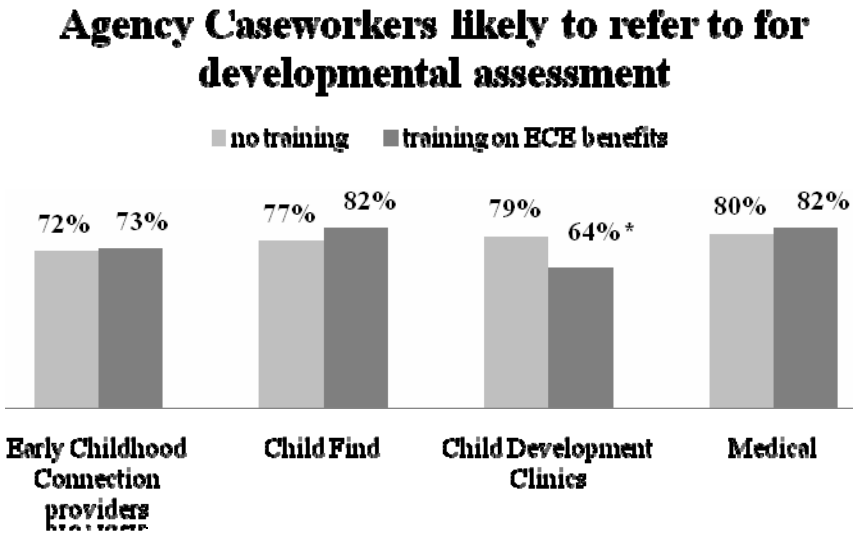
* $x^2=3.51, p < .10$

Caseworkers with training on the benefits of ECE programs were more likely to be knowledgeable that Child Find and medical providers provide early intervention services.



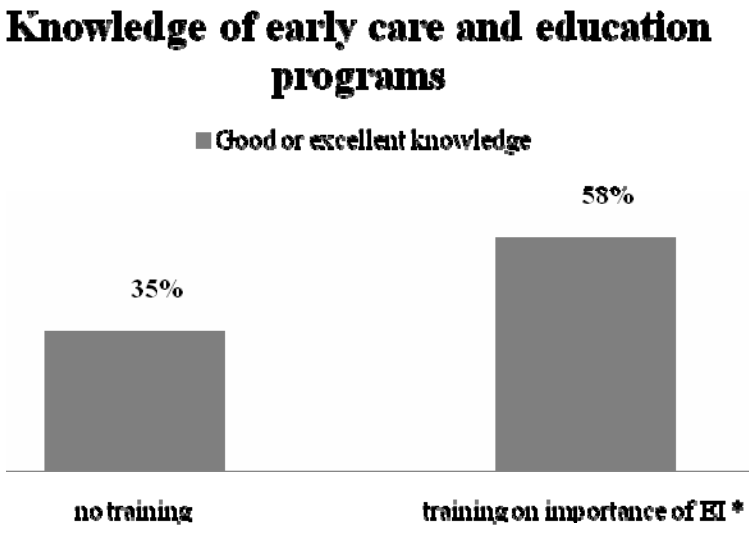
* $x^2=7.62$, $p < .01$; ** $x^2=7.67$, $p < .01$

Caseworkers with training on the benefits of ECE programs are less likely to refer to child development clinics.



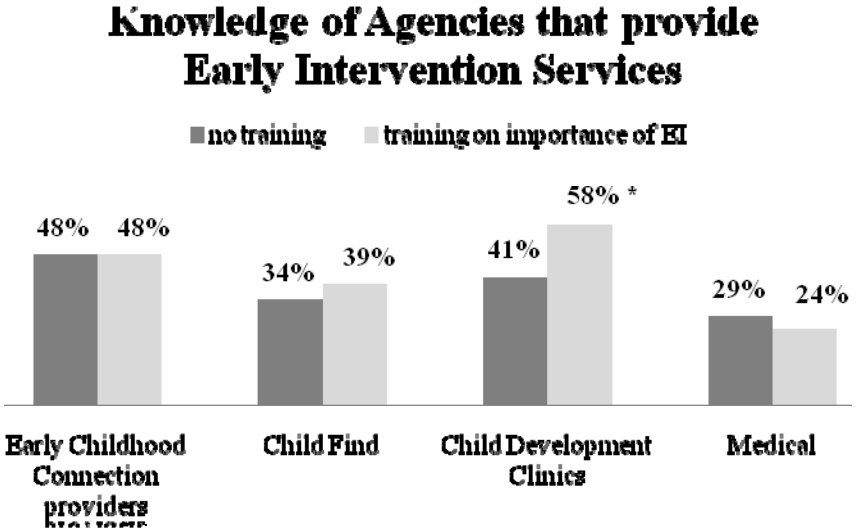
* $x^2=4.96$, $p < .05$

Did training on why early intervention is important make a difference?
Caseworkers with training on the importance of EI were more likely to rate their knowledge of ECE programs as good or excellent.



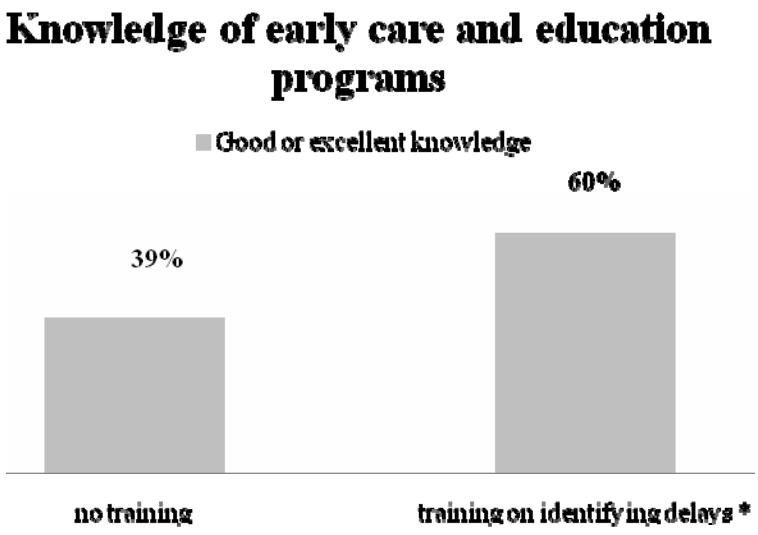
* $x^2=10.69$, $p < .001$

Caseworkers with training on the importance of EI were more likely to be aware that child development clinics provide early intervention services.



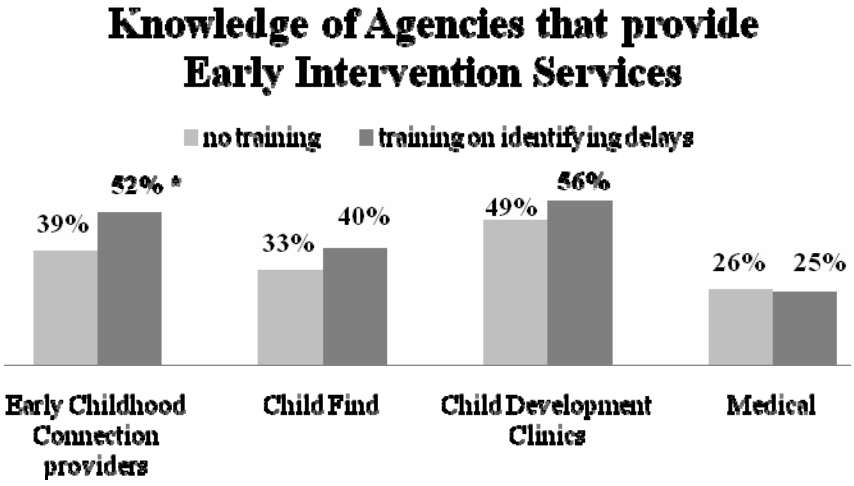
* $x^2=4.88$, $p < .05$

Did training on how to identify developmental delays of children make a difference?
Caseworkers with training on identifying developmental delays are more likely to rate their knowledge of ECE programs as good or excellent.

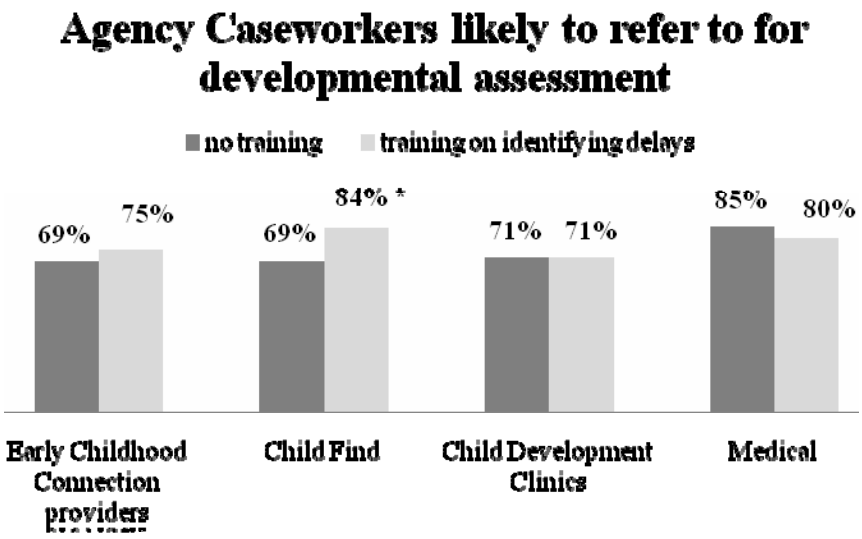


* $x^2=10.66,\ p < .001$

Caseworkers with training on identifying developmental delays are more likely to know that Early Childhood Connections provides early intervention services and more likely to refer to Child Find for early intervention services.



* $x^2=3.79,\ p < .05$


Agency Caseworkers likely to refer to for developmental assessment
no training
training on identifying delays
69%
75%
69%
84% *
71%
71%
85%
80%
Early Childhood Connection providers
Child Find
Child Development Clinics
Medical

* $x^2=6.83, p < .01$

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Appendices

Appendix 1: NSCAW Frequencies (See Section II of this report for a description of our methodology for this analysis.)

Table 1: Characteristics of Children, Caregivers, and Caseworkers in CPS Sample

Child, Caregiver, and Caseworker Characteristics	N (Weighted Response Rate)
Child Placement Type:	
Child in-home placement:	1403 (79.2%)
Parent	1309 (75.0%)
Relative	78 (3.7%)
Non-relative	16 (0.5%)
Child out-of-home placement:	699 (20.8%)
Foster home	390 (10.5%)
Kin care setting	285 (9.2%)
Other OOH care arrangement	24 (1.1%)
Child's Age:	
Age 0	872 (18.6)
Age 1	413 (17.6)
Age 2	218 (14.7)
Age 3	212 (16.3)
Age 4	199 (17.0)
Age 5	188 (15.8)
Child's Gender:	
Male	1106 (54.2)
Female	996 (45.8)
Child's Race:	
White	786 (44.8)
Black	783 (35.7)
Hispanic	388 (13.4)
Other	145 (6.1)
Child Type of Abuse:	
Physical abuse	386 (18.4%)
Sexual abuse	100 (6.3%)
Emotional abuse	99 (5.4%)
Neglect – failure to provide	605 (23.3)
Neglect – lack of supervision	514 (28.8%)
Abandonment	75 (2.7%)
Other maltreatment	138 (7.1%)
Unknown	185 (8.0%)
Caregiver's Education:	
None/Less than HS	587 (25.4%)

HS equivalent, HS diploma, Vocation diploma	1204 (60.8%)
Associate Degree, RN Diploma	127 (5.1%)
Bachelors degree	86 (3.7%)
Masters degree, M.D., Ph.D., Law, Dental	23 (1.0%)
Other	75 (4.1%)
Caregiver's Employment:	
Work full-time 35 or more hours/week	725 (39.9)
Work part-time less than 35 hours/week	227 (8.7)
Work sometimes, when work is available	50 (2.9)
Does not work	998 (44.7)
Unknown	102 (3.8)
Caseworker's length of service:	
Less than 1 year	145 (11.7%)
1-5 years	627 (44.6%)
6-10 years	321 (20.5%)
More than 10 years	244 (17.5%)
Unknown	88 (5.7%)
Caseworker's age:	
Less than 30 years old	373 (28.8%)
30-39 years old	443 (27.7%)
40-49 years old	270 (19.5%)
More than 50 years old	208 (15.7%)
Unknown	131 (8.4%)

Note: The number of subjects is 2,102 caregivers (1,403 permanent caregivers and 699 non-permanent caregivers) at Wave I and 1,425 caseworkers at Wave II.

Table 2: Occurrence of Developmental Delays in CPS Sample

Developmental Assessments	N (Weighted Response Rate)
Cognitive Score	
Children aged 0-3 receiving services – Battelle Developmental Inventory (BDI):	
No delay	657 (46.1%)
1 to 1.5 SD below mean	365 (26.8%)
More than 1.5 SD below mean	395 (27.2%)
Children aged 4-5 receiving services – Kaufman Brief Intelligence Test (K-BIT):	
No delay	248 (75.4%)
1 to 1.5 SD below mean	48 (13.9%)
More than 1.5 SD below mean	46 (10.7%)
Children aged 0-5 receiving services - Cognitive Score:	
No delay	905 (56.0%)
1 to 1.5 SD below mean	413 (22.4%)
More than 1.5 SD below mean	441 (21.6%)
Communication Score	
Children aged 0-5 receiving services - Preschool Language Scale (PLS-3):	
No delay	1060 (58.7%)
1 to 1.5 SD below mean	271 (16.0%)
More than 1.5 SD below mean	439 (25.3%)
Behavior Score	
Children aged 0-5 receiving services – Vineland Adaptive Behavior Scale (VABS):	
No delay	1,531 (63.3%)
1 to 1.5 SD below mean	246 (17.2%)
More than 1.5 SD below mean	325 (19.5%)

Note: The number of valid cases for the cognitive score was 1,759 (1,417 cases for the BDI and 342 cases for the K-BIT), for the communication score was 1,770, and for the behavior score was 2,102.

Table 3: Recognition of Developmental Problems by Intake Caseworker in CPS Sample

Recognition of Developmental Problems	N (Weighted Response Rate)
Percentage of recognition of major developmental/behavior problems by intake caseworker among children with developmental delays:	
Yes	215 (22.0 %)
No	634 (69.7%)
Don't know/non interview	87 (8.3%)

Table 4: Child Overall Health and Assessment of Developmental Needs from CPS Sample: Caregivers' Report

Child Overall Health and Assessment	In-home placement	Out-of-home placement
	N (Weighted Response Rate)	N (Weighted Response Rate)
Child Chronic Health Problems:		
Yes	371 (26.5%)	241 (34.0%)
No	1030 (73.3%)	453 (65.7%)
Child up-to-date with immunizations:		
Yes	1286 (93.2%)	627 (91.5%)
No	113 (6.6%)	56 (7.3%)
Child Tested for Learning Problems, Special Needs, or Developmental Disabilities:		
Yes	247 (20.5%)	234 (32.9 %)
No	1144 (78.6%)	440 (62.8 %)
Unknown	12 (0.9%)	25 (4.3%)
How Much Caregiver Thinks Child Needs to Be Tested (For Respondents Who Answered "No" for Above Question):		
Not at all	891 (77.7%)	288 (67.3%)
A little	110 (10.3%)	49 (9.8%)
Somewhat	92 (7.7%)	65 (12.9%)
A lot	42 (3.9%)	33 (9.1%)
Don't know	9 (0.3%)	5 (0.9%)
Learning Problems Identified by Professional:		
Yes	117 (10.4%)	147 (20.4%)
No	1285 (89.5%)	550 (79.6%)
Unknown	1	2
Child Receiving an I.E.P. or I.F.S.P (For Respondents Who Answered "Yes" for Above Question):		
Yes	58 (51.6%)	66 (43.4%)
No	57 (46.8%)	78 (55.1%)
Unknown	2 (1.6%)	3 (1.5%)

Note: The number of subjects is 2,102 caregivers (1,403 permanent caregivers and 699 non-permanent caregivers) at Wave 1.

Table 5: Early Care and Education Programs in CPS Sample: Caregivers' Report

Early Care and Education Programs	In-home placement	Out-of-home placement
	N (Weighted Response Rate)	N (Weighted Response Rate)
Children Aged 0-2 Enrolled in Any Child Care Program (Head Start, Nursery School, or ECE program)		
Yes:	187 (26.4%)	124 (29.7%)
In Head Start	19 (1.6%)	7 (1.4%)
Not in Head Start	168 (24.8%)	117 (28.3%)
No	761 (73.6%)	431 (70.3%)
Children Aged 3-5 Enrolled in Any Child Care Program (Head Start, Nursery School, or ECE program)		
Yes:	210 (45.1%)	71 (54.8%)
In Head Start	88 (14.9%)	22 (17.4%)
Not in Head Start	122 (30.3%)	49 (37.3%)
No	245 (54.9%)	73 (45.2%)

Note: The number of subjects is 2,102 caregivers (1,403 permanent caregivers and 699 non-permanent caregivers) at Wave 1.

Table 6: Service Needs for Health and Developmental Problems in CPS Sample: Caseworkers' Report[34]

Types of Services	N (Weighted Response Rate)
Identifying a learning problem or developmental disability	423 (23.2%)
Special education classes or services	135 (10.0%)
Emotional, behavioral, or attention problem	175 (13.4%)
Health problem	427 (22.3%)
Routine check-ups or immunization	1,102 (65.6%)

Note: The number of subjects is 1,425caseworkers at Wave 2.

[34] The table entries are numbers and weighted percentages of caseworkers who have responded as "yes" to all of the questions.

Table 7: Referral to Service by Caseworker in CPS Sample: Caseworkers' Report

Types of Services	N (Weighted Response Rate)
Identifying a learning problem or developmental disability:	
Referral made	296 (14.3%)
Already receiving service	68 (6.4%)
Referral not made	58 (2.4%)
No need and no referral	963 (72.9%)
Unknown	40 (4.0%)
Special education services:	
Referral made	64 (3.8%)
Already receiving service	34 (3.4%)
Referral not made	36 (2.7%)
No need and no referral	1254 (86.1%)
Unknown	37 (3.9%)
Emotional, behavioral, or attention problem:	
Referral made	118 (8.0%)
Already receiving service	18 (2.5%)
Referral not made	39 (2.9%)
No need and no referral	1216 (83.0%)
Unknown	34 (3.6%)
Health problem:	
Referral made	251 (12.7%)
Already receiving service	124 (6.4%)
Referral not made	50 (3.1%)
No need and no referral	965 (74.1%)
Unknown	35 (3.6%)
Routine check-ups or immunization:	
Referral made	917 (52.1%)
Already receiving service	158 (11.5%)
Referral not made	24 (1.7%)
No need and no referral	271 (26.8%)
Unknown	55 (7.9%)

Note: The number of subjects is 1,425caseworkers at Wave 2.

Table 8: Characteristics of Children, Caregivers, and Caseworkers in LTFC Sample

Child, Caregiver, and Caseworker Characteristics	N (Weighted Response Rate)
Child Out-of-Home Placement Type:	
Foster home	191 (67.4%)
Kin care setting	71 (30.0%)
Other OOH care arrangement	6 (2.6%)
Child's Age:	
Age 1	106 (35.2%)
Age 2	65 (29.7%)
Age 3	35 (10.2%)
Age 4	35 (14.2%)
Age 5	27 (10.7%)
Child's Gender:	
Male	134 (51.7%)
Female	134 (48.3%)
Child's Race:	
Black	138 (50.3%)
White	70 (30.3%)
Hispanic	49 (12.8%)
Other	11 (6.6%)
Child Type of Abuse:	
Physical abuse	34 (5.1%)
Sexual abuse	7 (3.6%)
Emotional abuse	8 (4.7%)
Neglect – failure to provide	104 (42.1%)
Neglect – lack of supervision	49 (20.7%)
Abandonment	21 (6.8%)
Other maltreatment	26 (12.1%)
Unknown	19 (4.9%)
Caregiver's Education:	
None/Less than HS	28 (10.3%)
HS equivalent, HS diploma, Vocation diploma	172 (58.7%)
Associate Degree, RN Diploma	28 (17.0%)
Bachelors degree	21 (6.8%)
Masters degree, M.D., Ph.D., Law, Dental	7 (3.2%)
Other	11 (4.0%)
Refused	1
Caregiver's Employment:	
Work full-time 35 or more hours/week	106 (37.2%)
Work part-time less than 35 hours/week	31(10.6%)
Work sometimes, when work is available	8(6.6%)
Does not work	106 (38.6%)
Unknown	17 (7.0%)
Caseworker's Length of Service:	
Less than 1 year	17 (5.3%)
1-5 years	117 (50.0%)

6-10 years	68 (25.3%)
More than 10 years	49 (15.9%)
Unknown	17 (3.5%)
Caseworker's Age:	
<30 years old	57 (23.8%)
30-39 years old	82 (32.2%)
40-49 years old	53 (17.4%)
>50 years old	43 (17.6%)
Unknown	33 (9.0%)

Note: The number of subjects is 268 non-permanent caregivers and caseworkers at Wave I.

Table 9: Occurrence of Developmental Delays in LTFC Sample

Developmental Assessments	N (Weighted Response Rate)
Cognitive Score	
Children aged 1-3 receiving services – Battelle Developmental Inventory (BDI):	
No delay	57 (40.9%)
1 to 1.5 SD below mean	52 (28.7%)
More than 1.5 SD below mean	65 (30.3%)
Children aged 4-5 receiving services – Kaufman Brief Intelligence Test (K-BIT):	
No delay	44 (90.3%)
1 to 1.5 SD below mean	7 (5.5%)
More than 1.5 SD below mean	5 (4.2%)
Children aged 1-5 receiving services - Cognitive Score:	
No delay	101 (52.9 %)
1 to 1.5 SD below mean	59 (23.1 %)
More than 1.5 SD below mean	70 (24.0 %)
Communication Score	
Children aged 1-5 receiving services - Preschool Language Scale (PLS-3):	
No delay	105 (51.1%)
1 to 1.5 SD below mean	31 (21.9%)
More than 1.5 SD below mean	65 (27.0%)
Behavior Score	
Children aged 0-5 receiving services – Vineland Adaptive Behavior Scale (VABS):	
No delay	131 (48.1%)
1 to 1.5 SD below mean	46 (21.8%)
More than 1.5 SD below mean	91 (30.1%)

Note: The number of valid cases for the cognitive score was 230 (174 for the BDI and 56 for the K-BIT), for the communication score was 201, and for behavior score was 268.

Table 10: Child Overall Health and Assessment of Developmental Needs in LTFC Sample: Caregivers' Report

Child Overall Health and Assessment	N (Weighted Response Rate)
Child Chronic Health Problems:	
Yes	102 (33.7%)
No	165 (66.2%)
Child up-to-date with immunizations:	
Yes	264 (99.3%)
No	4 (0.7%)
Child Tested for Learning Problems, Special Needs, or Developmental Disability:	
Yes	145 (42.1%)
No	115 (56.5%)
Unknown	8 (1.5%)
How Much Caregiver Thinks Child Needs to Be Tested (For Respondents Who Answered "No" for Above Question):	
Not at all	82 (79.2%)
A little	18 (10.2%)
Somewhat	8 (6.3%)
A lot	6 (1.5%)
Don't know	1 (2.7%)
Learning Problems Told by Professional:	
Yes	78 (22.5%)
No	187 (77%)
Unknown	3 (0.5%)
Child Receiving an I.E.P. or I.F.S.P (For Respondents Who Answered "Yes" for Above Question):	
Yes	47 (51.2%)
No	28 (33.8%)
Unknown	3 (15.0%)

Note: The number of subjects is 268 non-permanent caregivers.

Table11: Early Care and Education Programs in LTFC Sample: Caregivers' Report

Early Care and Education Programs	N (Weighted Response Rate)
Children Aged 0-2 Enrolled in Any Child Care Program (Head Start, Nursery School, or ECE program):	
Yes:	57 (25.8%)
In Head Start	4 (1.7%)
Not in Head Start	53 (24.1%)
No	114 (74.2%)
Children Aged 3-5 Enrolled in Any Child Care Program (Head Start, Nursery School, or ECE program):	
Yes:	60 (59.4%)
In Head Start	17 (19.0%)
Not in Head Start	43 (40.4%)
No	37 (40.6%)

Note: The number of subjects is 268 non-permanent caregivers.

Table 12: Service Needs for Health and Developmental Problems in LTFC Sample: Caseworkers' Report[35]

Types of Services	N (Weighted Response Rate)
Identifying a learning problem or developmental disability	115 (39.2%)
Special education classes or services	43 (14.0%)
Emotional, behavioral, or attention problem	53 (22.3%)
Health problem	116 (37.5%)
Routine check-ups or immunization	237 (92.6%)

Note: The number of subjects is 268 caseworkers.

[35] The table entries are numbers and weighted percentages of caseworkers who have responded as "yes" to all of the questions.

Table 13: Referral to Service by Caseworker in LTFC Sample: Caseworkers' Report

Types of Services	N (Weighted Response Rate)
Identifying a learning problem or developmental disability:	
Referral made	95 (34.9 %)
Already receiving service	8 (1.8%)
Referral not made	11 (2.4%)
No need and no referral	128 (55.4%)
Unknown	26 (5.5%)
Special education services:	
Referral made	22 (6.9 %)
Already receiving service	4 (0.6%)
Referral not made	16 (5.7%)
No need and no referral	202 (80.9%)
Unknown	24 (5.9%)
Emotional, behavioral, or attention problem:	
Referral made	43 (20.1%)
Already receiving service	2 (0.3%)
Referral not made	8 (1.9%)
No need and no referral	189 (72.2%)
Unknown	26 (5.5%)
Health problem:	
Referral made	80 (24.6%)
Already receiving service	28 (10.6%)
Referral not made	8 (2.3%)
No need and no referral	126 (56.9%)
Unknown	26 (5.6%)
Routine check-ups or immunization:	
Referral made	210 (82.7%)
Already receiving service	26 (9.8%)
Referral not made	1 (0.1%)
No need and no referral	7 (2.2%)
Unknown	24 (5.2%)

Note: The number of subjects is 268 caseworkers.

Appendix 2: Foster Parent Survey Instrument and Frequencies (See Section III of this report for a description of our methodology)

Survey Data

How many foster children ages 0-5 are currently in your care?

0 children	104	39.1%
1 child	98	36.8%
2 children	43	16.2%
3 children	16	6.0%
4 children	4	1.5%
10 children	1	0.4%

Altogether, how many foster children ages 0-5 have you fostered in the past 12 months?

1 child	118	44.7%
2 children	55	20.8%
3-6 children	67	25.4%
7-10	19	7.2%
11+	5	1.9%

On average, how many foster children do you generally have placed in your home at one time?

1	112	42.9%
2	78	29.9%
3	39	14.9%
4	22	8.4%
more than 5	10	3.8%

What type of placements do you generally accept?

Children birth to 5 years	242	92.0%
Children 6-12 years	117	44.4%
Children 12-18 years	51	19.4%
Children with disabilities	103	39.2%
Children with behavioral concerns	134	50.9%
Children with special medical concerns	112	42.6%
Respite placements	124	47.1%

How many total years have you been certified as a foster family?

1 year	55	22.2%

2-3 years	89	35.9%
4-5 years	39	15.7%
6-7 years	25	10.1%
8-10 years	18	7.3%
11-20 years	15	6.0%
21-41years	7	2.8%

What counties are you certified in?

All counties	7
Adams	61
Arapahoe	5
Archuleta	1
Baca	1
Bent	1
Boulder	41
Broomfield	2
Chaffee	0
Cheyenne	0
Clear Creek	1
Conejos	2
Costilla	3
Crowley	0
Custer	0
Delta	4
Denver	9
Dolores	5
Douglas	2
Eagle	4
Elbert	1
El Paso	1
Fremont	3
Garfield	2
Gilpin	5
Grand	1
Gunnison	1
Hinsdale	1
Huerfano	1
Jackson	0
Jefferson	16
Kiowa	17
Kit Carson	0
Lake	0
La Plata	0
Larimer	0
Las Animas	0

Lincoln	0
Logan	1
Mesa	13
Mineral	11
Moffatt	0
Montezuma	2
Montrose	2
Morgan	2
Otero	3
Ouray	0
Park	1
Phillips	1
Pitkin	0
Prowers	1
Pueblo	7
Rio Blanco	6
Rio Grande	1
Routt	1
Saguache	1
San Juan	0
San Miguel	0
Sedgwick	0
Summit	1
Teller	0
Washington	0
Weld	2
Yuma	5

Receipt of Information about Foster Children

When a child is placed in your care, to what degree are you informed about the child's health, development, or any special services he/she might be receiving?

	Never		Sometimes		Always	
Medical records	42	**16.3%**	108	**41.9%**	108	**41.9%**
Family history/Child's background	19	**7.3%**	130	**50.2%**	110	**42.5%**
Developmental evaluations/assessments	63	**25.6%**	92	**37.4%**	91	**37.0%**
Information on special services/therapies currently receiving	37	**15.1%**	67	**27.3%**	141	**57.6%**
Information on special services/therapies received in the past	59	**24.8%**	98	**41.2%**	81	**34.0%**
Information on regular medical provider	54	**21.6%**	94	**37.6%**	102	**40.8%**

When do you usually receive information on the child's health or development from their caseworker?

Upon placement	124	48.6%
1-2 weeks after placement	69	27.1%
More than 2 weeks but less than 1 month after placement	29	11.4%
More than 1 month, but less than 2 months after placement	13	5.1%
More than 2 month, but less than 3 months after placement	3	1.2%
More than 3 months after placement	6	2.4%
Never	11	4.3%

Access to Services

Survey Data

Have you ever identified or known a young child in your care as potentially having a developmental delay (i.e., delays in sensory, motor, language, social and emotional areas)?

Yes	173	67.1%
No	85	32.9%

If you identified a potential problem, what prompted these concerns? (common responses)

- Lack of ability to understand or speak at an age-appropriate level
- Behavior issues
- Drug or alcohol addicted parents
- Not meeting developmental milestones
- Specific special need (e.g. Down Syndrome)
- Lack of social skills
- Caseworkers identified problem

If you identified a child in your care as potentially having a developmental delay, what professional typically would you talk to first?

Medical Professional	68	39.1%
Daycare/Headstart Provider	2	1.1%
Caseworker	92	52.9%
Childfind Office	9	5.2%
Other Professional	3	1.7%

Besides yourself, do you feel there are other people who you rely on for identifying developmental needs? (check all that apply)

Daycare/Head Start Provider	45	26.0%
County Child Welfare Caseworker	66	38.2%
Child Placement Agency Worker	38	21.9%
Medical Professional	97	56.1%
GAL (Guardian ad litem)	13	7.5%
CASA (Court Appointed Special Advocate)	10	5.8%
Other parents	12	6.9%
Child Find	17	9.8%
Other (see below)	39	16.7%

Other responses…

Child Find	15
Schools	4
Therapists	10
Support Group	2
Boards of Cooperative Educational Services	2

Who do you think has primary responsibility for ***making referrals* for a child's developmental delay? (Check one)**

Myself	88	51.5%
Daycare/Head Start Provider	2	1.2%
County Child Welfare Caseworker	52	30.4%
Child Placement Agency Worker	2	1.2%
Medical Professional	24	14.0%
GAL (Guardian ad litem)	1	0.6%
CASA (Court Appointed Special Advocate)	0	0.0%
Other (schools, assessment groups)	2	1.2%

Once a delay is identified and a referral to a developmental screening/assessment has been made, on average, how quickly is it completed?

1-2 weeks	41	26.5%
3-4 weeks	70	45.2%
1 1/2 - 2 months	28	18.1%
3 - 6 months	14	9.0%
More than 6 months	2	1.3%

If your child is screened for developmental and found not to need services, would he/she be rescreened at a future time by providers?

Yes	95	88.0%
No	13	12.0%

Would he or she be rechecked automatically, or only if you ask for it?

Rechecked automatically	29	26.1%
Rechecked if I ask	82	73.9%

In general, how often do the following professionals visit your home?

	Weekly		Monthly		Couple times year		Yearly or less	
DHS Caseworker	23	**9.1%**	203	**79.9%**	18	**7.1%**	10	**4.0%**
Privately contracted caseworker	18	**16.2%**	27	**24.3%**	6	**5.4%**	60	**54.0%**
GAL	2	**0.9%**	20	**8.7%**	89	**38.7%**	119	**51.7%**
CASA	10	**7.0%**	34	**23.8%**	21	**14.7%**	78	**54.5%**

In general, who do the following professionals spend the majority of their time with during these visits?

	You		Child		Both	
DHS Caseworker	44	**17.2%**	11	**4.3%**	201	**78.5%**
Privately Contracted Caseworker	12	**24.0%**	1	**2.0%**	7	**74.0%**
GAL	48	**24.1%**	26	**13.1%**	125	**62.8%**
CASA	4	**4.7%**	35	**41.2%**	46	**54.1%**

Receipt of Services

Have you ever had/or have children who need special services (e.g. speech therapy, OT, etc.)?

Yes, proceed to next question	169	64.8%
No (skip to early care and education section)	92	35.2%

How frequently do you have transportation issues surrounding early intervention/developmental services?

Always	20	12.5%
Sometimes	38	23.8%
Never	102	63.8%

If you do, please describe the nature of your transportation issues. (common responses)

- Scheduling issues (conflicts with work)
- Inflexibility in county appointments
- Services very far away
- Cost of transportation (mileage is not reimbursed)
- Hard to figure out transportation with several foster children
- No car available
- Multiple appointments at the same time in different places
- Can't fit all children in single car

How satisfied have you been with coordination of developmental services with the following service providers? (please check your answer)

How satisfied are you with…	Very Dissatisfied		Somewhat Dissatisfied		Somewhat Satisfied		Very Satisfied	
Medical Professional	7	**4.5%**	6	**3.8%**	39	**25.0%**	104	**66.7%**
Early Intervention Screening/Assessment	8	**5.3%**	11	**7.3%**	50	**33.3%**	81	**54.0%**
Daycare/Headstart Providers	2	**2.2%**	8	**8.9%**	25	**27.8%**	55	**61.1%**
Physical/Speech/Occupational Therapy	8	**5.9%**	6	**4.4%**	38	**28.1%**	83	**61.5%**

If you have had challenges accessing early intervention/developmental services, please rate the following issues where 1 equals <u>No Problem</u> and 10 equals <u>Serious Problem</u>.

	Average score	% with score above 5
Transportation:	2.8	17.5%
Cost:	2.2	10.9%
Work Schedule Conflicts:	3.6	24.8%
Location of services:	3.4	20.9%
Turnover of specialist:	2.8	16.8%
Waiting list:	3.5	26.1%
(too many children needing services)		
Lack of providers who accept Medicaid:	4.8	43.0%
Takes too long to get screening/services:	3.6	25.0%

Other challenges…

- Caseworkers fired for poor work
- Lack of information from caseworker
- Have to explain situation over and over to agencies and providers
- Challenging to identify who has authority to make medical decision

- Delays in getting early education services
- Need to get birth parents to sign off on documents
- Services not available in rural communities
- Getting babysitting for other children
- School systems reluctant to provide services due to budget cuts
- Don't have a list of service providers
- Lack of coordination; School and health providers feel the other entity should provide the services
- Appointments canceled
- No services in the summer
- Services reduced (from two times a week to once a week) due to budget cuts
- No follow-up services once leave foster care

Overall, how satisfied have you been with the following services concerning your foster children's developmental needs?

How satisfied are you with…	Very Dissatisfied		Somewhat Dissatisfied		Somewhat Satisfied		Very Satisfied	
Medical Professional	5	**3.2%**	5	**3.2%**	30	**19.0%**	118	**74.7%**
Caseworker	10	**6.3%**	22	**13.8%**	51	**32.1%**	76	**47.8%**
Early Intervention Screening/Assessment	5	**3.3%**	13	**8.7%**	57	**38.0%**	75	**50.0%**
Daycare/Headstart Providers	2	**2.3%**	7	**8.0%**	30	**34.1%**	49	**55.7%**
Physical/Speech/Occupational Therapy	4	**3.0%**	9	**6.7%**	36	**26.9%**	85	**63.4%**
GAL	23	**17.8%**	22	**17.1%**	33	**25.6%**	51	**39.5%**
CASA	10	**19.2%**	6	**11.5%**	12	**23.1%**	24	**46.2%**

Early Care and Education (Daycare/Headstart Providers)

Have you ever had foster children enrolled in daycare/preschool/headstart programs?

Yes, proceed to next question	155	60.3%
No, skip three questions ahead.	102	39.7%

Have any of your foster children been enrolled in one of these programs in the last 12 months?

Yes, proceed to next question	113	75.8%
No, skip two questions ahead	36	24.2%

If any of your foster children are or have been enrolled in the last 12 months in a daycare/Head Start program, what types of settings were they in?

(Check all that apply)

Daycare in someone else's home	22	19.5%
Daycare Center	44	38.9%
Regular preschool	32	28.3%
Head Start	20	17.6%
Preschool Special Education	11	9.7%
Other, _____	10	8.8%

Have you ever been told that foster children in the child welfare system are a priority for placement in daycare/headstart programs, meaning they would move to the top of a waiting list if one existed?

Yes	37	25.9%
No	106	74.1%

If yes, where did you receive this information?

Child welfare caseworker	15	40.5%
Foster Parent Association	1	2.7%
Early Intervention Case Coordinator	3	8.1%
Medical Professional	2	5.4%
Daycare/Headstart Provider	18	48.6%
Friend/Relative/Other Foster Parent	2	5.4%
Other	5	13.5%

Do you receive subsidies from the state to help you pay for day care/preschool program for your foster children?

Yes	66	46.2%
No	77	53.8%

Have you had challenges accessing daycare or Head Start programs?

Yes	37	26.2%
No	104	73.8%

If you have had challenges accessing daycare/headstart programs, please rate the following issues: 1 equals <u>No Problem</u> and 10 equals <u>Serious Problem</u>.

		% with scores above 5
Transportation:	**2.4**	15.7%
Cost:	**3.3**	22.8%
Work Schedule Conflicts:	**3.2**	21.7%
Location of services:	**2.8**	19.3%

Waiting list: *(too many children needing services)*	**3.4**	24.0%
Program would not accommodate foster child's special needs:	**3.5**	26.0%

Knowledge/Training About Child Development

How confident are you about your knowledge on child development? Rate your response where 1 equals Not Confident and 10 equals Very Confident.

8.2

How did you learn what you know about child development? *(Check all that apply)*

I've never learned about child development	0	
I have children of my own	188	72.6%
I have professional experience with children	136	52.5%
I have formal education on child development	129	49.8%
I have attended training on child development	227	87.6%
Information from my caseworker	126	48.6%
Other:	69	26.6%

Other responses

- Books, articles
- School
- Information from the internet
- Various organizations that give seminars
- Experience with children
- Experience as foster parent
- Support groups
- Doctor visits/medical training

Have you received training on:

	Yes		No	
a) Developmental Stages	220	**85.3%**	38	**14.7%**
b) The early warning signs of childhood disabilities (e.g. Autism, ADHD…)	183	**70.9%**	75	**29.1%**
c) The benefits of the daycare/headstart/preschool setting.	129	**51.0%**	124	**49.0%**

Please tell us what improvements could be made to address the developmental needs of young foster children in the child welfare system?

Background Information:

What best describes your marital status?

Single	22	8.5%
Married	212	81.5%
Divorced	13	5.0%
Separated	2	0.8%
Widowed	3	1.2%
Committed Partnership	8	3.1%

How many other adults are available to help with the care of the foster children?

Number of adults available ranged from 0-12 with an average of 1.7

Adults available	#	%
0	31	12.1%
1	132	51.4%
2	42	16.3%
3-4	39	15.2%
5-6	9	3.5%
7-12	4	1.6%

How many biological and/or adoptive children under 18 live with your family?

` Number of biological and/or adoptive children ranged from 0-7 with an average of 1.6

Bio or adoptive children	#	%
0	70	27.0%
1	65	25.1%
2	66	25.5%
3-4	46	17.8%
5-7	12	4.6%

Please indicate which best describes the employment status of the primary foster parent(s)

	Foster Parent 1		Foster Parent 2	
I work full time at home	41	14.7%	36	14.8%
I work full time out of home	100	35.9%	142	58.7%
I work part time at home	11	3.9%	13	5.4%

I work part time out of home	27	9.7%	19	7.9%
I am a student	5	1.8%	5	2.1%
I am unemployed, looking for work	1	0.3%	3	1.2%
I am a stay at home parent	81	29.1%	13	5.4%
I am retired	12	5%	12	5.0%

Indicate which best describes the highest level of education completed by the primary foster parent(s)

	Foster Parent 1		**Foster Parent 2**	
8th grade or less	2	0.8%	5	2.2%
Some high school, didn't graduate	7	2.7%	7	3.2%
High school graduate or GED	52	20.0%	40	18.1%
Some college or 2yr degree	102	39.2%	83	37.6%
4 year college degree	43	16.5%	49	22.2%
More than 4 year college degree	50	19.2%	35	15.8%
Other _____	4	1.5%	2	0.9%

Which of the following best describes your racial/ethnic background? (check all that apply):

	Foster Parent 1		**Foster Parent 2**	
Caucasian/White	199	78.7%	175	80.6%
African American/Black	7	2.8%	4	1.8%
Native American/American Indian	4	1.6%	4	1.8%
Hispanic/Latin	35	13.8%	30	13.8%
Asian	2	0.8%	1	0.5%
Multi-racial	5	2.0%	3	1.4%
Other, please specify:	1	0.4%		

Please indicate which best describes the foster family's total income from all sources: (circle one response):

Less than $10,000	3	1.3%
10,000 to 19, 999	8	3.3%
20,000 to 29,999	18	7.5%
30,000 to 39,999	37	15.5%
40,000 to 49,999	33	13.8%
50,000 to 59,999	29	12.1%
60,000 to 69,999	24	10.0%
70,000 to 100,000	41	17.2%
over 100,000	46	19.2%

Appendix 3: Caseworker Survey Instrument and Frequencies (See Section III of this report for a description of our methodology.)

Survey Data

What County(ies) does your agency serve?

Adams	27	9.8%
Alamosa	7	2.5%
Arapahoe	16	5.8%
Archuleta	0	0.0%
Baca	0	0.0%
Bent	0	0.0%
Broomfield	3	1.1%
Chafee	0	0.0%
Cheyenne	1	0.4%
Clear Creek	0	0.0%
Conejos	2	0.7%
Costilla	0	0.0%
Crowley	1	0.4%
Custer	1	0.4%
Delta	5	1.8%
Delores	1	0.4%
Denver	47	17.0%
Douglas	1	0.4%
Duray	1	0.4%
Eagle	6	2.2%
Elbert	0	0.0%
El Paso	12	4.3%
Fremont	0	0.0%
Garfield	6	2.2%
Gilpin	1	0.4%
Grand	2	0.7%
Gunnison	1	0.4%
Hinsdale	1	0.4%
Huerfano	3	1.1%
Jackson	0	0.0%
Jefferson	8	2.9%
Kiowa	0	0.0%
Kit Carson	2	0.7%
Lake	0	0.0%
La Plata	6	2.2%
Larimer	28	10.1%
Las Animas	0	0.0%

Lincoln	4	1.4%
Logan	6	2.2%
Mesa	6	2.2%
Mineral	1	0.4%
Moffatt	0	0.0%
Montezuma	6	2.2%
Montrose	3	1.1%
Morgan	10	3.6%
Otero	3	1.1%
Ouray	0	0.0%
Park	1	0.4%
Phillips	0	0.0%
Pitkin	1	0.4%
Prowers	6	2.2%
Pueblo	29	10.5%
Rio Blanco	2	0.7%
Rio Grande	2	0.7%
Routt	1	0.4%
Saguache	1	0.4%
San Juan	1	0.4%
San Miguel	1	0.4%
Sedgwick	0	0.0%
Summit	1	0.4%
Teller	3	1.1%
Washington	1	0.4%
Weld	10	3.6%
Yuma	1	0.4%

What is your current position?

Supervisors	12.1%
Caseworkers	87.9%

Do you work for a private or public agency?[36]

Public agency	264	96.0%
Private agency	11	4.0%

What are your responsibilities in your job? (check all that apply)

Intake work	138	50.2%
Expedited permanency planning	124	45.1%
"other work"	166	60.4%

[36] All of the following results are for caseworkers only.

How long have you been working in the child welfare field?

Less than 2 years	58	21.2%
2-5 years	72	26.3%
6-10 years	69	25.2%
More than 10 years	75	27.4%

How many families are currently on your caseload?

no families	7	2.6%
1-10 families	78	29.2%
11-20 families	149	55.8%
21-40 families	30	11.2%
40 families	3	1.1%

Typically, what percentage of the children on your caseload are between the ages of 0 and 5?

0-10% young children	35	12.9%
11-25% young children	53	19.5%
26-50% young children	89	32.7%
51-75% young children	63	23.2%
76-100% young children	32	11.8%

Please indicate whether you have received training on the following topics.

	Took Training when start job	Training mandatory	Took training since starting job	Training mandatory
Child Abuse and Neglect	**77.5%**	**76.4%**	**67.0%**	**63.0%**
	183/236	175/229	120/179	116/184
The role that child care/Head Start can play in a child's development	**39.1%**	**30.0%**	**49.3%**	**29.3%**
	86/220	57/190	105/213	53/181
How child abuse and neglect affects a child's development	**78.3%**	**72.3%**	**80.6%**	**57.4%**
	177/226	159/220	174/216	117/204
Why early identification of a child's special needs is important	**61.2%**	**53.5%**	**70.1%**	**48.0%**
	134/219	114/213	157/224	95/198
Developmental	**70.7%**	**65.7%**	**72.1%**	**45.8%**

	Took Training when start job	Training mandatory	Took training since starting job	Training mandatory
milestones	159/225	136/207	158/219	88/192
How to identify a child's developmental delays	**41.7%**	**36.7%**	**61.1%**	**31.8%**
	91/218	72/196	143/234	62/195

	Took training at any point on…	Took no training on…
Child Abuse and Neglect	**81.2%**	**18.8%**
	224/276	52/276
The role that child care/Head Start can play in a child's development	**53.6%**	**46.4%**
	148/276	128/276
How child abuse and neglect affects a child's development	**84.8%**	**15.2%**
	234/276	42/276
Why early identification of a child's special needs is important	**76.4%**	**23.6%**
	211/276	65/276
Developmental milestones	**81.2%**	**18.8%**
	224/276	52/276
How to identify a child's developmental delays	**67.0%**	**33.0%**
	185/276	91/276

Were you provided any information from your job on… ***(check all that apply)***

Early Head Start	96	38.4%
Head Start	143	57.2%
CO Preschool Program	69	27.6%
child care or day care in general	168	67.2%

Which of the following agencies provided any information on how they could provide early intervention or special educational services?

Early childhood connections/ Part C services	124	48.2%
Child Find	97	37.7%
Local Child Development Clinics	139	54.1%
Medical providers	65	25.3%

When do you assess the development of a child on your caseload?

Automatically assess the development of a child when child comes onto their caseload 174 64.7%
When a foster parent or other guardian asks them to
46 17.1%
When they notice something is wrong or some skills are delayed
106 39.4%
When a court orders it
27 10.0%
Don't assess a child's development
7 2.6%
Not part of my job
14 5.2%

How do you <u>initially</u> assess the development of a child who comes onto your caseload?

Use knowledge of child development
183 68.0%
Use a screening tool
12 4.5%
Refer to a professional who can assess their development
52 19.3%
Refer children to an professional because my agency has that as a policy
8 3.0%
Don't refer children
3 1.1%
It is not part of my job
7 2.6%

What tool? **ASQ, Denver**

How do you conduct <u>ongoing</u> assessments of children not eligible for early intervention services?

Use knowledge of child development
121 45.0%
Use a screening tool
7 2.6%
Refer to a professional who can assess their development
97 36.1%
Refer children to an professional because my agency has that as a policy
5 1.9%

Don't refer children
7 2.6%
It is not part of my job
29 10.8%

What tool? **ASQ, Denver**

When there is a need to refer a child for developmental concerns, whom would you refer them to?

Early childhood connections/ Part C services	150	72.8%
Child Find	177	79.7%
Local Child Development Clinics/Hospital	145	70.7%
Medical providers	181	81.2%

Generally, how long do they take to assess the child?

	Less than 1 mo	1 mo	2 mo	3 mo	4-6 mo	6 mo +
Early Childhood Connection	42 / 30.2%	49 / 35.3%	38 / 27.3%	7 / 5.0%	3 / 2.2%	0 / 0.0%
Child Find	49 / 29.5%	48 / 28.9%	42 / 25.3%	16 / 9.6%	9 / 5.4%	2 / 1.2%
local Child Development Clinics	49 / 36.6%	35 / 26.1%	28 / 20.9%	15 / 11.2%	5 / 3.7%	2 / 1.5%
Medical Providers	92 / 55.8%	40 / 24.2%	18 / 10.9%	7 / 4.2%	6 / 3.6%	2 / 1.2%

How are you informed of the results?

	Get report automatically	Have to call for report	Not informed
Early Childhood Connection	56 37.8%	62 41.9%	30 20.3%
Child Find	66 40.5%	66 40.5%	31 19.0%
local Child Development Clinics	55 39.6%	71 51.1%	13 9.4%
Medical Providers	28 16.6%	120 71.0%	21 12.4%

Who do you think has the <u>primary</u> responsibility for identifying the developmental needs of the child? ***(Just check one)***

Foster Parent/ Biological Parent	127	47.0%
Pediatrician/Medical provider	63	23.3%
Caseworker	53	19.6%
Early Intervention Coordinator	21	7.8%

Child or day care teacher	6	2.2%
GALS/CASA	0	0.0%

Have any of the 0-5 year old children on your caseload received early intervention or preschool special education services? (for example, physical therapy or speech therapy)

Yes	224	82.4%
No	32	11.8%
Don't Know	16	5.9%

Do you receive notices about IEP/IFSP meetings (Individual Education Plan or Individual Family Service Plan)?

Yes	160	71.7%
No	62	27.8%
Don't Know	1	0.4%

Do you attend IEP/IFSP meetings?

Do attend IEP/IFSP meetings	168	75.0%
Would like to but don't have time	11	4.9%
No, I am not told about them	26	11.6%
It is not my job	19	8.5%

If yes, how often do you attend?

Sometimes	32	23.7%
Almost every time	78	57.8%
Every time	25	18.5%

How do you perceive your role on these IEP/IFSP teams? (common responses listed below)

- To make referrals based on information
- To be an advocate for the child and the family
- To monitor services that are being delivered to the child
- To give the history, family background and family dynamics as they might affect services
- To be a resource for the parent
- To gain knowledge about the child and the services they are receiving
- To coordinate services: "My presence makes sure we are collaborating to accomplish the same goal"
- "Only have a role if the foster parent feels I need to be there"
- "Depends on custody arrangement"
- "Don't get informed enough to have a defined role"

How would you rate your knowledge of early education programs like child care, day care, preschool, head start, etc?

Basic knowledge	128	47.1%
Pretty good knowledge	122	44.9%
Excellent knowledge	22	8.1%

Thinking about the children in your caseload who are <u>0 to 2 years old</u>, what percentage would you say are enrolled in a program like Early Head Start, family day care, day care or preschool?

None	49	18.4%
1-20%	109	40.8%
21-40%	36	13.5%
41-60%	27	10.1%
61-80%	9	3.4%
81-100%	20	7.5%
don't know	17	6.4%

Thinking about the children in your caseload who are <u>3 to 5 years old</u>, what percentage would you say are enrolled in a program like Head Start, family day care, day care or preschool?

None	10	3.7%
1-20%	67	24.6%
21-40%	65	23.9%
41-60%	49	18.0%
61-80%	36	13.2%
81-100%	27	9.9%
don't know	18	6.6%

Do you think all of the children in the child welfare system who might benefit from these programs have access to them?

"Yes", all of them do	93	34.3%
Children have <u>some</u> access to early childhood programs	96	35.4%
Children do not have access to early childhood programs	82	30.3%

Why? (common responses listed below)

Why Access to Early Education Programs is Limited

- Lack of knowledge about available programs on caseworker and parent's part
- Lack of funding
- Lack of space available in early education programs

- Lack of programs in rural areas and particular counties
- Lack of communication between caseworkers and foster parents
- Lack of comprehensive planning
- Lack of transportation
- Lengthy enrollment process
- Difficulty in getting all necessary paperwork from parents/guardians
- Referrals not made early enough
- Parents/guardians distrustful of child care

What is the <u>most common</u> reason that you refer a child to such a program (if they are not already enrolled when they come into your caseload)?

When there is a diagnosed special need	97
35.9%	
When a parent requests it	50
18.5%	
When there is a concern about the child's safety	35
13.0%	
For "Other reasons"	47
17.4%	
When the family needs coverage for work	23
8.5%	
Usually don't refer children to early education programs	15
5.6%	
Refer when a foster parent needs a break (respite)	3
1.1%	

"Other" responses (common responses listed below)

- When there are developmental delays in the child
- When it can provide support for the family
- To develop social and cognitive skills

Have you ever tried to place a child in a preschool, childcare or head start program and had a problem enrolling him or her?

Yes	103	38.1%
No	167	61.9%

Why? (common responses listed below)

Problems with Enrolling Children in Early Education

- Enrollment documentation hard to get (from parents/guardians)
- Child not eligible
- Program full/waiting list
- Parent doesn't follow through on referral/enrollment

- Paperwork from child welfare end takes too long
- Program wouldn't take child with significant behavioral or medical needs
- Hours of program don't match parent/guardian's employment
- Caseworker doesn't know how to apply

If a foster parent or a biological parent in family preservation was not employed, would you still consider placing the child in a child care or Head Start program?

Yes	253	93.7%
No	17	6.3%

Why? (common responses listed below)

- As a respite for parent
- For child's safety
- As a stimulating environment
- If a parent is mentally ill
- To provide positive attention
- For exposure to other children
- For socialization
- It is an environmental that can be monitored/assessed
- To get an early start on learning
- To provide a structured environment

Does your county use Special Circumstance Child Care Assistance funds to place children in child care?

County does use special circumstance child care assistance funds	224	83.6%
County does not use special circumstances child care assistance funds	5	1.9%
Don't know	39	14.6%

Is it harder to access child care programs for children in foster care than for children who live with their biological parents and are part of the family preservation program?

Equally hard for both groups	177	70.5%
Harder to access child care for children who live with their foster parents	48	19.1%
Harder to access child care for children who are in a family preservation program	26	10.4%

Do you or any one else in your agency provide the foster parent with information for them to assess the child's development?

Yes	190	71.4%
No	25	9.4%
Don't know	51	19.2%

What type of information on child development is given to parents?

Give foster parent a brochure or handout on child development	116 45.0%
Actually talk to foster parent about child development	80 31.0%
Give no information	19 7.4%
Do something else	43 16.7%

Thinking about your caseload of children 0-5 years old, typically which of the following people or agencies do you communicate with and coordinate with?

	Daily/weekly	**Monthly**	**Less than monthly**	**Never**
Early intervention coordinator	14 5.8%	69 28.6%	95 39.4%	63 26.1%
Mental health specialist	78 30.5%	138 53.9%	25 9.8%	15 5.9%
Early education teacher	29 11.4%	119 46.7%	74 29.0%	33 12.9%
Foster parent	167 63.7%	83 31.7%	7 2.7%	5 1.9%
Biological parent	178 68.2%	64 24.5%	6 2.3%	13 5.0%
Medical provider	30 11.5%	102 39.2%	109 41.9%	19 7.3%
CASA	22 9.2%	110 46.2%	46 19.3%	60 25.2%
GAL	61 23.5%	149 57.3%	40 15.4%	10 3.8%

If there was one thing you would change to better address the developmental needs of children 0-5 in the child welfare system, what would it be? (common responses listed below)

- Streamline referral process
- More and better training for caseworkers and foster parents
- Provide assessment instruments

- Increase parent's awareness of their role in the child's development
- More standardized system
- Availability of services in "remote" areas
- Refer all children who come into contact with DSS automatically to early intervention
- Provide information about milestones to caseworkers
- Automated system of screening and referral upon intake
- Provide tools for caseworkers to use with parents about early intervention, development, early education, etc. (perhaps a flowchart). Clearly distinguish the services available to each age group.
- Make access to initial evaluations easier
- Additional money for special circumstances child care
- Have someone on staff to do child assessments
- Improve coordination between child protection agency and local agencies that address early intervention
- More funding for transportation to services

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This research was made possible by Grant # 90YE0076, from the Office of Planning, Research and Evaluation, Administration for Children and Families in the U.S. Department of Health and Human Services.

ISBN13: 978-0-9708327-5-7