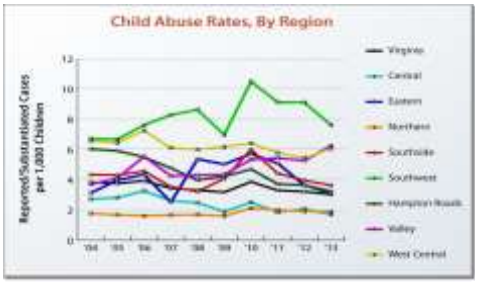
The Decision Tree

Child Indicator Seeds for Success

Serving Virginia's Most Fragile Children

I was reviewing an IFSP today that took me straight to my computer to investigate the occurrence of child abuse and neglect in Virginia. The IFSP follows in the test your inter-rater reliability section (identifying information altered) but here is what I found in my heavy-hearted investigation.

- **In Virginia, a child is abused or neglected every 75 minutes, and every 14 days a child dies from such mistreatment.** The immediate impact of abuse or neglect on a child is tragic, but so, too, are the long-term consequences -- affecting children, their communities, and the Commonwealth as a whole. Child abuse is often hidden, may occur over time, and is usually preventable. (VaPerforms)
- Data from the Virginia Department of Social Services (DSS) shows that in 2013 51,346 Virginia children were reported as possible victims of abuse and neglect. 6,205 of these were founded reports, meaning that a review of the facts gathered during an investigation met the standard of evidence required in Virginia. **Thirty percent of the children experiencing maltreatment were under the age of 4,** and 73 percent were under the age of 12. The most common type of abuse was neglect -- a failure to provide adequate food, shelter, clothing, or supervision. Sixty-seven percent of Virginia's child abuse victims in 2013 were white; the remainder were black (34%) or Asian (1%). (VaPerforms)
- The Central region had the lowest rate of child maltreatment in 2013 at 1.7 substantiated cases per 1,000 children. The Southwest and Valley regions had the highest rates, with 7.6 and 6.3 cases, respectively. (VaPerforms)



- Child abuse and neglect are not confined to any particular socioeconomic class, race or ethnicity, or religion. **Children younger than 4 are at the greatest risk of severe injury or death.**
- There are a number of situations that place children at particular risk for being abused or neglected, including:
  - Parents who were themselves abused as children
  - Parental depression, stress, or other mental health problems
  - Parents who lack knowledge of child development and children's needs
  - Lack of caregiver support for dealing with children with disabilities or developmental delays
  - Teenage parents
  - Parental or family substance abuse
  - Unemployment and poverty
  - Community violence
  - Family isolation
  - Family violence, such as intimate partner violence
- While physical injuries may or may not be immediately visible, abuse and neglect can have consequences for children, families, and society that last lifetimes, if not generations. The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioral, and societal consequences. In reality, however, it is impossible to separate them completely. Physical consequences (such as damage to a child's growing brain) can have psychological implications (cognitive delays or emotional difficulties, for example).
- Nationally child abuse and neglect affects over 1 million children every year. Child abuse and neglect costs our nation $220 million every day: for investigations, foster care, medical and mental health treatment, special education, juvenile and adult crime, chronic health problems, and other costs across the life span. In 2012, the estimated cost to address child abuse was a staggering $80 BILLION.
- While child abuse and neglect affects us all fiscally, the emotional impact it has on those directly impacted in the care of a child including social services, foster families and early interventionist must also be acknowledged.

Test Your Inter-rater Reliability

Our state's focus on child indicator ratings has led many to wonder, "Are we all rating children similarly?"

As part of our efforts to improve results for children, we will be focusing each month on increasing our statewide inter-rater reliability. We will be using examples of narratives from around the state that ideally will include observations of functional behaviors, parent/caregiver input, results from assessment tools and informed clinical opinion. Below is an example of a narrative from a recent Assessment for Service Planning. Using the limited information provided in the narrative and the process outlined in the child Indicator Booklet talk thru the scenario with your colleagues to determine a rating. The ratings given by the assessment team can be found at the end.

Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family? **Did the narrative contain jargon?**
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Mark's Age: 4 months Adjusted Age: NA

Referral Information, Medical History, Health Status: Mark is a 4-month old boy who was referred to E.I. by Cloudy County DSS after he suffered a broken femur and six broken ribs from alleged abuse by his uncle. Prior to his injuries, he spent 2 months in Sunnyside Medical Center NICU due to prenatal drug exposure and complications from withdrawal. Since being in foster care, the femur and ribs have healed and Mark appears healthy.

Daily Activities and Routines: Mark presently lives in a foster home with foster parents, his biological sister and another foster baby. His foster mother stays home with him and the other children most days. They have bi-weekly visits with Mark's biological family and the other foster child's family members. The family attends church on Sunday afternoons and Wednesday evenings. They also spend time with extended family members. Foster mother reports that Mark fights sleep very badly. She states that he has to be swaddled up tightly and patted on the bottom quite harshly to fall asleep. She states he sleeps all night normally and really only cat naps during the day. She reports he sleeps very lightly and they have to be very quiet in order not to wake him.

Family Concerns: Foster mom is most concerned with the way Mark holds his head constantly to the right. She also has concerns that he is not reaching for toys or grabbing them.

Family Priorities: Foster mother wants Mark to get the assistance he needs in order to be age appropriate in his development.

Developmental Levels: Cognitive- 4 months Gross Motor- 3 months Fine Motor- 2 months Receptive Language- 4 monthsExpressive Language- 4 months Social/Emotional- 3 months Adaptive/Self Help- 3 months

Social/Emotional Skills including Positive Social Relationships: Mark's foster mother reports that he seems to be more alert in new surroundings like church or the store, and he will look around a lot more there than he does

at home. Mark has been observed during assessment as a very social baby. He smiles and coos when spoken to. He will also chuckle when tickled.
Foster mother indicates, however, that Mark seems to have a difficult time self regulating and needs a lot of external support to calm himself and get himself to sleep. She reports when he wakes up in his bed, he will lay quietly for awhile. However, if he sees a caregiver, he then begins to cry.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Mark is beginning to pay more attention to objects and people. He will watch his own hands and will follow a moving toy. However, the PT noted during the assessment that he will not turn his head as far to the left or hold the position as long as he does to the right. She also noted he will not reach toward toys as much and is still using more of a reflexive grip instead of using a purposeful grasp.
Foster mother reports he definitely shows recognition for caregivers and will turn his head toward a voice. She also states he gets excited when he sees the bottle and begins to kick his legs.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Although Mark performs many age-appropriate skills, it has been noted that it is the quality of his skills that are a concern. For example, while on his tummy, he holds his head well above the floor. However, the PT noted that he is arching his neck back in an extension position that is characteristic of NAS babies. Also, if he holds a toy, it is reflexive and with a clenched fist. He holds his hands fisted often as well. Foster mother reports he does not attempt to place his hands on the bottle during feeding. She also states he has the same weak cry for everything making it hard to know what he needs.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:

Social/Emotional Skills including Positive Social Relationships: Rating 5- Mark shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

Acquiring and Using Knowledge and Skills, including early language/communication: Rating 5- Mark shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

Use of Appropriate Behaviors to Meet Needs: Rating 5- Mark shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

Determining the indicator ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three indicator areas.

Be sure to check out the new updates in the Practice Manual regarding Eligibility Determination for children with:

Toxic exposure, in utero to include fetal alcohol syndrome, drug withdrawal, and others (anticonvulsants, anticoagulants): In these cases there must be medical documentation that the baby was affected by prenatal toxic exposure. This category includes, but is not limited to, Fetal Alcohol Spectrum Disorders; Neonatal Abstinence Syndrome; symptoms of withdrawal; and evidence of "effects" of toxic exposure such as irritability, difficulties with self-soothing, and/or rigid or flaccid muscle tone.

Additional information about effects of toxic exposure can be found at http://aia.berkeley.edu/media/roundup/Effects%20of%20Prenatal%20Substance%20Exposure%20on%20Children.pdf