Report on Children with Disabilities Served by the Child Welfare System

Department of Children and Families

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Executive Summary

As required by 2015 Wisconsin Act 365, this report presents the plan developed by the Department of Children and Families (DCF) for identifying and addressing areas in which there are needs for improvement in the practices used to investigate reports of suspected or threatened abuse or neglect of a child with a disability. Consistent with the Act 365 requirements for the plan's development, DCF established a broad-based workgroup composed of key stakeholders with experience and expertise in the child welfare system and/or with children with disabilities. The workgroup held monthly meetings, open to the public, from June through December 2016.

Disability is defined by Wisconsin Statute Chapters 106 and 115 as a "physical or mental impairment that substantially limits one or more major life activities, a record of having such an impairment or being regarded as having such an impairment. This includes but is not limited to cognitive disabilities, hearing impairments, speech or language impairments, visual impairment, emotional behavioral disabilities, orthopedic impairments, Autism, traumatic brain injuries, other health impairments and learning disabilities."

Children with disabilities are at higher risk of child abuse and neglect than their peers. Risk factors faced by children with disabilities and their families that are not experienced by other families could include one or more of the following:

- Lack of services or supports to meet fully the child's unique needs, thereby placing demands and stress on the child's parents;
- Inadequate supports to alleviate the demands on parents or other caregivers while ensuring a safe environment for children with disabilities;
- Financial burden and stress on the family due to the cost of meeting the child's unique needs, which may not be fully covered by other funding sources, such as health insurance;
- Increased risk of social isolation for the child or family due to lack of respite care or in-home supports and due to other families not being comfortable with or interested in socializing with the child and/or family;
- Heightened dependence on paid and/or informal caregivers for the child's care, including intimate personal care, creating potential opportunities for abuse;
- Possible lack of ability by the child to protect him/herself from maltreatment;
- Increased risk of the child being targeted for abuse by some maltreaters due to child's more limited ability to self-protect or self-advocate;
- Due to the heavy emphasis on teaching children with disabilities to be compliant in general, the child may be unwilling or reluctant to communicate maltreatment because he/she will appear non-compliant; and
- Perception that child may not be viewed as credible by law enforcement or other professionals may inhibit individuals from reporting possible child maltreatment.

Scope and Experience of Children with Disabilities in the Child Welfare System

National research has found that accurate, reliable national data on the incidence of children with disabilities in the child welfare system are not available. Child welfare practitioners and researchers consider the federal child welfare disability data to be unreliable because (1) states are not required to collect this data and (2) reporting relies on child welfare workers who may not be trained to identify or assess, or may not document, that a child has a disability. To gain a more accurate and comprehensive projection of the scope of children with disabilities in Wisconsin's child welfare system, under the direction of the workgroup, DCF staff linked child welfare data with disability data from the Department of Public Instruction (DPI) K-12 system and the Department of Health Services (DHS) Medicaid data for calendar years 2013-14. Key findings from the analyses of the combined data are:

- Within the matched data set, DCF data alone reported 12% of children in the child welfare system have disabilities; DPI and/or DHS data reported an additional 25 % of children in the child welfare system have disabilities;
- Based on this finding, it appears that a significant proportion, approximately slightly over one-third, of children in the Wisconsin child welfare system have some type of disability;
- Children with disabilities are over-represented in the child welfare system compared to their representation in the general population;
- Children with disabilities involved in the child welfare system are more likely than children without disabilities to be involved in the more intensive stages of the child welfare system, such as out-of-home care placement; and
- Children with disabilities are more likely to have repeated contacts with the child welfare system than children without disabilities.

Current Strengths and Challenges in Responding to and Serving Children with Disabilities

To gather information on current strengths and challenges in serving children with disabilities, the workgroup reviewed current policies and practices and developed and administered a survey to child welfare workers throughout the state. Key findings are:

- Wisconsin child welfare workers are aware that a large proportion of children in the child welfare system have disabilities;
- The majority of Wisconsin child welfare workers felt somewhat, very, or extremely comfortable assessing children with disabilities;
- The Wisconsin child welfare system uses an analytic safety model that provides a robust framework for assessing and responding to safety of all children, including children with disabilities;
- Current child welfare training and standards have some, but limited, content regarding responding to and serving children with disabilities specifically; and

- Barriers experienced by child welfare workers include: (a) lack of sufficient disability-related resources for children and family, (b) variation in availability of resources across the state, and (c) lack of knowledge by the child welfare worker on how to access available resources.

Practices in Other States

In its review of other state practices, the workgroup found that a few states—Tennessee, California, Virginia—have developed specific training on responding to and serving children with disabilities in the child welfare system and a few jurisdictions—Oregon; Los Angeles County, CA; Vermont; and Texas—have developed specific standards on responding to and serving children with disabilities in the child welfare system.

Recommendations

The workgroup developed the following recommendations to more effectively and consistently respond to, engage, and serve children with disabilities and their families in Wisconsin's child welfare system. Preventing and responding to maltreatment of children with disabilities is a cross-system, community responsibility; as such, the child welfare system does not necessarily play the lead role in implementing each of the recommendations developed by the workgroup. Similarly, implementation of some of the recommendations is dependent on collaboration and support by other systems, such as the Medicaid and K-12 systems, with the child welfare system.

To prevent maltreatment of children with disabilities:

- Increase evidence-informed education to parents and professionals who work with children and families about the heightened risk of maltreatment for children with disabilities.
- Empower children with disabilities by increasing education and self-advocacy efforts regarding personal safety and boundaries.

To strengthen identification of disabilities, information gathering and assessment:

- Link appropriate DPI and DHS disability-related data, as determined through further collaboration among DCF, DPI, and DHS, into the child welfare eWiSACWIS information system to improve the integrity of the disability data in the child welfare information system and to provide timely and accurate information to child welfare workers regarding a child's disability.
- To help create a network of resources to support child welfare workers, provide child welfare workers access to information about individuals and organizations who can serve as resources to assist in effectively responding to and engaging with children with disabilities and their families by leveraging to the extent possible existing information and referral sources, such as the regional Children and Youth with Special Health Care Needs centers.

- Strengthen training for child welfare workers on best practices for effectively responding to, engaging, and serving children with disabilities.
- Update child welfare standards to incorporate best practices for effectively responding to, engaging, and serving children with disabilities.

To provide access to services for families who touch, but do not enter the child welfare system:

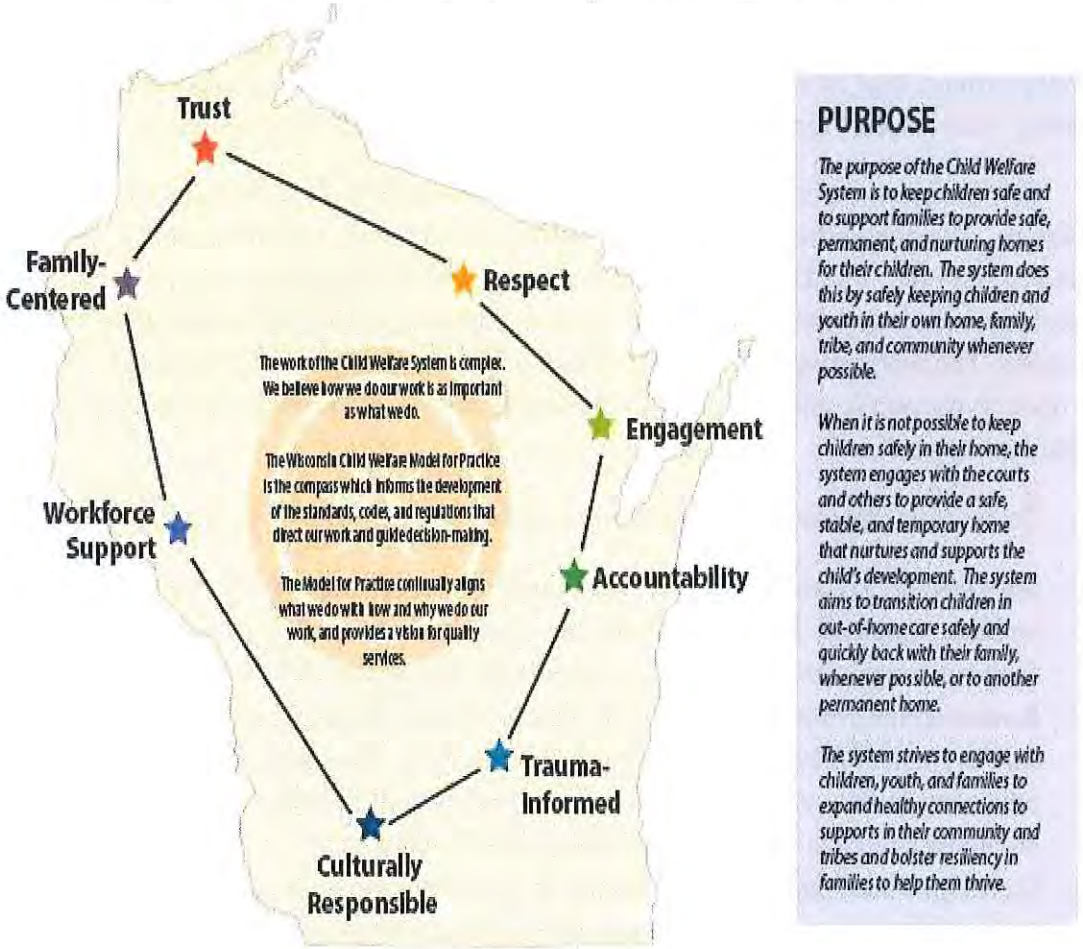
- Refer, via a "warm handoff" from the child welfare worker, all screened-out cases and cases closed after Initial Assessment involving a child with a disability to the county children's long term care unit or county children's mental health unit to link family to any appropriate, available services to help the family remain stable and help prevent maltreatment and involvement in the child welfare system in the future.
- Explore options for providing navigation assistance/care coordination through a system other than the child welfare system to screened-out families and families with cases closed after Initial Assessment to help these families navigate and access appropriate supports and services and remain stable and help prevent maltreatment and involvement in the child welfare system in the future.

Report on Children with Disabilities Served by the Child Welfare System

Introduction

The purpose of Wisconsin's child welfare system, as articulated in the Wisconsin Child Welfare Model for Practice, is to keep children safe and to support families to provide safe, permanent, and nurturing homes for their children. The system strives to engage with children, youth, and families to expand healthy connections to supports in their community and tribes and bolster resiliency in families to help them thrive. The following core values guide the work of the child welfare system: Trust, Respect, Engagement, Accountability, Trauma-informed Practices, Culturally-responsible Practices, Workforce Support, and Family-Centered Approaches. The Wisconsin Child Welfare Model for Practice serves as the compass that guides the work and decision-making in the child welfare system, including the focus area of this report: serving children with disabilities in the child welfare system.

Figure 1: Wisconsin's Child Welfare Model for Practice



Workgroup Formation and Process

In April 2016, state legislation was enacted, 2015 Wisconsin Act 365, which focused on the issue of children with disabilities in the child welfare system. Specifically, 2015 Wisconsin Act 365 requires the Department of Children and Families (DCF, or the Department) to develop and implement a plan for identifying and addressing areas in which there are needs for improvement in the practices used to investigate reports of suspected or threatened abuse or neglect of a child with a disability. In developing that plan, DCF is required to use an open public participation process. The full text of Act 365 is provided in Appendix A. This report constitutes the Department's plan.

Consistent with Act 365, DCF established a workgroup composed of a broad range of stakeholders with experience and expertise in the child welfare system and/or with children with disabilities. The workgroup was chaired by the DCF Administrator for the Division of Safety and Permanence and included representatives from the Department of Children and Families, the Department of Health Services (DHS), the Department of Justice (DOJ), the Department of Public Instruction (DPI), the Office of Children's Mental Health, the Child Abuse and Neglect Prevention Board, the Children's Court Improvement Project, Child Advocacy Centers (CAC), the state Mental Health Council, counties, Tribes, local law enforcement agencies, disability advocacy groups, deaf advocacy groups, parents of children with disabilities, and child care providers. A full list of the workgroup membership is included in Appendix B.

The charge to the workgroup was to strengthen child welfare services for children with disabilities. The charge included, but was deliberately broader, than the specific issue areas detailed in Act 365. The Department's intent was that the workgroup undertake the most comprehensive view possible of preventing and addressing child maltreatment for children with disabilities. The workgroup met on a monthly basis from June through December. All meetings were open to the public and followed open meeting laws. The workgroup meeting schedule is provided in Appendix C.

To carry out its charge, the workgroup undertook the following steps:

- Initiated and reviewed extensive data analyses based on data linkages between the child welfare, statewide K-12 education, and Medicaid information systems to understand the scope and experience of children with disabilities in the child welfare system;
- Reviewed information regarding the current child welfare system, children's long term care system, children's mental health system, K-12 special education system, child advocacy center system and law enforcement system in Wisconsin to understand the strengths and gaps in the current systems in Wisconsin;
- Developed and implemented a survey to child welfare workers throughout the state to gather information about the experiences and challenges of child welfare workers in their work with children with disabilities and their families; and

- Reviewed national research and practices in other states to identify best practices for responding to, engaging, and serving children with disabilities and their families.

As required by Act 365, for purposes of the workgroup and this report, disability is defined by Wisconsin Statute Chapters 106 and 115 as a "physical or mental impairment that substantially limits one or more major life activities, a record of having such an impairment or being regarded as having such an impairment. This includes but is not limited to cognitive disabilities, hearing impairments, speech or language impairments, visual impairment, emotional behavioral disabilities, orthopedic impairments, Autism, traumatic brain injuries, other health impairments and learning disabilities."

Risk of Maltreatment for Children with Disabilities

National research finds that certain factors increase the risk that a child experiences maltreatment (Goldman et al., 2003). It is important to note that these factors do not cause child maltreatment and the presence of one or more of these factors does not always result in child maltreatment. These risk factors include:

- Parent's experience of maltreatment as a child;
- Parent's negative attitude toward the child or lack of knowledge of child development;
- Parental substance abuse or mental health issues;
- Single parent households;
- Social isolation or lack of support; and
- Family violence or violence in the community.

In addition to the risk factors above, national research finds that children with disabilities face additional risk factors for child maltreatment (Child Welfare Information Gateway, 2012). As noted above, these factors do not cause child maltreatment and the presence of one or more of these factors does not always result in child maltreatment. The risk factors unique to children with disabilities include:

- Lack of services or supports to meet fully the child's unique needs, thereby placing demands and stress on the child's parents;
- Inadequate supports to alleviate the demands on parents or other caregivers while ensuring a safe environment for children with disabilities;
- Financial burden and stress on the family due to the cost of meeting the child's unique needs, which may not be fully covered by other funding sources, such as health insurance;
- Increased risk of social isolation for the child or family due to lack of respite care or in-home supports and due to other families not being comfortable with or interested in socializing with the child and/or family;

- Heightened dependence on paid and/or informal caregivers for the child's care, including intimate personal care, creating potential opportunities for abuse;
- Possible lack of ability by the child to protect him/herself from maltreatment;
- Increased risk of the child being targeted for abuse by some maltreaters due to child's more limited ability to self-protect or self-advocate;
- Due to the heavy emphasis on teaching children with disabilities to be compliant in general, the child may be unwilling or reluctant to communicate maltreatment because he/she will appear non-compliant; and
- Perception that child may not be viewed as credible by law enforcement or other professionals may inhibit individuals from reporting possible child maltreatment.

Data Analysis

In the interest of developing data-driven findings and recommendations, the workgroup sought data on the scope and experience of children with disabilities in the child welfare system. As described more fully below, accurate data are not currently available at the national or state levels. In response to this gap, the workgroup initiated a significant amount of original data analysis using multiple data sources.

National Data on Scope of Maltreatment of Children with Disabilities

National research has found that accurate, reliable data on the incidence of children with disabilities in the child welfare system are not available at the national or state levels (Child Welfare Information Gateway, 2012). Data reported by states through the National Child Abuse and Neglect Data System (NCANDS) to the federal Administration on Children and Families for federal fiscal year (FFY) 2013 indicates that 12.6% of children substantiated for abuse or neglect have a disability. However, disability rates reported by states vary widely from 1.1% in Alabama to 47.6% in South Carolina; and a number of states (CO, IA, LA, MI, NY, NC, ND, PA, VA) do not report any data. Wisconsin NCANDS data for FFY21013 indicates that 15.3% of children substantiated for maltreatment had a disability (USDHHS, 2015). Child welfare practitioners and researchers consider the NCANDS disability data to be unreliable and to represent an undercount of the true incidence of children with disabilities in the child welfare system for the following reasons: (a) states are not required to collect this data, (b) the data is based on reporting by the child welfare workers who may not be trained to identify or assess, or may not document, that a child has a disability, and (c) receipt of child welfare services is not contingent on assessment and documentation of a child's disability (Child Welfare Information Gateway, 2012).

Very few research studies have examined the incidence of children with disabilities in the child welfare system. A recent comprehensive review by Lightfoot (2014) of existing studies highlights the following two studies as the most thorough. Sullivan and Knutson (2000) completed a study in Nebraska in 2000, utilizing data from multiple systems (including the child

welfare, education and law enforcement systems), and found that 25% of maltreated children had a disability. The study also found that children with disabilities are 3.4 times more likely to be maltreated than children without disabilities. The second study is a 2012 meta-analysis by Jones et al. (2012) of 17 studies, which found that children with disabilities are 3.68 times more likely to experience maltreatment than their peers.

Analysis of Scope of Maltreatment of Children with Disabilities in Wisconsin

To gain more comprehensive and accurate information regarding the scope of children with disabilities in the Wisconsin child welfare system, DCF staff, in collaboration with staff from DPI and DHS, completed analyses linking DCF child welfare data with DPI K-12 educational data, and with DHS Medicaid data. DPI and DHS data on children's disability status is more reliable than DCF data because assessment and documentation of a disability is required before receiving disability-related services in these systems. Specifically, a child diagnosed with a disability per s.115.76 is eligible for an Individualized Education Plan (IEP) in the DPI system; and a child is eligible for certain types of Medicaid and long term care services in the DHS system, including the Children's Long Term Support (CLTS) program, Birth to Three, Katie Beckett Medicaid, and Supplemental Security Income (SSI) Medicaid, if the child meets the DHS disability criteria for these programs, as described below.

It is important to note that none of the three information systems includes comprehensive information on all children with disabilities. The limitations of the DCF information system were described above; limitations of the DPI and DHS data systems are:

- Because DPI data covers children in the K-12 public school system, children in private schools are not included in the DPI data system;
- DHS disability programs apply significantly more narrow eligibility criteria than the disability definition utilized by DPI and DCF; and
- There may be some children who meet the disability criteria in either the DPI or DHS systems but have not undergone an assessment and therefore are not documented as having a disability.

Wisconsin has a state-supervised, county-administered child welfare system in all counties other than Milwaukee, where the child welfare system is administered by the state through the DCF Division of Milwaukee Child Protective Services (DMCPS). County child welfare agencies and DMCPS carry out the child welfare functions described below. These child welfare functions are summarized in a flowchart format in Appendix D.

1. **Access Report**: A local child welfare agency receives a report of alleged child abuse and/or neglect from a member of the community. The child welfare worker assigned the report and the supervisor either (a) screens out the report, or (b) screens in the report. If screened in, the report is assigned an initial assessment.

2. **Initial Assessment (IA)**: When a CPS Report is screened-in, a child welfare worker conducts an assessment that includes a face-to-face visit(s) with the child, as well as interviews and information-gathering from other individuals, to determine whether the alleged maltreatment occurred (maltreatment finding) and whether the child is safe (safety decision).
3. **Substantiated Maltreatment:** The child welfare agency determines whether the maltreatment allegation is substantiated meaning there is a preponderance of evidence to support the allegation.
4. **Out-of-Home Care (OHC):** At any point during this process, if the local child welfare agency determines that the home environment threatens the child's immediate safety, subject to court approval the child may be removed from the home and placed in an Out-of-Home Care placement if it is not possible to put in place sufficient in-home supports to maintain the child safely at home. Children and youth may be placed into OHC due to concerns related to juvenile justice issues.

Children in at least one of the four subgroups above—Access, Initial Assessment, Substantiated Maltreatment, and Out-of-Home Care-- at some point in calendar years 2013 and 2014 were included in the data linkage project for this report.

For purposes of this report, data from the child welfare information system eWiSACWIS covering children aged 6 and older in the four child welfare stages described above (Access, Initial Assessment, Substantiation, and Out-of-Home Care) in calendar years 2013 and 2014 were matched with data in the DPI K-12 information system. Children who are assessed with a disability in the DPI K-12 system are enrolled in an Individualized Education Program (IEP); for this reason IEP status in the DPI data system is used as the indicator for the presence of a disability.

The same set of data from the child welfare system for calendar years 2013 and 2014 was also linked with data from the DHS Medicaid Management Information System encounter data. The DHS Medicaid information system indicates the presence of disabilities through two mechanisms: (1) identification of a disability during a screen used to collect information about functional status, as well as to determine eligibility for the CLTS waiver programs, and/or (2) enrollment to a Medicaid or long term care program that is contingent on a presence of a disability, including Supplemental Security Income (SSI) Medicaid, Birth to 3 program, and Katie Beckett Medicaid. A description of these programs is included in Appendix E. As noted above, the disability eligibility criteria for any of these DHS programs is significantly more narrow than the definition of disability applied in the DCF and DPI systems; for this reason, DHS disability data includes only children with the most complex needs.

Figure 2 below summarizes the results of the DCF/DPI/DHS data match. DCF data alone identifies 12% of the children in the child welfare system as having a disability (see yellow

box)[1] when considering as a group the child welfare population at the four stages listed above (Access, Initial Assessment, Substantiation, and Out-of-Home Care). By linking DCF and DPI data, the DPI K-12 data system identifies an additional 22% of school-aged children in the child welfare system as having a disability (see red boxes). By adding DHS data to the data linkage, DHS data identifies an additional 3% of children in the child welfare system as having a disability (see blue box). Linking the data from all three systems (DCF, DPI, and DHS) results in the finding that an estimated 37% of children in the child welfare system have a disability. It is noteworthy that the estimated scope using all three data sources is approximately 3 times higher than the rate documented in the child welfare system alone. A full description of the technical aspects of the data matching is included in Appendix F.

Figure 2: Interagency Comparison of Children with Documented Disabilities

DCF: Documented Disability	DHS: Documented Disability	DPI: Documented Disability			Total
		No	Yes	Subtotal	
No	No	11,131 **64%**	2,477 **14%**	13,608 **78%**	15,393 **88%**
	Yes	463 **3%**	1,322 **8%**	1,785 **10%**	
Yes	No	690 **4%**	526 **3%**	1,216 **7%**	2,065 **12%**
	Yes	166 **1%**	683 **4%**	849 **5%**	
Total		12,450 **71%**	5,008 **29%**	17,458 **100%**	

This finding has a number of important implications:

- Information in the child welfare system considerably understates the prevalence of children with disabilities served by the child welfare system; and
- A significant proportion, approximately slightly over one-third, of children in the child welfare system has a disability.

This analysis highlights that linking DPI and DHS data into the child welfare information system will result in more reliable disability status documentation in the child welfare information system and provide child welfare workers more accurate and timely information

[1] The discrepancy between 12% and the 15.3% reported to ACF can be attributed to (1) the population including all CPS reports, rather than only CPS reports that were substantiated for maltreatment, and (2) a different time period.

about a child's disability status. Immediate knowledge about a child's disability will enable the child welfare worker to draw on appropriate experts and resources, such as the IEP specialist, medical professionals, and family members, for consultation and guidance on how to most effectively respond to, engage, and serve a child with disabilities. Similarly, more timely and accurate information about a child's disability will enable the child welfare worker to identify and access appropriate resources, such as communication devices, interpreters, or interview settings that minimize sensory distractions, to engage more effectively with and gather information from a child with disabilities.

Prevalence of Children with Disabilities at Different Stages of the Child Welfare System

Further analysis was undertaken to understand the scope of children with disabilities at each stage of the child welfare system. DPI disability data is used for this analysis because it is the most comprehensive and reliable of the three data sources. As shown in Figure 3, the proportion of children with disabilities increases as the level of child welfare involvement deepens, with a report of alleged maltreatment at the Access stage being the least intrusive level of child welfare involvement and out-of-home care placement being the most intensive level of child welfare involvement.

Figure 3: Proportion of Children Aged 6 and Older with DPI Disability Diagnosis and IEP at Each Stage of the Child Welfare System: 2013-2014

Stage of Child Welfare System	
Access	24.8
Initial Assessment	26.4
Substantiated Maltreatment	27.3
Out-of-Home Care	36.9

Risk of Repeated Involvement in the Child Welfare System

Cases are screened-out or closed after Initial Assessment because the local child welfare agency determines that the family is currently safely caring for the child, and therefore is not in need of further child welfare involvement at the time. However, many of these families are facing stressors that cause their family stability to be fragile. These families are at risk of disruption or deterioration in their stability or the parent or caregiver's capacity which could trigger another contact with the child welfare system in the near future.

DCF child welfare data from 2011-14 was analyzed to assess the relative rate of repeat involvements with the child welfare system for child with and without disabilities. The analysis finds that children with disabilities in alleged maltreatment reports that were screened-out or closed after Initial Assessment are at higher risk of repeat involvements (i.e., re-referrals) with the child welfare system than children without disabilities. As shown in Figure 4, 43% of cases that are screened-out or closed after Initial Assessment that involve a child with a disability are re-referred to the child welfare system for a subsequent incident of alleged maltreatment within a

year. The rate of re-referrals for children with disabilities is close to twice the rate, 23%, of re-referrals for cases that are screened out or closed after Initial Assessment not involving a child with a disability. The high rate of re-referrals does not imply that the initial report should have been screened-in; rather the re-referral(s) may reflect changes in the family's stability or the child's heightened and vulnerable exposure to non-parental caregivers, which increase the risk for maltreatment as explained earlier.

While not in need of child welfare services at the time the case is screened-out or closed after Initial Assessment, many of these families would benefit from services and supports from other systems, such as the children's long term care or mental health system or specialized community-based services, that could help support and preserve their family stability and keep the children safe from maltreatment. Currently, counties have the discretion to refer families who are screened out or closed after Initial Assessment to other services. Families who are screened out or are closed after Initial Assessment are sometimes, but not always, referred to other services that could meet their needs, depending on the county. Systematic referral and assistance in accessing available services could help these families avoid future involvement in the child welfare system by maintaining their ability to provide safe, stable, and nurturing homes for their children.

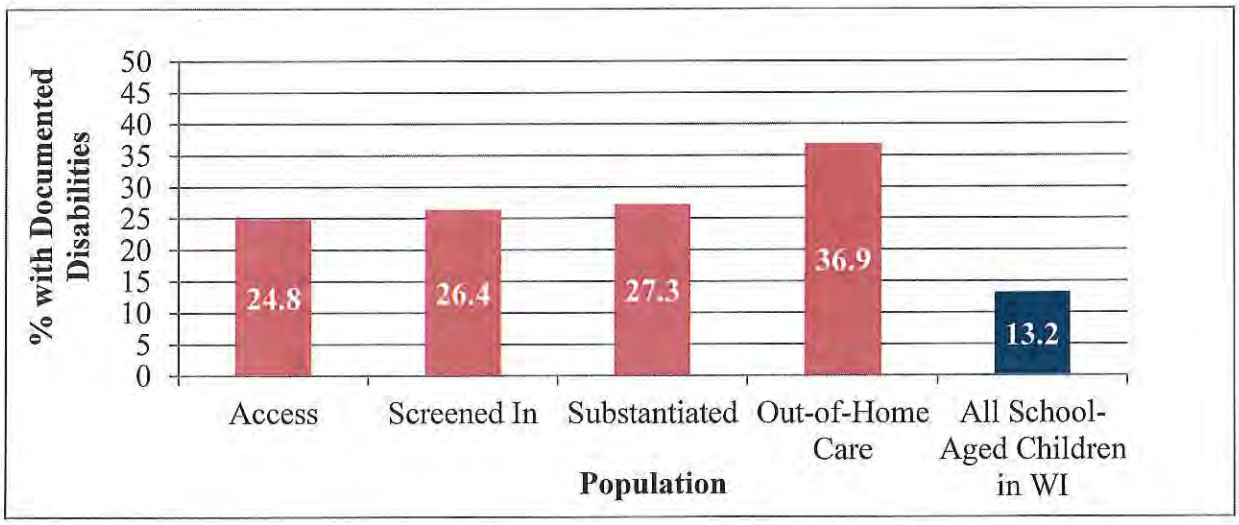
Figure 4: Children Re-Referred to the Child Welfare System, 2011-2014

Child Population: First Report (Since 2011)	Re-Referred within a Year		
	No Disability	Disability	Total
Screen-Out	18,548 **21%**	1,438 **46%**	19,986 **22%**
Screen-In/Closed After IA	18,531 **24%**	2,024 **41%**	20,555 **25%**
Sub-Total (Screened Out or Closed)	37,079 **23%**	3,462 **43%**	40,541 **23%**
Total (Any CPS Report)	40,733 **23%**	4,126 **42%**	44,859 **24%**

Over-Representation in the Child Welfare System

Children with disabilities are over-represented in the child welfare system compared to their representation in the general population. As shown in Figure 5, based on DPI and DCF linked data, children with documented disabilities in the DPI system account for approximately 37% of the Wisconsin child welfare population in out-of-home care; in contrast, children with a DPI documented disability account for only approximately 13% of the Wisconsin general school-aged population.

Figure 5: Children Aged 6 and Older with Documented Disabilities, 2013-2014



Current Strengths and Challenges in Wisconsin in Responding to Children with Disabilities

To understand the current strengths and challenges in Wisconsin in responding to and serving children with disabilities who may be maltreated, the workgroup (1) reviewed the current policies and practices of the systems that interact with children with disabilities who are reported for maltreatment and (2) with the assistance of the University of Wisconsin (UW)-Madison School of Social Work and the UW-Madison Survey Center, developed and administered a survey to all Wisconsin child welfare workers to gather information on their experiences and challenges in serving children with disabilities and their families.

Prevention Efforts

Preventing child maltreatment is a community-wide responsibility that involves all individuals and organizations in a community that interact with children and families. Workgroup members noted that there are few educational and public awareness efforts targeted to parents, other caregivers, and professionals who work with families with children with disabilities regarding the heightened risk of child maltreatment for children with disabilities. Expansion of evidence-informed education to parents and professionals who work with families of children with disabilities will help prevent maltreatment by heightening understanding of the increased vulnerability of children with disabilities. While it is not the child's responsibility to self-protect, another component of maltreatment prevention is empowering children with disabilities through the expansion of education and self-advocacy efforts that increase the awareness of children about personal safety and the importance of communicating with a parent or trusted adult if the child's personal safety or boundaries may have been violated. Education and self-advocacy are particularly important to nurture in children who have disabilities as they are often taught or directed to be compliant with adult directives and requests.

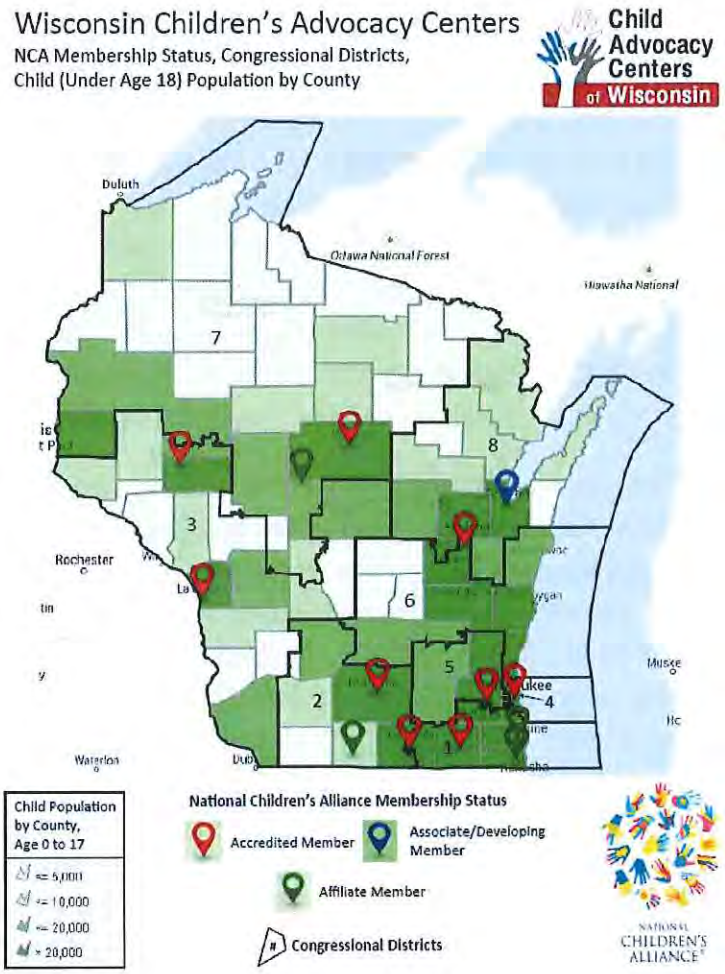
Identification, Information-gathering, Assessment, and Investigation

Child welfare workers throughout the state receive training from a centralized training system, the Wisconsin Child Welfare Professional Development System (WCWPDS). DCF contracts with the UW-Madison School of Social Work to administer the WCWPDS. All child welfare workers in Wisconsin are required to complete the standardized WCWPDS Pre-Service and Foundation training courses, and complete a specified number of hours of on-going training. The content of on-going training varies by the worker's role and responsibility within a local child welfare agency and is at the agency's, supervisor's and worker's discretion, based on his/her interest and needs. On-going training is met through a range of specialized courses offered by WCWPDS or certain other professional opportunities. Current WCWPDS Foundation training for child welfare workers has some, but limited and generalized content regarding responding to and serving children with disabilities, specifically.

All child welfare agencies throughout the state follow standards issued by DCF, which cover Safety Intervention, Access, Initial Assessment, and Ongoing Services and are available at: https://dcf.wisconsin.gov/cwportal/policy. The Wisconsin child welfare system uses an analytic safety assessment and decision-making model, based on a modified version of the national Action for Child Protection safety model. Wisconsin's safety model provides a robust framework for assessing safety of all children, including children with disabilities, by specifying Present and Impending Danger Threats, Child Vulnerability, and Parental Protective Capacities that the child welfare worker needs to consider. One of the Impending Danger Threats that a worker considers is: the child has exceptional needs which the parents/caregivers cannot or will not meet. Current standards require child welfare workers to gather and assess information regarding the child's functioning, including any disabilities, during the Initial Assessment stage; but have limited guidance regarding best practices, such as types of questions, for responding to and engaging children with disabilities specifically.

Child Advocacy Centers (CACs) play an important role, in partnership with child welfare and law enforcement, in the information-gathering and investigation stages of child maltreatment cases. A CAC is a child-friendly, safe place where children are evaluated when an allegation has been made regarding abuse, neglect, or exposure to violence. At CACs medical evaluations and forensic interviews are conducted by medical and other professionals with specialized training and extensive experience in child abuse and neglect and child interviewing techniques. CAC professionals use trauma-informed and child-friendly protocols that reflect the developmental level and any unique needs of each child. The information gathered by the CAC professionals is shared with and utilized by the multidisciplinary team involved in the child maltreatment case, including child welfare and law enforcement workers. Currently, CACs operate in some but not all parts of the state. Specifically, 14 Child Advocacy Centers operate in the locations shown on the map below. The Wisconsin CACs are part of the regional and national CAC associations, which provide training and technical assistance.

Figure 6: Map of Wisconsin Children's Advocacy Centers



The Department of Health Services administers five regional centers for Children and Youth with Special Health Care Needs (CYSHCN), which are dedicated to supporting families with children and youth with special health care needs and the professionals who serve them. The Centers are staffed by specialists who can connect the caller to community resources. The CYSHCN services are free and private. Knowledge and use of the regional CYSHCN centers is not widespread among child welfare workers.

Services for Children in the Child Welfare System

Consistent with federal law, the child welfare agency refers all children under the age of 3 who are substantiated to have been maltreated to the Birth to 3 Program, which is Wisconsin's federal Early Intervention program under Part C of the Individuals with Disabilities Education Act (IDEA). The Birth to 3 Program provides early intervention services for children

experiencing at least a 25% developmental delay. Birth to 3 is a voluntary program. Based on the DCF/DHS matched data population, Figure 7 shows that 17% of children aged 0-3 who are substantiated for neglect are enrolled in the Birth to 3 program. Key factors affecting the participation rate in Birth to 3 are the eligibility criteria and the voluntary nature of the program.

Figure 7: Substantiated Child Welfare Cases Enrolled in Wisconsin's Birth to 3 Program in 2013-14

Substantiated Children 0-3 Years Old	2,796
Substantiated Children 0-3 Years Old able to be matched with DHS data	2,076
Substantiated Children in DCF/DHS matched population enrolled in Birth to 3 Program	353
% of Children 0-3 Years Old enrolled in Birth to 3 program in DCF/DHS linked data set	**17.0%**

During the Ongoing Services stage, for children who enter out-of-home care, child welfare workers administer the Child and Adolescent Needs and Strengths (CANS) assessment, which is a national, validated assessment tool. The CANS captures information about the child's level of functioning and is used to help determine the services and placement setting that most effectively meets the child's needs, including disability-related needs.

In six counties in southwest Wisconsin (Milwaukee, Racine, Kenosha, Waukesha, Ozaukee, and Washington) children who are placed in out-of-home care are eligible for a specialized Medicaid program, called Care4Kids. Care4Kids provides coordinated, comprehensive health care in a way that is trauma-informed and meets the unique needs of children in out-of-home care. A care team develops an individualized care plan for each child that reflects the child's unique needs, including any disability-related needs, and provides care coordination to facilitate access to the services. Approximately 3,000 children are currently enrolled in Care4Kids.

Worker Survey

With the assistance of Dr. Kristi Slack and Yonah Drazen at the UW-Madison School of Social Work and the UW-Madison Survey Center, the workgroup developed and implemented a survey to collect information from child welfare workers on their experiences working with children with disabilities. The full summary of the survey is provided in Appendix G and the survey instrument is provided in Appendix H. The UW-Madison Survey Center sent the survey

to the 1945 child welfare workers in Wisconsin. Responses were received from 677 workers, for a response rate of 35%. Key findings are:

- Child welfare worker respondents were aware that a large proportion of children in the child welfare system have disabilities; on average, respondents estimated that 47% of children in the child welfare system have some type of disability. See Figure 8.
- 38-59% of respondents felt very or extremely comfortable identifying signs that indicate children may have a disability, with the rate varying with the type of disability. See Figure 8.
- 49-57% of respondents felt very or extremely comfortable assessing children with disabilities; another 32-36% reported feeling somewhat comfortable with safety assessment, with the rate varying with the type of disability. See Figure 8.
- Approximately half of respondents indicated they did not know ways to communicate, or know how to access resources to assist with communication with children who are non-verbal due to a disability or are deaf. See Figure 8.
- Approximately half of respondents indicated that for children with disabilities who need to be placed temporarily out of their home, there are usually or always barriers finding an out-of-home care setting and other services that match the needs of the child.
- Barriers experienced by respondents in engaging and serving children with disabilities include: (a) lack of sufficient disability-related resources for children and family; (b) variation in availability of resources across the state, with very limited available resources in small, rural counties; and (c) lack of knowledge by respondents about available resources.

Figure 8: Worker Survey Responses: Percent of Respondents Choosing Each Response (N=677)

	Comfortable Identifying Development Disabilities	Comfortable Identifying Physical Disabilities	Comfortable Identifying Mental illness	Comfortable Identifying sensory impairments	Comfortable assessing safety of children with Development Disabilities	Comfortable assessing safety of children with Physical Disabilities	Comfortable assessing safety of children with Mental illness	Comfortable assessing safety of children with sensory impairments
Not at all comfortable	2.7	1.5	2.7	4.1	2.8	2.7	2.8	3.2
A little comfortable	11.5	8.3	11.7	16.8	8	8.1	8.7	12
Somewhat comfortable	38.4	30.9	35.7	41.2	34.1	32.3	34.4	36
Very comfortable	36.9	45.6	38.6	29.4	43.1	44.5	42.1	38.7
Extremely comfortable	10.5	13.7	11.4	8.4	12	12.4	12	10

	You know resources available to children w/ disabilities in community	You know how to communicate/access resources to communicate w/ children who are non-verbal?	You know how to communicate/access resources to communicate w/ children who are deaf?	You know how to communicate/access resources to communicate w/ children who have other challenges
Strongly Disagree	4.3	12.4	17	9.6
Somewhat Disagree	15.4	35	35.6	32.5
Somewhat Agree	64.4	45	38.3	51.4
Strongly Agree	16	7.6	9.2	6.5
Observations	677	675	677	677

	Mean	Median	Min	Max	Count
In past month, what % of your cases involved a child who may have a disability?	47	50	0	100	597

Practices in Other States

As noted above, as part of its information-gathering, the workgroup reviewed practices in other states. A small number of states have adopted practices designed to strengthen the response and services of the child welfare system for children with disabilities. The following states have developed specialized training related to maltreatment of children with disabilities:

- Tennessee developed a training on interviewing children with disabilities: http://cacnd.com/images/Interviewing_Children_with_Disabilities.pdf
- California developed a curriculum for Law Enforcement First Responders and Child Protective Services Frontline Workers: http://www.disabilityandabuse.org/resources/child-abuse-victims-instructors-manual.pdf
- Virginia developed a three-part webinar series on recognizing and responding to abuse and neglect of children with disabilities: http://partnership.vcu.edu/tippingthescales/index.html

In general, these trainings cover: the disproportionate rate of maltreatment for children with disabilities; different types of disabilities; myths and biases about children with disabilities; and effective communication and interviewing strategies to be used with children with disabilities. Some states, particularly Virginia and California, have held cross-system trainings on this topic, including both child welfare workers and law enforcement officers.

With respect to child welfare standards, the following jurisdictions have issued practice guidelines for conducting investigations of child abuse and neglect cases involving children with disabilities:

- Oregon Interviewing Guidelines http://www.doj.state.or.us/victims/pdf/oregon_interviewing_guidelines.pdf
- Los Angeles Child Abuse and Neglect Protocol http://docplayer.net/9555513-Los-angeles-child-abuse-and-neglect-protocol.html
- Vermont Department for Children & Families – Child Safety Interventions http://dcf.vermont.gov/sites/dcf/files/FSD/Policies/52.pdf
- Texas: Investigation of Report of Child Abuse and Neglect http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.261.htm

Of these, the Oregon guidelines are the most thorough. The Oregon guidelines describe types of disabilities using the following framework:

- Communication Disabilities
- Intellectual Disabilities
- Social/Emotional Disabilities
- Physical Disabilities

The guidelines identify the types of disabilities that fall into each category (for example, autism is in the communication category; Down Syndrome is in the intellectual category, etc.) and provide strategies to utilize when interviewing children with each type of disability. The Oregon guidelines are based on the following principle: "The most important thing to remember when interviewing a child with disabilities is that the child is first and foremost a child; the disability should not define him. All children have strengths and limitations. Building on the child's strengths and making accommodations for limitations shows him/her respect and allows for the most successful interview."

A few other states, including Oklahoma, Illinois, and New York, are in the process of or are considering implementing new policies to improve how the child welfare system responds to and serves children with disabilities.

Additional resources identified by the workgroup related to best practice training or interviewing techniques are:

- Promoting Justice: An Essential Resource Guide for Responding to Abuse Against Children with Disabilities, published by Safe Place in Texas: http://www.ncdsv.org/SP_Promoting-Justice_2015.pdf

- US Dept. of Justice – Victims with Disabilities: The Forensic Interview: http://ojp.gov/ovc/publications/infores/pdftxt/VictimsGuideBook.pdf

Recommendations

In addition to the material already described, the workgroup took into account the following in the development of its recommendations:

- Children with disabilities are children first and are not defined by their disability.
- Approaches to responding to and serving children with disabilities need to be family-centered—a core value of both the children's long-term care system and the child welfare system
- Preventing and responding to maltreatment in children with disabilities is a cross-system, community-wide responsibility that involves all adults and organizations that interact with children and families. For this reason, the child welfare system does not necessarily play the lead role in implementing each of the recommendations developed by the workgroup. Similarly, implementation of some of the recommendations is dependent on collaboration and support by other systems, such as the Medicaid and K-12 systems, with the child welfare system.
- Child welfare workers do not have the clinical training and knowledge, and cannot be expected, to be experts in all types of disabilities. Rather, child welfare workers need to have timely access to disability-related experts and resources to assist and support them.
- Heavy demands are already placed on child welfare workers and workers in other systems serving children and families. The workgroup seeks to provide tools to facilitate the child welfare worker's functions.

Based on its work, the workgroup recommends the following:

To prevent maltreatment of children with disabilities:

- Increase evidence-informed education to parents and professionals who work with children and families about the heightened risk of maltreatment for children with disabilities.
- Empower children with disabilities by increasing education and self-advocacy efforts regarding personal safety and boundaries.

To strengthen identification of disabilities, information gathering and assessment

- Link appropriate DPI and DHS disability-related data, as determined through further collaboration among DCF, DPI, and DHS, into the child welfare eWiSACWIS information system to improve the integrity of the disability data in the child welfare information system and to provide timely and accurate information to child welfare workers regarding a child's disability.

- To help create a network of resources to support child welfare workers, provide child welfare workers access to information about individuals and organizations who can serve as resources to assist in effectively responding to and engaging with children with disabilities and their families by leveraging to the extent possible existing information and referral sources, such as the regional Children and Youth with Special Health Care Needs centers.
- Strengthen training for child welfare workers on best practices for effectively responding to, engaging, and serving children with disabilities. Consider best practice models in other states and consider including in the training the following elements:
    - How identification of a disability should influence information gathering
    - Developmental stages of children and baseline behaviors for common disabilities
    - Importance of evaluating the reporter and network of people as reliable sources of information about the child's disability and ways of communicating
    - Understanding of typical and atypical medical challenges of the individual (e.g., sensory sensitivities, food aversions)
    - Understanding behavioral patterns specific to the child
    - Inclusion of experiential and immersive components that involve people with disabilities
    - Discussion of common biases about children with disabilities and of caretaking skills of parents and/or caretakers with disabilities
- Update child welfare standards to incorporate best practices for effectively responding to, engaging, and serving children with disabilities. Consider best practice models in other states, particularly Oregon, including the following:
    - Lines of questioning that may help elicit additional information that is child-specific such as "how does the child (best) communicate?"
    - Reaching out to medical professionals and educators with history of interacting with the child to understand unique traits of the individual child
    - Reinforcing importance of collaboration and training with law enforcement
    - Using careful, concrete language
    - Using specialized forensic interviewing protocols
    - Providing accommodations, as required by the Americans for Disabilities Act

To provide access to services for families who touch, but do not enter the child welfare system:

- Refer, via a "warm handoff" from the child welfare worker, all screened-out cases and cases closed after Initial Assessment involving a child with a disability to the county children's long term care unit or county children's mental health unit to link family to any appropriate, available services to help the family remain stable and help prevent maltreatment and involvement in the child welfare system in the future.
- Explore options for providing navigation assistance/care coordination through a system other than the child welfare system to screened-out families and families with cases closed after Initial Assessment to help these families navigate and access appropriate

supports and services and remain stable and help prevent maltreatment and involvement in the child welfare system in the future.

Conclusion

The Department of Children and Families is committed to strengthening services for children with disabilities in the child welfare system and plans to implement, in collaboration with other involved systems and partners, the recommendations in this report. The Department thanks the members of the workgroup and the other partners who supported this work, including the UW-Madison School of Social Work and the UW-Madison Survey Center, for contributing their time, thought, and expertise to this project.

References

Child Welfare Information Gateway (2012). *The Risk and Prevention of Maltreatment of Children with Disabilties.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/focus.pdf

Goldman, J., Salus, M. K., Wolcott, D., & Kennedy, K. Y. (2003). *A coordinated response to child abuse and neglect: The foundation for practice.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect. Retrieved from http://www.childwelfare.gov/pubs/usermanuals/foundation

Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., et al. (2012). Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *Lancet, 380*(9845), 899-907.

Lightfoot, E. (2014). Children and Youth with Disabilities in the Child Welfare System: An Overview. *Child Welfare, 93*(2), 23-45.

Sullivan, P.M. & Knutson, J.F. (2000). Maltreatment and Disabilities: A Population-Based Epidemiological Study. *Child Abuse & Neglect, 24*(10), 1257-1273.

U.S. Department of Health and Human Services (USDHHS), Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2015). *Child Maltreatment 2013*. Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

APPENDIX A

2015 Wisconsin Act 365

2015 WISCONSIN ACT 365

AN ACT *to create* 48.981 (11) of the statutes; **relating to:** development and implementation of a plan for identifying and addressing areas in which there is a need for improvement in the practices used to investigate reports of abuse or neglect involving children with disabilities.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 48.981 (11) of the statutes is created to read:

48.981 **(11)** INVESTIGATIONS INVOLVING CHILDREN WITH DISABILITIES. (a) In this subsection, "child with a disability" means a child with a disability, as defined in s. 106.50 (1m) (g), including a child with a disability, as defined in s. 115.76 (5) (a).

(b) The department shall develop and implement a plan for identifying and addressing areas in which there is a need for improvement in the practices used to investigate reports of suspected or threatened abuse or neglect of a child with a disability. In developing that plan the department shall use an open public participation process that includes the input of representatives of law enforcement agencies, the department of health services, and other stakeholders that the department considers appropriate. On completion of the plan, the department shall post the plan on its Internet site and distribute copies of the plan to all agencies that conduct abuse and neglect investigations in this state. At a minimum, the department shall consider including in the plan all of the following:

1. A requirement that each agency, on receipt of a report of suspected or threatened abuse or neglect, ask the reporter whether the child who is the subject of the report is a child with a disability.

2. Procedures for agencies to use to identify and address any specific categories of disabilities that a child with a disability reported to the agency may have.

3. Procedures to ensure that each agency is in compliance with Part A of Title II of the Americans with Disabilities Act, 42 USC 12131 to 12134. Those procedures shall include reasonable modifications to the rules, policies, and practices of the agency, the removal of architectural, communication, and transportation barriers, and the provision of auxiliary aids and services as necessary to enable a person with a disability to receive the services or participate in the programs or activities provided by the agency.

4. Interviewing strategies tailored to the investigation of abuse or neglect reports involving children with disabilities that include forensic interviewing strategies for interviewing those children, including children with communication issues.

5. Information on how to access collateral information regarding a child with a disability.

6. Information on how to access specialized follow-up services for children with disabilities.

8. Plans for the training of agency staff in the implementation of the plan.

(c) The department shall take action on the plan under par. (b) by January 1, 2017. Each agency that conducts abuse and neglect investigations in this state shall adopt the plan by July 1, 2017, and shall provide a copy of the plan to all law enforcement agencies within the jurisdiction of the agency as well as to any other person on request.

APPENDIX B

Members of Workgroup on Children with Disabilities in the Child Welfare System

Chair: Fredi-Ellen Bove, Division of Safety and Permanence, DCF

Lead Staff: Erin Miess, Division of Safety and Permanence, DCF

Members:

1. Kristin Allen – Lac du Flambeau Tribe
2. Allison Budinkski – Division of Safety and Permanence, DCF
3. Kelly Bueschel, Division of Management Services, DCF
4. Wendy Coomer – Governor's Autism Council
5. Emily Erickson, Division of Safety and Permanence, DCF
6. Elizabeth Hecht – DHS Children's Long Term Support Council
7. Kelly Hodges, MD – Children's Hospital of Wisconsin/Child Advocacy Center
8. Chris Holmes – Penfield Children's Center
9. Mike Hipple – Wisconsin Augmentative Alternative Communication Network
10. Elizabeth Hudson – Office of Children's Mental Health,
11. Dan Idzikowski – Disability Rights Wisconsin,
12. Tamara Jackson – Board for People with Developmental Disabilities
13. Joanne Juhnke – Wisconsin Family Ties, Inc.
14. Megan Kenyon – Wisconsin Association of the Deaf
15. HeeJin Kim, Division of Safety and Permanence, DCF
16. Greg Leck – Wisconsin Chiefs of Police Association
17. Stacy Lenz – Department of Justice
18. Kris Moelter – Child Abuse and Neglect Prevention Board
19. Lonna Morouney, Secretary's Office, DCF
20. Brent Nelson – Child Welfare Professional Development System
21. Brent Oleson – Badger State Sheriff's Association
22. Deb Rathermel - Division of Long-Term Care, DHS
23. Lisa Roberts – Waukesha County Health and Human Services Department
24. Mark Ryskoski – Trempealeau County Department of Human Services
25. Teresa Steinmetz –Division of Care and Treatment Services, DHS
26. Alice Sykora – Former Executive Director, Deaf Unity
27. Michelle Urban , MD – Division of Milwaukee Child Protective Services, DCF
28. Barbara Van Haren – Department of Public Instruction
29. Michelle Zaccard – Children's Court Improvement Program

APPENDIX C

Meeting Schedule of Workgroup on Children with Disabilities in the Child Welfare System

Wednesday, June 7th, 2016, 12:30-4pm

Thursday, July 7th, 2016, 8:30am-12pm

Tuesday, August 9th, 2016, 12:30-4pm

Tuesday, September 6th, 2016, 12:30-4pm

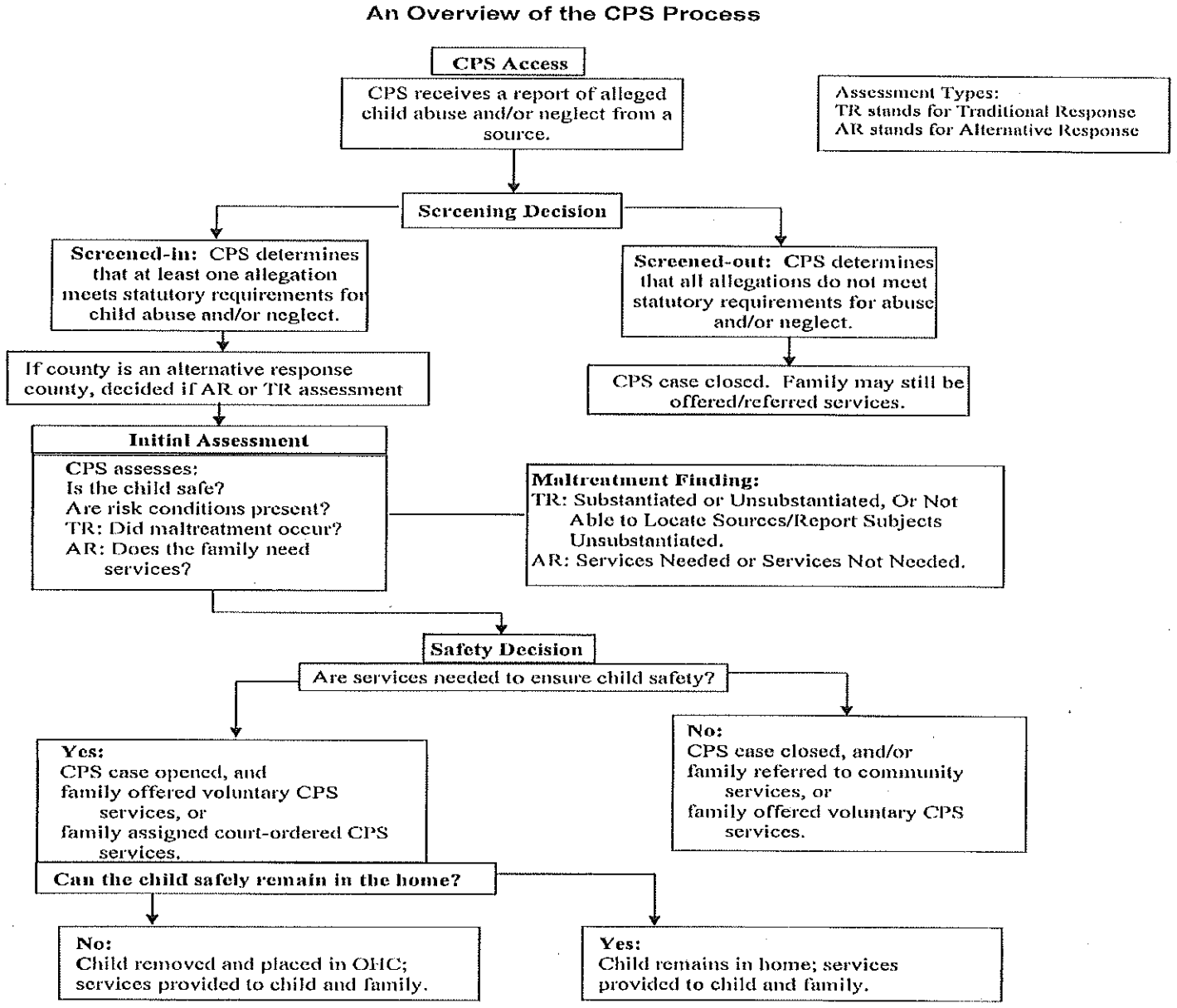
Wednesday, October 5th, 2016, 12:30-4pm

Monday, November 7th, 2016, 8:30am-12pm

Wednesday, December 14th, 2016, 12:30-4pm

APPENDIX D

Flowchart of Child Welfare System



APPENDIX E

Description of Wisconsin Medicaid and Long Term Care Programs for Children with Disabilities

Children's Long-Term Support Functional Screen (CLTS FS) —the CLTS FS identifies whether a child meets the institutional level of care criteria indicating that he or she is at risk of needing care in an institution. CLTS Functional Screen (CLTS FS) is used to determine functional eligibility for the CLTS Waiver Program, as well as five additional programs: Comprehensive Community Services, Community Recovery Services, Children's Community Options Program, Katie Beckett Program, and Mental Health Wrap Around. These programs require level of care in one or more target groups that classify the disability type:

- **Developmental Disability Target Group:** Children at risk of needing care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).
- **Physical Disability Target Group**
  - Physical Disability Hospital Level of Care Target Group: Children at risk of needing care in a hospital.
  - Physical Disability Nursing Home Level of Care Target Group: Children at risk of needing care in a nursing home.
- **Severe Emotional Disturbance/Disability (Mental Health) Target Group:** Children at risk of needing care in a psychiatric hospital.

In addition to the above three target groups, there is a specific indicator for a medical determination of disability as approved by the Disability Determination Bureau (DDB) and reviewed by the Social Security Administration (SSA). According to Wisconsin's DHS, "[f]or both SSA and State of Wisconsin benefit programs the definition of disability, as defined by the Social Security Act, is used... The definition of disability for children states that the child must have a physical or mental condition(s) that very seriously limits his or her activities; and the condition(s) must have lasted, or be expected to last, at least 12 months or result in death."[2] If a child has a disability according to DDB and SSA, then the child may be eligible for Supplemental Security Income (SSI) and/or the Katie Beckett Program (the latter of which also requires the child has a functional eligibility of institutional level of care, as determined by the CLTS FS).

- **DDB/SSA Indicator**

Enrollment—all of the following programs are contingent on the presence of a disability:

- **Supplemental Security Income Medicaid (SSIMA)**: a child must meet the medical disability determination criteria as indicated above by DDB

- **Birth to 3 Program**: a federal Early Intervention program under Part C of the Individuals with Disabilities Education Act (IDEA), this program evaluates a child's eligibility via a team consisting of a service coordinator and at least two professionals. Birth to 3 early intervention services are delivered to produce improved outcomes for the child, similar to their typically developing peers. As part of the transition to exit from the Birth to 3

[2] Retrieved from: https://www.dhs.wisconsin.gov/ddb/decisions.htm. Last Updated 11/2/2014

Program, the service coordinator evaluates if children are eligible for DPI's special education services (IDEA Part B), and if so, refers the child to his or her local educational agency (LEA) by age 3. According to Wisconsin's DHS, eligibility requirements include "a developmental delay of at least 25% in one area of development [that includes (1) cognitive, (2) physical/motor, (3) speech and language, (4) social and emotional, and (5) adaptive], a physician diagnosed condition with a high probability of developmental delay, or atypical (unusual) development that adversely affects your child's overall development."[3]

- **Blind/Visually Impaired**
- **Communication Delay**
- **Deaf/Hard of Hearing**
- **Developmental Disability – Autism Spectrum Disorder**
- **Developmental Disability – Brain Trauma**
- **Developmental Disability – Cerebral Palsy**
- **Developmental Disability – Epilepsy**
- **Developmental Disability – Mental Retardation**
- **Developmental Disability – Other or Unknown**
- **Physical Disability / Mobility Impairment**
- **Severe Emotional Disturbance**
- **Severe Health Impairments**

- **Children's Long-Term Support (CLTS) Waiver Program**: a Medicaid Home and Community-Based waiver program that offers a variety of supports and services to children with significant disabilities and their families in order for the child to remain in the home or other community setting; enrollment requires functional eligibility for an institutional Level of Care determination and Target Group designation. A child must be determined to have a heightened "level of care need that is "typically provided in an institutional setting such as a hospital, a nursing home, or an institution for people with developmental disabilities."[4] For the purposes of this analysis, children who are placed on the CLTS wait list are included, as they have been identified as having a disability
  - **Developmental Disability Target Group**
  - **Physical Disability Target Group**
  - **Severe Emotional Disturbance/ Mental Health Target Group**

- **Katie Beckett Program (KBP MA):** The Katie Beckett Program provides Medicaid coverage for children with significant disabilities, who require an institutional level of care. The functional eligibility criteria are the same as the CLTS Waiver Program.

- **Other Disabled Medicaid**: other Medicaid services/programs may be eligible for children who meet the DDB/SSA disability criteria, as defined above

[3] Retrieved from: https://www.dhs.wisconsin.gov/birth to3/family/qualify.htm Last Updated: 7/20/2016
[4] Retrieved from: https://www.dhs.wisconsin.gov/clts/waiver/family/eligibility.htm Last Updated: 2/23/2016

APPENDIX F

Technical Background on Data Linkage between DCF, DPI, and DHS Data

The purpose of this document is to describe in detail the business rules employed to exchange DCF data with DHS and DPI. All variable names are italicized.

Data Cleaning Business Rules

After importing and cleaning the Access, Initial Assessment (IA), and Placement Activity and Detail (PAD) annual reports for 2013 and 2014, a data set that captures the (1) Access, (2) IA, (3) Substantiated Allegations, and (4) Out-of-Home Care populations is created.

Create Clean Concatenated Data Sets

Import 2 Years of Access, IA, and PAD information

Annual 2013 and 2014 Access, IA, and Placement Activity and Detail reports are imported. These data sets are named "raw_access_[year]", "raw_ia_[year]", and "raw_pad_[year]", respectively.

Keep Subset of Variables

Only a subset of the variables in each of the above reports is necessary for this analysis. As such, the following variables are kept for each of the reports; the resulting data sets are named "access_[year]", "ia_[year]", and "pad_[year]", respectively (similar variables are displayed in the same row in the table below):

Access	IA	PAD
County	County	Query_end_date*
Report_id	Region	Placement_county
Report_type	Report_date*	Site_region
Recd_date*	Child_id	Child_id
Child_id	Child_name	Child_name
Child_name	Dob*	Child_dob*
Dob*	Gender	Child_gender
Gender	Prmry_race	Child_race
Prmry_race	Maltreatment_finding	Removal_date*
Scrin_rsn	Ia_disposition	Plcmt_begin_date*
Scrout_rsn	Id_mci	Plcmt_end_date*
Id_mci		Discharge_date*
		Discharge_reason
		Id_mci

Concatenate to One Data Set per Report Type and Deduplicate

Each of the report types is concatenated to one data set, resulting in the following data sets: "access_all", "ia_all", and "pad_all". For the access report, the length of *child_name* is set to $35. The resulting data sets are then deduplicated by *_all_*.

Keep Only Date Part

For the variables followed by an asterisk in the table above, only the date part of the values are kept; in other words, the time stamp portion of the values are deleted.

Create Analysis Data Sets

Create 4 Data Sets by Base Population

Four base populations will be sent to DHS: (1) Access, (2) IA, (3) Substantiated Maltreatments, and (4) OHC. The following data sets are created:

- Base1_access : all access reports
- Base3b_ia: all IA
- Base5_sub: all IAs where *maltreatment_finding* = "Substantiated"
- Base8_ohc: all OHC

Create *Most Recent Year (recd_year)* Variable for PAD

After sorting the "base8_ohc" dataset by descending *plcmt_begin_date*, transpose wide by *child_id*. Keep only the most recent year and create a *recd_year* variable to capture the most recent year a child was in OHC. For the remaining data sets, sort by descending *recd_date* to keep the most recent record a child appears in each data set.

Create *Child ID, MCI ID, and SSN Crosswalk*

Using a merged data set for all four populations to create a master crosswalk of child ID, MCI ID, and SSNs. 30 children with multiple SSNs are dropped.

Create Final Data Set for Exchange

All four data sets are merged, whereby each row refers to a unique child (identified by *child_id*).

Only 46,872 of the 128,440 children have an MCI ID, which is equivalent to approximately a 36.5% match rate. 60,657 children are matched using SSN.

The final analysis file includes 119,411 children with the following match rate:

Population	Only SSN	Only MCI ID	SSN & MCI ID	Denominator	Total
Access	13966	492	39967	113882	48%
Initial Assessment	6973	339	27114	62816	55%
Substantiated Maltreatment	637	115	5828	8932	74%
Out-of-Home Care	211	343	14691	15508	98%

Create Analysis Data Sets for DPI

The same data sets as above are prepped for the Foster Care Data Client , with the following exceptions:

- Children whose names include the substring "Unknown" are dropped
- Children with missing date of birth are dropped
- Children with genders not "M" (for male) or "F" (for female) are dropped

This data is then matched with DPI for Wisconsin Student Numbers (WSNs). Finally, only children who are at least 6 years old are included in the analysis.

APPENDIX G

Worker Survey Results

Flash Survey #3: Children with Disabilities in Child Protective Services (CPS) in Wisconsin

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The University of Wisconsin-Madison Survey Center (UWSC) was hired by the Division of Safety and Permanence within the Department of Children and Families to conduct a series of brief surveys of the child welfare workforce. The purpose of these surveys is to identify strengths and challenges faced by the child welfare workforce in Wisconsin. Input from these surveys will help the Department of Children and Families and counties partner in their efforts to continually improve upon policy, process and practice standards, as well as training and technical assistance.

Responses from the surveys are submitted to a centralized database managed by UWSC, where they are combined with the answers from all respondents. All answers are confidential—none of the survey responses are linked to identifying information (e.g., names, worker ID numbers). These surveys are intended to be very brief (e.g., 10 minutes or less), and are designed to gauge workforce knowledge on a particular topic, professional needs and challenges, and strengths and gaps in practice and policy areas.

This third "Flash Survey" is on *how Child Protective Services (CPS) currently responds to working with children with disabilities and how we can help strengthen this response*. Wisconsin Statute Chapter 106 defines "disability" as a physical or mental impairment that substantially limits one or more major life activities, a record of having such an impairment or being regarded as having such an impairment. This includes but is not limited to cognitive disabilities, hearing impairments, speech or language impairments, visual impairment, emotional behavioral disabilities, orthopedic impairments, autism, traumatic brain injuries, other health impairments and learning disabilities. The survey instrument is provided in Appendix H.

The survey was sent electronically by the University of Wisconsin-Madison Survey Center on October 4, 2016 to 1,945 email addresses representing frontline workers with job responsibilities in child protective services. Of those, 58 emails bounced back as invalid. Reminder emails went out on October 19th and October 26th to email addresses from whom no response had yet been received. The survey response window closed on November 4, 2016. The final sample file included 677 workers, for an overall response rate of 34.8%.

Table 1 shows the responses provided by the full sample (N=677) to questions related to worker comfort level, knowledge, and self-reported skills in interactions involving a child with a known or suspected disability. Just under half of the workforce (47.4%) reported feeling very or extremely comfortable identifying children with developmental disabilities, and another 38.4% felt somewhat comfortable with this task. Comfort level increased for physical disabilities (59.3% felt very or extremely comfortable), followed by mental illness (50%) and sensory impairments (37.8%). This pattern was generally true across worker job functions. Workers tended to report greater comfort identifying physical disabilities and mental illness than developmental disabilities and sensory impairments.

In general, workers with IA and ongoing job functions reported slightly higher levels of comfort identifying different types of disabilities than workers with Access job functions, with two exceptions. 43.8% of workers with Access functions reported high levels of comfort identifying children with developmental disabilities, whereas 37.1% of workers with Initial Assessment functions and 47.7% of workers with Ongoing functions reported high levels of comfort with this task. Workers with Access and ongoing job functions had identical high comfort levels identifying children with physical disabilities (58.6%), and 62.1% of workers with IA job functions were comfortable with this task.

Over half (55.1%) of all workers reported feeling very or extremely comfortable assessing safety for children with developmental disabilities, and another 34.1% reported feeling somewhat comfortable with safety assessment. This level of comfort was slightly higher for children with physical disabilities (56.9%), followed by children with mental illness (54.1%) and children with sensory impairments (48.7%). Half (50.5%) of workers with Access functions felt very or extremely comfortable with safety assessments involving children with developmental disabilities; 62.6% of workers with Initial Assessment functions and 55.8% of workers with Ongoing functions reported high comfort levels with these safety assessments. Similar patterns were observed for other types of disabilities.

16% of survey respondents strongly agreed and 64.4% of respondents somewhat agreed that they were aware of the resources in the community available to children with disabilities. There was little response variation to this question across job functions.

Communication with children who have disabilities presented more of a challenge to workers. 7.6% of respondents strongly agreed and 45% somewhat agreed that they knew how to communicate or access services to communicate with non-verbal children, 9.2% strongly agreed and 38.3% somewhat agreed that they knew how to communicate with or access services to communicate with children who are deaf, and 6.5% strongly agreed and 51.4% somewhat agreed that they had communication knowledge for children with other types of disabilities. Similar patterns in responses were observed across job functions.

Across sets of questions in Table 1 (i.e., those pertaining to identification of disabilities, those pertaining to safety assessment, and those pertaining to communication), the internal reliability was quite high, indicating that individual workers tended to answer similarly across questions within each of these question sets. That is, workers who were comfortable with one task tended to be comfortable with other tasks, and discomfort was likewise concentrated in individual workers.

Workers were also asked to report the percentage of cases encountered in the past month that they believe involved a child with a disability. Across all workers, 47% was the average response.[5] For workers with Access job functions, the average response was 40%; 38% for workers with Initial Assessment job functions; and 48% for workers with Ongoing job functions.[6]

Table 1. Introductory Questions, Full Sample (N=677)

	Comfortable ID Development Disabilities	Comfortable ID Physical Disabilities	Comfortable ID Mental illness	Comfortable ID sensory impairments	Comfortable assessing safety of children with Development Disabilities	Comfortable assessing safety of children with Physical Disabilities	Comfortable assessing safety of children with Mental illness	Comfortable assessing safety of children with sensory impairments
Not at all comfortable	2.7	1.5	2.7	4.1	2.8	2.7	2.8	3.2
A little comfortable	11.5	8.3	11.7	16.8	8.0	8.1	8.7	12.0
Somewhat comfortable	38.4	30.9	35.7	41.2	34.1	32.3	34.4	36.0
Very comfortable	36.9	45.6	38.6	29.4	43.1	44.5	42.1	38.7
Extremely comfortable	10.5	13.7	11.4	8.4	12.0	12.4	12.0	10.0
Observations	677	677	677	677	677	677	677	677

	Agree: You know resources available to children w/ disabilities in community	Know how communicate/access resources to communicate w children:Non-verbal?	Know how communicate/access resources to communicate w children: deaf?	Know how communicate/access resources to communicate w children:other challenges
Strongly Disagree	4.3	12.4	17.0	9.6
Somewhat Disagree	15.4	35.0	35.6	32.5
Somewhat Agree	64.4	45.0	38.3	51.4
Strongly Agree	16.0	7.6	9.2	6.5
Observations	677	675	677	677

	Mean	(SD)	Median	min	max	count
In past month, what % of your cases involved child who may have a disability?	47	(30)	50	0	100	597
Observations	597					

Approximately 30% of workers estimated that under 21% of the cases they encountered in the last month involved children with disabilities (not shown in table), whereas approximately 15% of workers estimated that over 79% of the cases they encountered in the last month involved children with disabilities. Estimates ranging from 21% through 79% were evenly distributed across the remaining 55% of workers.

With respect to Table 1, the comfort level with identifying developmental disabilities varied across regions. For example, Northeastern and Southern region workers were least likely to report feeling extremely comfortable, and Northern and Milwaukee regions were most likely to report feeling extremely comfortable with this task. Workers in the Western region were least likely to report feeling extremely comfortable identifying physical disabilities, and Northern and Milwaukee region workers were most likely to report feeling extremely comfortable identifying

[5] Eighty respondents did not answer this question, perhaps because they did not have an active caseload in the past month.

[6] The median response across all groups was similar to the mean response across groups, indicating that the means were not skewed by "outlier" responses.

physical disabilities. Northern and Milwaukee region workers were most likely to report feeling extremely comfortable identifying mental illnesses; all other regions had equivalent rates of feeling extremely comfortable with this task. Milwaukee workers were most likely to report extreme comfort with identifying sensory impairments; all other regions had similar rates of extreme comfort with this task.

Workers from Northern and Milwaukee regions were significantly more likely than workers from other regions to report feeling extremely comfortable assessing for safety of children, regardless of the type of disability. Workers from all regions were similarly knowledgeable about available community resources for children with disabilities. Compared to other regions, Milwaukee and Southeastern workers were more likely to report high levels of knowledge about communicating with (and accessing resources to communicate with) children who are non-verbal due to a disability. Milwaukee and Southeastern workers were also more likely than other workers to report high levels of knowledge about communicating with (and accessing resources to communicate with) children who are deaf.

All workers were also asked to identify resources that they have used to assist children with disabilities involved in their cases (Q8 in the survey). Taking the collective responses of survey participants, 42% related to county-administered services, 30% involved community service providers, and 20% were K-12 resources. Workers were also asked to identify barriers that they experience in cases involving children with disabilities (Q9). The most common answers were related to limited availability of services (32% of responses), child communication issues (9%), and lack of knowledge about available resources or about the disability itself (8%). Finally, all workers were asked to identify what would help them better meet the needs of children with disabilities involved in their cases (Q10). Half of the responses to this question involved making more services available, followed by training (19%) and information about available resources (7%).

Table 2 presents the answers asked only of workers with Access job functions (N=212). Half of workers with Access job functions state that they "always" ask a reporter if he or she is aware that an alleged child victim has a disability, and another one-third report asking this question "usually." Over two-thirds (68.3%) state that they usually or always ask the reporter if other children in the household may have a disability, and a similar percentage (70.1%) usually or always ask if an adult in the household may have a disability. Almost all (94.3%) state that they always include information about children's disabilities in the Access report, whereas closer to half (50.2%) say that they include information on disability-related services in the Access report if they learn a child may have a disability. When Access workers were asked what percentage of all children reported to CPS in Wisconsin may have a disability, the average response was 44.5%.

Table 2. Questions for Access Workers (N=212)

	Do you ask if reporter is aware child victim has a disability?	Do you ask reporter if other household children have disabilities?	Do you ask reporter if adults in household have a disability?	If you learn child has disability, do you include in report?	If you learn child has disability, do you include info re: dis. services?
Never	2.4	4.7	5.2	0.5	1.9
Rarely	15.1	26.9	24.5		9.6
Usually	33.0	35.8	44.3	3.8	37.3
Always	49.5	32.5	25.9	94.3	50.2
NA				1.4	1.0
Observations	212	212	212	212	209

	Mean	(SD)	min	max	count
Children reported to CW agencies in WI: What % do you think have disability?	44.52	(20.62)	5.00	90.00	170.00
Observations	170				

Table 3 presents the answers to questions asked only of workers with Initial Assessment job functions (N=206). 36.9% of IA workers state that they "usually" or "always" need to make accommodations for children with disabilities during interviews or other contacts. Just over half (56.8%) report that they always ask a caregiver whether an alleged child victim has a disability, and another 36.4% usually ask this question. A similar response pattern emerged for asking a caregiver whether other children in the household have a disability. Two-thirds (68%) usually or always ask about services a child with a disability is receiving. Over 90% of IA workers who suspect a child may have a disability without services in place usually or always refer the child for an evaluation. 71.1% of IA workers usually or always contact the county LTS worker if a child has a disability, and nearly all usually or always gather information from collateral contacts in such situations. If an IA worker suspects a child may have a disability, nearly all state that they usually or always include this information in the IA report, as well as information about any services in place.

For cases that are closed after the Initial Assessment that involve a child who has or may have a disability, 24.4% state that they always refer the family to disability-related services and 58.7 % state that they usually refer the family to disability-related services. Workers state that for children with suspected disabilities who need to be placed in out-of-home care during an IA investigation, 50.8% usually or always face barriers in matching a child with an appropriate placement. When IA workers were asked what percentage of all children undergoing initial assessments in Wisconsin may have a disability, the average response was 45.6%.

Table 3. Questions for IA Workers (N=206)

	Do you need to accommodate children with disabilities during interviews?	Do you ask the caregiver whether the alleged child victim has a disability?	Do you ask the caregiver whether other children have a disability?	If you learn abt a disability, do you ask what services family is receiving?	If you suspect child has disability (and no services), do you refer to eval?	If child has a disability, do you contact county LTS worker?	If child has a disability, do you gather from collateral contacts?	If child has a disability, do you include this info in IA report?	If child has a disability, do you include info in IA re: services?	For cases closing at IA, do you refer families to services for disability?	Placing disabled children: do you experience barriers matching needs?
Never	3.9	0.5	0.5		0.5	7.5				3.5	4.5
Rarely	53.4	6.3	10.7	2.4	5.0	21.4	5.0	1.0	2.0	11.9	21.4
Usually	29.6	36.4	36.9	27.2	45.3	46.3	57.7	12.4	14.9	58.7	43.3
Always	7.3	56.8	51.9	68.0	46.8	24.9	37.3	86.6	81.6	24.4	7.5
NA	5.8			2.4					1.5	1.5	23.4
No Resources					2.5						
Observations	206	206	206	206	201	201	201	201	201	201	201

	Mean	(SD)	min	max	count
Children who have IAs in WI: What % do you think have disability?	45.60	(19.87)	5.00	92.00	174.00
Observations	174				

IA workers were also asked about any arrangements they have made to accommodate the needs of children with disabilities (Q22). Over half (56%) of workers' answers involved community service providers, 25% involved K-12 resources, and 3% involved county-administered services. IA workers who have referred children suspected of having a disability for an evaluation were asked about the programs and services to which they make these referrals (Q28). Here, responses were most often related to county-administered services (59%), 25% involved community service providers, and 15% involved K-12 resources.

Workers with IA job functions were asked to identify factors that hinder their ability to gather information to make safety or substantiation decisions in cases involving children with disabilities (Q32). The most common responses to this question related to issues communicating with a child (20%), followed by "lack of knowledge" about available resources or the child's disability (5%) and issues involving "family understanding" about the disability (4%).

IA workers were also asked about the services and programs they refer children to when a case involving a child with a disability is closed after an initial assessment (Q34). Two-thirds of responses involved county-administered services, 21% involved community service providers, and 13% involved K-12 resources. Finally, IA workers were asked to identify barriers they encounter when finding an appropriate placement to meet the needs of a child with a disability who needs to be removed from the home (Q36). The most common responses were related to the limited availability of services (50%), followed by "lack of knowledge" about resources or about the child's disability (13%), and issues with "family understanding" of the child's disability (4%).

Table 4 presents the answers to questions asked only of workers with Ongoing job functions (N=382). 38% of Ongoing workers state that they usually or always make accommodations for children with disabilities during face-to-face meetings or other contacts. Three quarters report usually or always contacting a county LTS worker when a child has or is suspected to have a disability, and 93.8% usually or always gather information from collateral contacts in such cases. If a child is suspected to have a disability without services in place, 90.9% of Ongoing workers report usually or always referring the child for an evaluation. 58.8% report usually or always experiencing barriers in matching the needs of a child with a disability to an appropriate placement.

86.5% of Ongoing workers usually or always collect information regarding child disabilities when conducting Confirming Safe Environments, and 92.7% report usually or always including goals to support the child needs during permanency planning. During family interaction sessions for children with disabilities, 34.2% of Ongoing workers report usually or always needing to make accommodations for a child.

When Ongoing workers were asked what percentage of all children in out-of-home care in Wisconsin may have a disability, the average response was 53.1%.

Table 4. Questions for Ongoing Workers (N=382)

	Do you need to accommodate children with disabilities during interviews?	If child has a disability, do you contact county LTS worker?	If child has a disability, do you gather from collateral contacts?	If you suspect child has disability (and no services), do you refer to eval?	Do you experience barriers matching needs of disabled children to placements?	Do you collect info re: child disabilities when Confirming Safe Environments?	During permanency planning, do you include goals to support child needs?	Do you need to accommodate children with disabilities during interviews?
Never	10.2	13.2	1.9	1.6	10.8	6.2	4.0	35.8
Rarely	49.2	11.6	4.3	5.6	30.5	7.3	3.2	30.1
Usually	30.4	44.4	46.5	36.6	49.9	37.7	32.6	19.8
Always	7.6	30.9	47.3	54.3	8.9	48.8	60.1	14.4
NA	2.6							
No resources				1.9				
Observations	382	372	372	372	371	371	371	369

	Mean	(SD)	min	max	count
Children in Ongoing CPS in WI: What % do you think have disability?	53.05	(22.73)	0.00	100.00	332.00
Observations	332				

Ongoing workers were asked about any arrangements they have made to accommodate the needs of children with disabilities during face-to-face meetings or other contacts (Q40). Most responses involved community service providers (34%), followed by K-12 resources (13%) and county-administered services (7%).

Ongoing workers who have referred children suspected of having a disability for an evaluation were asked about the programs and services to which they make these referrals (Q44). Two-thirds (64%) of responses involved county-administered services, 18% involved K-12 resources, and 17% involved community service providers. Ongoing workers were asked to identify barriers they encounter when finding an appropriate placement to meet the needs of a child with a disability who needs to be removed from the home (Q47). 43% of responses to this question related to the limited availability of services, 11% involved "lack of knowledge" about resources or a child's disability, and 6% involved issues with "family understanding" of their child's disability. Finally, Ongoing workers were asked to specify the types of accommodations that they have made for children with disabilities during family interaction sessions (Q50). Responses were equally divided between county-administered services and K-12 resources (10% each), and 4% involved community service.

APPENDIX H

Survey to Child Welfare Workers

2015 Wisconsin Act 365 requires the Department of Children and Families (DCF) to develop and implement a plan for identifying and addressing areas in which there is a need for improvement in the practices used to investigate reports of suspected or threatened abuse or neglect of a child with a disability. DCF must use an open public participation process to develop the plan that includes input from stake holders that DCF considers appropriate. Please complete the survey below to assist us in understanding how CPS currently responds to working with children with disabilities and how we can help strengthen this response.

Wisconsin Statute Chapter 106 defines "disability" as a physical or mental impairment that substantially limits one or more major life activities, a record of having such an impairment or being regarded as having such an impairment. This includes but is not limited to cognitive disabilities, hearing impairments, speech or language impairments, visual impairment, emotional behavioral disabilities, orthopedic impairments, Autism, traumatic brain injuries, other health impairments and learning disabilities.

All Workers

1. How comfortable are you at identifying signs that indicate children may have the following types of disabilities or issues?
    a. Developmental Disabilities
    b. Physical Disabilities
    c. Mental Illness
    d. Sensory Impairments (e.g. hearing, visual)
    * Options for each: Not at all, a little, somewhat, very, extremely

2. How comfortable are you assessing the safety of children with the following types of disabilities or issues?
    a. Developmental Disabilities
    b. Physical Disabilities
    c. Mental Illness
    d. Sensory Impairments (e.g. hearing, visual)
    * Options for each: Not at all, a little, somewhat, very, extremely

3. What percentage of your cases in the past month involved a child whom you perceived may have a disability?

4. To what extent do you agree that you know the resources available to children with disabilities in your county/community?

   Choices: Strongly Disagree, Somewhat Disagree, Somewhat Agree, Strongly Agree
5. To what extent do you agree that you know ways to communicate, or know how to access resources to assist with communication, which children who:
   a. Are non-verbal due to a disability?
   b. Are deaf?
   c. Have other communication challenges due to a disability?

   *Choices: Strongly Disagree, Somewhat Disagree, Somewhat Agree, Strongly Agree
6. What resources, if any, have you used to assist children with disabilities in your cases?
7. What, if any, barriers do you experience in cases involving children with disabilities?
8. What, if anything, would help you better meet the needs of children with disabilities in your cases?

Access Workers

1. Of the children reported to a child welfare agency in Wisconsin for alleged maltreatment, what percentage do you think have a disability?
2. How often do you ask if the reporter is aware of or suspects the alleged child victim has a disability?

   *Choices: Never, Rarely, Usually, Often
3. How often do you ask the reporter whether other children in the household have or may have a disability?

   *Choices: Never, Rarely, Usually, Often
4. How often do you ask the reporter whether adults in the household have or may have a disability?

   *Choices: Never, Rarely, Usually, Often
5. If you learn that a child has or may have a disability, how often do you include this information in the Access report?

   *Choices: Never, Rarely, Usually, Often
6. If you learn that a child has or may have a disability, how often do you include information in the Access report about any identified disability-related supports and/or services that the child is receiving?

   *Choices: Never, Rarely, Usually, Often

Initial Assessment

1. Of the children undergoing Initial Assessments in the child welfare system in Wisconsin, what percentage do you think have a disability?
2. How often have you needed to accommodate children with disabilities based on their needs during interviews or other contacts?
   *Choices: Never, Rarely, Usually, Often, if never
   *What arrangements have you made? (e.g. American Sign Language Interpreters)
3. How often do you ask the caregiver whether the alleged child victim has or may have a disability?
   *Choices: Never, Rarely, Usually, Often
4. How often do you has the caregiver weather other children in the household have or may have a disability?
   *Choices: Never, Rarely, Usually, Often
5. If you learn that the alleged child victim or other children in the household has or may have a disability, how often do you ask the caregiver what services, if any, the family is receiving? *Choices: Never, Rarely, Usually, Often
6. If you suspect that a child in the household has an unidentified disability and the family is not receiving services, how often do you refer the child to a program/service for further evaluation of the suspected disability?
   *Choices: Never, Rarely, Usually, Often
   *To what programs/services do you refer?
7. If you learn that a child has or may have a disability, how often do you gather information from collateral contacts (e.g., health care provider, teacher, child care provider, CLTS) regarding the child's disability?
   *Choices: Never, Rarely, Usually, Often
8. If you learn that a child has or may have a disability, how often do you include this information in the Initial Assessment report?
   *Choices: Never, Rarely, Usually, Often
9. If you learn that a child has or may have a disability, how often do you include information in the Initial Assessment report about the services that child is receiving?
   *Choices: Never, Rarely, Usually, Often
10. What factors, if any, hinder your ability to gather information to make safety or substantiation decision in cases involving children with disabilities?
11. For cases that are closed after the Initial Assessment that involve a child who has or may have a disability, how often do you refer the family to services related to the disability?
    *Choices: Never, Rarely, Usually, Often
    *To what programs/services do you refer?

12. If a child needs to be placed in out-of-home care during the Initial Assessment, how often do you experience barriers in matching a child with a disability to a placement provider with the skills and experience necessary to best meet the child's needs?
    *Choices: Never, Rarely, Usually, Often

Ongoing

1. Of the children in Ongoing Services in the child welfare system in Wisconsin, what percentage do you think have a disability?
2. How often have you needed to accommodate children with disabilities based on their needs during face-to-face meetings or other contacts?
    *Choices: Never, Rarely, Usually, Often
    *What arrangements have you made?
3. If you learn that a child has or may have a disability, how often do you gather information from collateral contacts (e.g. health care provider, teacher, child care provider, CLTS) regarding the child's disability?
    *Choices: Never, Rarely, Usually, Often
4. If you suspect that a child in the household has an unidentified disability and the family is not receiving services, how often do you refer the child to a program/service for further evaluation of the suspected disability?
    *Choices: Never, Rarely, Usually, Often
    *To what programs/services do you refer?

For children in out-of-home care:

1. How often do you experience barriers in matching a child with a disability to a placement provider with the skills and experience necessary to best meet the child's needs?
    *Choices: Never, Rarely, Usually, Often
    *Explain barriers you have encountered.
2. How often do you collect information regarding the disabilities of a child in placement when conducting the Confirming Safe Environments?
    *Choices: Never, Rarely, Usually, Often
3. During permanency planning for a child with a disability, how often do you include child specific goals in the permanency plan to support the educational, health, safety and emotional needs of the child?
    *Choices: Never, Rarely, Usually, Often
4. During family interaction sessions for children with disabilities, how often have you needed to accommodate the child and/or family to ensure the child's needs are met?
    *Choices: Never, Rarely, Usually, Often
    *What arrangements have you made?