

# UTS TRAINING TIMES

First Steps

Volume 5 Issue 2

May 2009

## Inside this issue...

- ⇒ Each year, more than 20,000 Hoosier children are abused and neglected – that equates to 56 children being harmed every day and one child each week losing his or her young life to child abuse. April was Child Abuse & Neglect Prevention Month. Indiana law requires that any and all citizens aware of a child being abused or neglected must report it to the Department of Child Services. Information on child abuse and neglect is provided by Prevent Child Abuse Indiana .
- ⇒ A significant number of families adopt children from foreign countries. Many of these children are referred to and receive First Steps services. Sharon Glennen, PhD, CCC-SLP, is professor and chair of the Department of Audiology, Speech Language Pathology and Deaf Studies at Towson University. Her adoption of two children from Russia prompted her interest in language development and disorders in internationally adopted children. Dr. Glennen’s, “Mythbusters” article looks at speech and language development in children adopted from foreign countries. This article was recommended by a First Steps provider and is reprinted with the author’s permission. While we are not always successful in obtaining reprint permission, provider recommendations are always appreciated.
- ⇒ A preview copy of the latest state-issued First Steps Provider Newsletter May 2009 is included. The newsletter provides important state updates and policy information on Co-Treat Practices, Changing Enrollment Status and Provider Matrix Guidelines. . Questions or comments regarding information contained in the Provider Newsletter on pages 12-18 should be directed to state First Steps staff at [Firststepsweb@fssa.in.gov](mailto:Firststepsweb@fssa.in.gov).

<b>Table of Contents</b>	
<b>Speech &amp; Language “Mythbusters” for Internationally Adopted Children</b>	<b>4</b>
<b>Indiana First Steps—Early Intervention System, State Issued Provider Newsletter Vol. 3, Issue 1 May 2009</b>	<b>12</b>
<b>Child Abuse and Neglect</b>	<b>20</b>



INDIANA’S UNIFIED TRAINING SYSTEM

“Creating Learning Opportunities for Families and Providers Supporting Young Children”

## First Steps Enrollment and Credential Training Requirements

Provider Level—New	Training for Enrollment	Training for Initial Credential
Service Coordinator (Intake and Ongoing) New to First Steps December 2007 and after	SC 101—SC Modules (self-study)	SC 102—SC follow up at 3-6 months (on-site)* SC 103— SC follow up at 6-12 months (on-site)* Quarterly—Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential
Direct Service Provider (new to First Steps December 2007 and after)	First Steps Orientation or DSP 101—Provider Orientation Course (self-study)	DSP 102—Half day follow up at 3-6 months (on-site) DSP 103— Half day follow up at 6-12 months (on-site) Quarterly—Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential
Provider Level Credentialed	Training for Enrollment	Training for Annual Credential
Service Coordinator (Intake or Ongoing who has completed initial credential)	SC Orientation and Service Coordination Level 1 or SC 101—SC Modules (self-study)	Quarterly—Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 3 points for annual re-credential
Direct Service Provider (who has completed initial credential)	First Steps Orientation (on-site or self-study) or DSP 101—Provider Orientation Course (self-study)	Quarterly—Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 3 points for annual re-credential

\* Replaces Service Coordination Level 2

### Attention New Providers and Service/Intake Coordinators

The Bureau of Child Development Services requires all providers and service coordinators to complete the *Training Times* assessment as part of your mandatory training requirements for credentialing.

New providers must establish an account on the UTS website (<http://www.utsprokids.org>). Obtaining an account is easy.

1. Click on Account Login in the upper right hand corner.
2. On the login page click on Create One Here
3. Enter your information (note that UTS Training Times is mailed to your primary address—you are encouraged to use your home address, especially if it is difficult to get personal mail at your workplace, e.g. hospital system). UTS does not give any of your training profile information to anyone outside of First Steps. The BCDS and UTS will periodically send you email updates regarding First Steps.
4. When all information has been entered click on Update Information.
5. Register for your annual training fee.

6. Once your payment has been posted, you can take the Training Times assessment, under My Quizzes.
7. If you have questions or encounter problems email Janice in the UTS Connect office at: [registration@utsprokids.org](mailto:registration@utsprokids.org)

**Indiana First Steps**  
**UTS Training Times**  
**Ann Ruhmkorff, Editor**  
**Tamara Hardin, ProKids Executive Director**  
**Renee Jarboe, Training Manager**  
**Betsy Ray, Training Coordinator**  
**Mindy Dunn, Field Trainer**  
**Janice Sams, Administrative Assistant**  
**Erin Cress, Training Assistant**

Published quarterly by Indiana's Unified Training System (UTS) - Programmatic Training at ProKids, Inc. 6923 Hillside Ct. Indianapolis, IN 46250. Indiana's Unified Training System (UTS) is funded through a grant from Indiana First Steps, Bureau of Child Development Services, Division of Developmental Disability and Rehabilitative Services, FSSA. Subscription fee is included as a part of the annual training fee for enrolled First Steps providers. Copies may be downloaded from the UTS ProKids web page.

**Web Address:** <http://www.utsprokids.org>  
**Email:** Training questions [training@utsprokids.org](mailto:training@utsprokids.org)  
**Registration questions:** [registration@utsprokids.org](mailto:registration@utsprokids.org)

# UTS Training FAQs

**Question-:** How can I get my registration confirmation code if I didn't print it after completing my Annual Training Fee registration?

**Answer:** Log on to your account at [www.utsprokids.org](http://www.utsprokids.org) and click on the My Trainings tab. Click on 2009 Annual Training Fee listed under the Upcoming Trainings heading to see a description of the fee and your confirmation number. If you click on the 2009 Annual Training Fee title that appears under the Attended and Passed Trainings heading, the confirmation number will not be displayed.

**Question:** I registered and completed a distance learning FSCT class and I see that under my quizzes there is no credential point value next to my quiz score. How can I get this corrected?

**Answer:** The credentialing documentation for this training is not posted under "My Quizzes" but under "My Trainings". Log on to your training profile on the UTS/ProKids website [www.utsprokids.org](http://www.utsprokids.org), click on the "My Trainings" tab and scroll down the page you will find this training with your credentialing points posted.

**Question:** How to I make-up Trainings Times assessments that are no longer available in the 'My Quizzes' section of my UTS Profile?

**Answer:** Due to the timeliness of some Training Times information, Training Times make-up quizzes over 6 months old are not available in the 'My Quizzes' section of your UTS Profile. You will need to email UTS [training@utsprokids.org](mailto:training@utsprokids.org) for the form to take these overdue assessments.

**Question :** Why are there quizzes in "My Quizzes" tab that do not pertain to me?

**Answer:** The top section in the 'My Quizzes' tab shows all available UTS quizzes. These are quizzes that correspond with other courses UTS offers, not necessarily those specific to your individual training profile. You should only take the quizzes that correspond with the courses you have registered for and that apply to you. Please ignore all other quizzes in this section. **No credential points are given for taking a quiz for a course in which you were not enrolled, regardless of the quiz score.**

**Question:** I need an ASL interpreter for training, will UTS provide interpreters?

**Answer:** Yes, UTS will provide ASL interpreters for its trainings. Please email [registration@utsprokids.org](mailto:registration@utsprokids.org) with your request. In order to secure interpreters, requests should be made at least 2 weeks in advance of the training.

**Do you have a UTS question?? Please email it to [training@utsprokids.org](mailto:training@utsprokids.org).**

## Service Coordination Workgroup Contacts

Questions or comments regarding the many roles and responsibilities and policies and procedures effecting Service Coordination can be sent to any of the Service Coordinator Workgroup contacts listed below.

Cluster A: Clare Mann at [cmann@nwifs.org](mailto:cmann@nwifs.org)  
Cluster B: Bridget Sovinski at [bsovinski@neccfs.org](mailto:bsovinski@neccfs.org)  
Pam Schena at [pschena@neccfs.org](mailto:pschena@neccfs.org)  
Cluster CH: Paula Anderson at [paulaanderson.achieva@yahoo.com](mailto:paulaanderson.achieva@yahoo.com)  
Cluster D: Chris Burton at [cb1ststeps@yahoo.com](mailto:cb1ststeps@yahoo.com)  
Cluster E: Angie Jarvis at [ajarvis@awsusa.org](mailto:ajarvis@awsusa.org)  
Kristi Seheer at [kseheer@awsusa.org](mailto:kseheer@awsusa.org)  
Cluster F: Jennifer Stutler at [jstutler@hamiltoncenter.org](mailto:jstutler@hamiltoncenter.org)  
Cluster G: Debbi Davis at [spoe@cibaby.org](mailto:spoe@cibaby.org)  
Cluster I: Jane Wirth at [scwest@brsinc.org](mailto:scwest@brsinc.org)  
Cluster J: Becky Haymond at [bhaymond@areaxi.org](mailto:bhaymond@areaxi.org)  
UTS: Mindy Dunn at [mdunn@ustprokids.org](mailto:mdunn@ustprokids.org)

# Speech and Language “Mythbusters” for Internationally Adopted Children

by Sharon Glennen

**Original Publication Citation:** Glennen, S. (2008, Dec. 16). Speech and Language "Mythbusters" for Internationally Adopted Children. *The ASHA Leader*, 13(17), 10-13. *Reprinted with permission from the author.*

Eleven years ago the adoption of my 17-month-old son from Russia started an unexpected journey into international adoption research. His initial attempts to learn English were perplexing. Words were often unintelligible with a unique phonological rule system that didn't match any textbook patterns. Although his language comprehension developed rapidly, his expressive language was unusual. Despite having more than 150 words in his vocabulary, he rarely combined them.

As a concerned mother I combed the literature for information about speech and language development in internationally adopted children. Back then most of the “evidence” was a collection of anecdotal reports that painted a less-than-rosy, and at times quite scary, picture for his future. Evidence-based information was limited to studies of children adopted from Romania that were conducted by Eleanor Ames and her colleagues, and Michael Rutter and his colleagues.

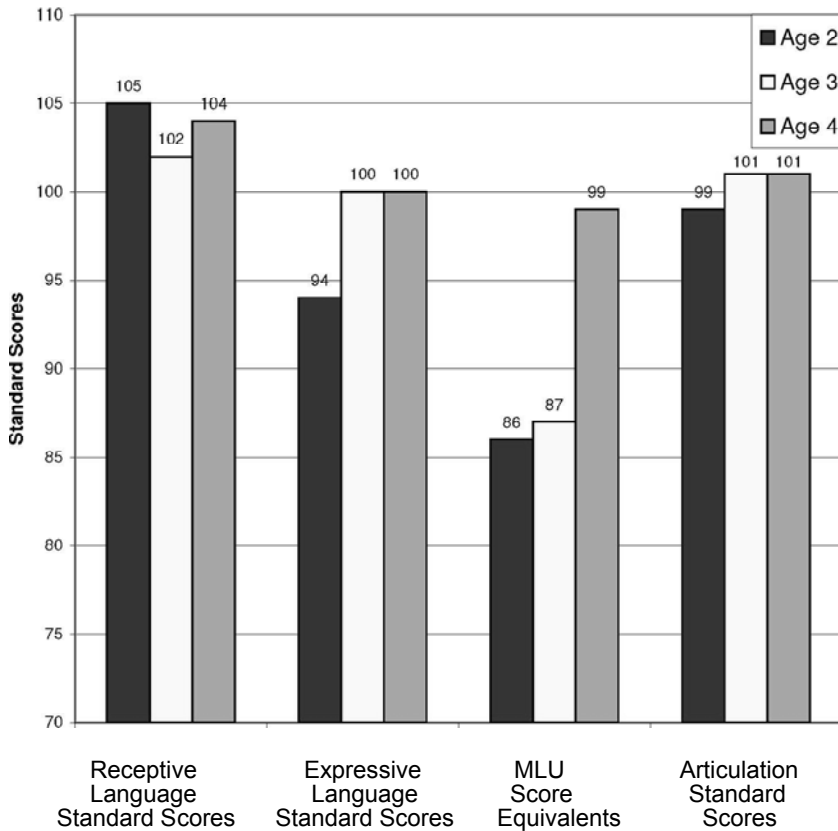
Although the information was important, their studies did not specifically examine speech and language. Thus my son's issues planted the seeds that led to a line of personally relevant research focused on speech and language development in internationally adopted children (Glennen, 2005; Glennen 2007; Glennen in press; Glennen & Masters, 2002). Since then, other colleagues including Jennifer Roberts, Kathleen Scott, Deborah Hwa-Froelich, Karen Pollock, Rena Krakow, and Jennifer Windsor have added to the growing body of research about speech and language development and disorders in internationally adopted children. However, many professionals aren't familiar with this information.

In our house the Discovery Channel series “Mythbusters” is a family favorite. Each episode takes popular myths based in history, legend, movies, or news and uses evidence to prove the myths as true, plausible, or busted. Now that we have 10 years of research regarding the speech and language abilities of internationally adopted children, it's time to do some “myth-busting” of our own. What follows is a list of common myths about international adoption and speech and language. I confess that I used to believe most of them, provided professional advice based on them, and wrote about some of them in early publications (Glennen, 2002). However, it's time to set the record straight. We need to use evidence, not myths, to make clinical decisions about speech and language for internationally adopted children.

**Myth 1: Internationally adopted children need many years to fully “catch up” in English language acquisition.**

**Evidence: The majority of internationally adopted children have rapid language-learning curves that begin within a few days of arriving home.** After one year home, children adopted under the age of 24 months develop English language comprehension, production, and articulation abilities that are well within normal limits using standard norms (Glennen, 2007) (See Figure 1). This rate of progress does not mean it takes only one year to develop full language potential; in fact, skills keep improving during the preschool years, especially in the area of expressive syntax. However, the initial surge of language “catch up” occurs rapidly within the first year home. We know less about children adopted at older ages, but preliminary data indicates equally rapid rates of language learning. Within one year of adoption, most children adopted as 2-year-olds score within normal limits on English language tests of comprehension and expression (Glennen, in press) (See Figure 2). Children adopted as 3-and 4-year-olds also score within normal limits on English language comprehension measures after one year, but take more time to develop expressive language

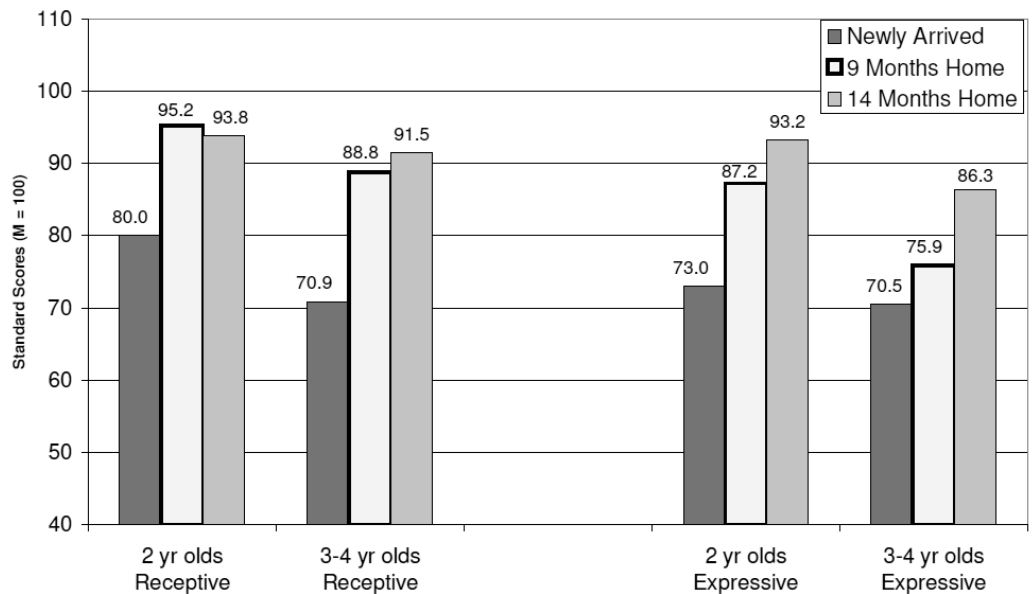
**English Language Development in Internationally Adopted Infants and Toddlers**



**Figure 1.** English language development in children adopted from Eastern Europe between the ages of 12 and 24 months (n = 26). Average scores for the group are depicted at ages 2, 3, and 4. Age 2 data were collected one year after adoption; age 3 data were collected two years after adoption; age 4 data were collected three years after adoption. Two-year-old language means are based on the *Preschool Language Scale IV* (PLS-IV); 3-year old data are based on either the PLS-IV or *Clinical Evaluation of Language Functions-Preschool 2* (CELF-P2); all 4-year-old data are based on the CELF-P2. Articulation data are from the *Goldman Fristoe Test of Articulation-2*. MLU data indicate conversions of MLU to standard score equivalents based on Miller and Chapman (1981).

**English Receptive and Expressive Language Development During the First Year Home in Children Adopted Internationally at Age 2 and Ages 3 to 4**

**Figure 2.** English language development in children adopted from Eastern Europe at ages 2, and 3 to 4 (2 yr old n = 7; 3-4 yr old n = 8). Data was collected within 3 months of adoption, 9 months after adoption, and 14 months after adoption. Assessment means at arrival are from the *Preschool Language Scale IV* (PSL-IV). Assessment means at 9 months home are from the PLS-IV for the 2 year olds, and *Clinical Evaluation of Language Functions-Preschool 2* (CELF-P2) for the 3 and 4 year olds. All 14 months home assessment results are from the CELF-P2.



## Speech and Language “Mythbusters” for Internationally Adopted Children

abilities fully in English. More research is needed to fully understand these issues, however significant English language delays after the first two years home appear to be rare and should be treated as true language or speech disorders.

### **Myth 2: Early environmental deprivation results in severe, lifelong language-learning disorders.**

**Evidence: Orphanages are not good places to raise children. Children who remain in orphanages have significant language delays and the length of stay correlates highly with poor cognitive and language abilities** (Johnson, 2000; O'Connor et al., 2000; Rutter et al., 1998; Miller, 2005; Windsor, Glaze, Koga, & the Bucharest Early Intervention Project Core Group, 2007). At birth, children have a range of potential language abilities that fall along the normal curve. Some children have the potential to develop exceptional language skills, others have less potential. When children enter orphanages, environmental and nutritional deprivation gradually erodes their potential.

The poorer the level of care, and the longer the length of institutionalization, the more potential is lost. The result is a group of children who still have language abilities arrayed into a normal curve, but the curve has shifted downward. While many children will still fall within the “normal range,” lost potential translates into proportionately more children falling below average. Once potential is lost, the more important question is whether it can be regained when the environment improves.

Research indicates that many children raised in orphanages have permanent neurobiological changes related to chronic stress within their environment (Gunnar & Quevedo, 2007; Miller, 2005). Chronic abnormal stress reactions lead to overproduction of cortisol and high levels of glucocorticoids in the brain. Prolonged exposure to glucocorticoids leads to structural changes in the brain, primarily the hippocampus, which is important for memory storage and retrieval. Other areas of the brain affected by abnormal regulation of glucocorticoids include the frontal lobe, responsible for executive function and abstract thinking; the cingulate gyrus, responsible for attention and self-control; and the amygdala, responsible for processing emotions. However, some children are genetically more resilient to the neurobiological effects of stress and are not as affected by the orphanage environment (Gunnar & Quevedo). In addition, the neurobiology of stress reactions responds to improvements in the environment, such as adoption into a nurturing home with consistent caregivers (Gunnar & Quevedo).

Adoption goes a long way to counteract lost potential resulting from environmental deprivation. The majority of infants and toddlers adopted into American homes have mild to low-average delays when they first arrive, but make incredible progress during the first years at home (Glennen, 2005; Glennen 2007; Roberts et al., 2005). The incidence of speech and language disorders in children adopted before age 2 is 22% (Glennen, 2007). Although this is higher than the 2%-8% reported in the general preschool population (Law, Boyle, Harkness, & Nye, 2000), the overwhelming majority of internationally adopted children who are adopted before age 2 have normal English language abilities after one year home (Glennen, 2007, Roberts et al., 2005). Internationally adopted children who do not meet this benchmark have true disorders, and need to be diagnosed and treated.



“The way I see it, if you want the rainbow you gotta put up with the rain.” — *Dolly Parton*

## “Mythbusters” (continued)

**Myth 3: The child’s first language (L1) will affect aspects of learning the new adopted language.**

**Evidence: Studies of young internationally adopted children have found that the first language has no inhibitory or facilitory effect on learning a new language or its phonology.** Young children transitioning from Russian to English learned English language morphological structures in the same developmental sequence as children who spoke English their entire lives (Glennen, Rosinsky-Grunhut, & Tracy, 2005). Children transitioning from Mandarin to English developed the English sound system similarly (Pollack & Price, 2005). Finally, children adopted from China learned vocabulary in patterns typical for children who spoke English (Snedeker, Geren & Shafto, 2007). The children in these studies were all adopted under the age of 2 and likely did not have a well-developed first-language base to affect English language learning.

Based on my clinical experience, children adopted at older ages do show signs of interference and facilitation between the birth and adoptive languages. However, it is unknown whether they follow the same patterns as bilingual children or if they transition differently from one language to another. Functional MRI studies of adults who were internationally adopted as children confirm that adult adoptees no longer recognize nor understand their first language, even those who were adopted at school age (Pallier et al., 2003). However, the same fMRI studies also confirm that internationally adopted adults process their new adopted language using different areas of the brain than those of native language speakers.

**Myth 4: Internationally adopted children are bilingual and should be treated like other second-language learners.**

**Evidence: Internationally adopted children are bilingual only for a short period of time after adoption.** Because most adoptive parents do not speak the child’s birth language (L1), children quickly lose abilities in the language. According to Gindis (2003), children adopted at ages 3–4 lose most expressive use of L1 within 6 to 12 weeks of adoption; receptive abilities are lost within 16–22 weeks. At that point, internationally adopted children are monolingual in English, but the language is not yet fully acquired.

Children who are adopted at older ages are especially affected because they begin school soon after arriving home. If they struggle academically, it is difficult to validly assess speech or language disorders until English develops further. By then, valuable intervention time is lost. Parents adopting children older than 3 years are advised to gather information about their child’s speech and language development during the adoption process. If there are reported concerns in the birth country, the educational team should consider conducting an assessment and begin to provide supports within the classroom soon after the child arrives home.

**Myth 5: Most internationally adopted children do well at young ages but have language-related academic difficulties that emerge when they reach the elementary grades.**

**Evidence: Most children adopted before age 2 have normal language abilities during the preschool years, and continue to have normal literacy and academic language abilities at school age.** However, the data on speech and language in school-age internationally adopted children are mixed. Initial teacher survey data by Dalen and Rygvold (2006) found that internationally adopted children from poor countries with third-world health care systems had worse “academic language” than nonadopted children. In contrast, children adopted from countries with good health care and economic resources were equal to—if not better than—nonadopted children.

## “Mythbusters” (continued)

Recent direct assessments of children adopted at young ages from China indicate that by school age, most are performing at average to above-average levels on literacy measures (Scott, Roberts, & Krakow, 2008). Similarly, parent-reported data on children adopted at young ages from Eastern Europe found that by school age, 80% were in regular education classrooms without accommodations (Glennen & Bright, 2005). However, the same parents reported that 27% of the children were receiving speech and language intervention.

One crucial factor across all studies of school-age children is the child’s age at adoption. Parent-reported data on children adopted at 3–6 years of age from Eastern Europe found that after five years home, 57% of girls and 82% of boys were diagnosed with communication disorders (Beverly, McGuinness, & Blanton, 2008). Similarly, Dalen and Rygvold (2006) found that children adopted from Colombia at older ages were more likely to have poor academic language abilities at school age than children adopted at younger ages.

The important fact is that most children adopted before age 2 have normal language abilities during the pre-school years, and continue to have normal literacy and academic language abilities at school age. Internationally adopted children who experience difficulty with higher-level academic language tasks should be assessed and provided with appropriate supports and services based on assessment results.

**Myth 6: Internationally adopted children require unique speech and language diagnosis and intervention methods.**

**Evidence: Newly arrived infants and toddlers can be reliably assessed using measures of prelinguistic abilities such as vocalizations, gestures, and social pragmatic abilities** (Glennen, 2007) (See Table 1). Children adopted at 12–24 months of age who initially scored within normal limits on the Communication and Symbolic Behavior Scales-Developmental Profile (Wetherby & Prizant, 2002) did well when reassessed one year later. Conversely, all but one of the children who initially scored below normal limits continued to have poor language and speech abilities one year later.

The rate at which a child learns to comprehend new words is another important factor to consider when assessing newly arrived children (Glennen, 2007). Children who learn to comprehend new words at a rapid pace do better than children who learn new words at a slower rate. Surprisingly, the rate of learning to express new words is not as predictive when children first arrive home.

The guidelines in Table 1 are useful for newly arrived children; however, after one year home children adopted before age 2 can be assessed using standard English language procedures. The exception is measures of expressive syntax such as mean length of utterance (MLU). Expressive syntax and morphology requires additional time to develop in internationally adopted children and is not a reliable measure of language abilities until children are age 4 (See Figure 1). Although the children catch up quickly in vocabulary, including expressive vocabulary, measures of MLU, sentence repetition, and morphology elicitation tasks indicates that expressive syntax and morphology take longer to develop to English-language norm levels. We can rule out processing difficulties as the cause of these delays because the same children score well on tasks that assess comprehension of complex directions, and tests of syntax and morphological comprehension.

In contrast to infants and toddlers, children adopted at older ages are difficult to assess when they first arrive. Prelinguistic guidelines that work for young children are not developmentally appropriate for older children, and linguistic measures are not valid. However, preliminary evidence based on a small number of children who were adopted between the ages of 2 and 4, indicates they can be assessed using most standard English language comprehension measures after one year home (Glennen, in press). Expressive language emerges more slowly; children adopted at ages 3 and 4 can be assessed using expressive language measures two

## “Mythbusters” (continued)

years after adoption (see Figure 2).

<b>Table 1. Language and Speech Assessment Guidelines for Newly Arrived Internationally Adopted Infants &amp; Toddlers</b>	
<b>Prelinguistic Communication Abilities</b>	<b>When to Refer for Speech-Language Intervention</b>
Social communicative abilities • Eye contact • Frequency of communication • Intent of communication (i.e., attention, request, protest, comment)	Social communication should be normal for the child’s age. Refer any child with poor eye contact or infrequent communication attempts.
Use of gestures • Variety of gestures • Gestures combined with vocalizations • Gestures combined with eye gaze shifts (from object to person and back) • Complexity of gestures (single versus combination gestures)	Use of gestures for communication should be low average to average for the child’s age. Refer any child with mild or greater delays in gestural communication.
Vocalizations • Frequency of vocalizations • Vocalizations used to communicate • Variety of vocalizations (i.e., number of syllables, repeating versus non-repeating syllables and sounds) • Sound inventory (consonants heard within vocalizations) • Production of first words (for children adopted after age 16 months)	Some newly adopted children may be unusually quiet. In secure play-based settings the child should begin to vocalize. With the exception of expressing words, vocalization abilities should be low average or better for the child’s age.
Symbolic play • Developmental level of play (i.e., banging versus true symbolic) • Variety of play (i.e., variety of objects used and actions performed) • Use of combinations in play (i.e., pouring into a cup then drinking from it)	Symbolic play should be low average to average for the child’s age. Refer any child with mild or greater delays in symbolic play abilities.
<b>Comprehension Abilities in the Adopted Language</b>	
English comprehension after 3 months home • Comprehension of simple commands and first words • Developmental quotient Score for word comprehension on the Macarthur Communicative Development Inventory–Words & Gestures (See Glennen 2007)	Children adopted after age 12 months should quickly show signs of comprehending the new language. Refer any child who is not rapidly developing these skills. MCDI developmental quotient for word comprehension should be 47 or higher (Glennen 2007). Refer any child who falls below this threshold.

If it is determined that a child has a speech or language delay, the process of making a diagnosis and developing intervention plans is identical to that for any other child. The internationally adopted children I follow (2005, 2007) provide an example of this process. One year after adoption, 22% percent of the children had delays in speech, language, or both. They had a variety of diagnoses including global developmental delays, expressive language delay, receptive language delay, autism, and phonological disorders. In summary, there was no unique “international adoption speech and language disorder” or unique intervention. Speech and language intervention should target each child’s diagnosis and symptoms, not the adoption status.

## “Mythbusters” (continued)

**Myth 7: Now that evidence-based information is available, professionals are making better decisions about speech and language in internationally adopted children.**

**Evidence: Some SLPs are unaware of current research and do not use it in making treatment decisions.** From 54% to 68% of internationally adopted children are referred for speech and language assessments, and 35%–50% receive intervention (Glennen, 2007; Glennen & Masters, 2002; Mason & Narad, 2005) a rate that is higher than the incidence of disorders in this population (22%). The decision to assess or treat is often made randomly. During the first year home, 17 of 27 (68%) newly adopted toddlers followed in my research were separately assessed for speech and language by early intervention teams (Glennen, 2007). Thirteen of the children (48%) were then seen for speech and language intervention. This group included five of the six children who were later diagnosed with language and speech delays, but also included 8 children whose language developed normally. According to prelinguistic language assessments conducted when the children were first adopted, these eight did not need speech and language treatment. Although these 8 children surely benefited from the intervention, many of them were functioning at the top of their peer group when they were first adopted, and continued to develop language at a rate that surpassed their peers. Early intervention alone did not cause this to happen.

Reports about services for older internationally adopted children are also cause for concern. One child in my longitudinal study was adopted from Eastern Europe at age 4. By second grade she was struggling academically and her parents requested a school-based assessment. School officials insisted the child had to be tested in her birth language. The parents protested this decision, as the child had neither heard nor spoken the language for four years. They noted that the Individuals with Disabilities Education Act requires assessment in the child’s primary language and maintained that the birth language was no longer primary. Their protest delayed the assessment process until the case was finally brought to the attention of the head of English as a second language services, who asked the school to proceed with English language testing. My son had a true expressive language and phonological disorder that required treatment, and he received the early language intervention he needed. However, some internationally adopted children, are put on “wait and see” protocols for extended periods of time, or referred to ESOL programs that fail to meet their extensive language-learning needs. Conversely, other children receive services even when they excel on every language measure given (Glennen, 2007). It’s time to stop providing services based on anecdotes and myths, and instead make clinical decisions for internationally adopted children based on research.

**Sharon Glennen, PhD, CCC-SLP**, is professor and chair of the Department of Audiology, Speech Language Pathology and Deaf Studies at Towson University. The adoption of two children from Russia prompted her interest in language development and disorders in internationally adopted children. Contact her at [sglennen@towson.edu](mailto:sglennen@towson.edu).

Portions of this article were previously published as Glennen, S. (2007). International adoption speech and language mythbusters. *Perspectives on Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations: American Speech Language Hearing Association Division 14 Newsletter*, 14(3), 3–8.

### References

- Ames, E. (1997) *The Development of Romanian Children Adopted into Canada: Final Report*. Burnaby, B.C.: Simon Fraser University. Funded by National Welfare Grants.
- Beverly, B., McGuinness, T., & Blanton, D. (2008). Communication and academic challenges in early adolescence for children adopted from the former Soviet Union. *Language, Speech and Hearing Services in Schools*, 39, 303-313.

## “Mythbusters” References

- Dalen, M. & Rygvold, A.L. (2006). Educational achievement in adopted children from China. *Adoption Quarterly*, 9, 45-58.
- Gindis, B. (2003). What should adoptive parents know about their child's language-based school difficulties? Post-Adoption Learning Center, Retrieved May 28, 2007 from <http://www.adoptionarticlesdirectory.com/Article/What-should-adoptive-parents-know-about-their-children-s-language-based-school-difficulties---Part-1-15>
- Glennen, S. (2002). Language development and delay in international adoption: A review. *American Journal of Speech Language Pathology*, 11, 333-339.
- Glennen, S. (2005). New arrivals: Speech and language assessment for internationally adopted infants and toddlers within the first months home. *Seminars in Speech and Language*, 26, 10-21.
- Glennen, S. (2007). Predicting language outcomes for internationally adopted children. *Journal of Speech, Language & Hearing Research*, 50, 529-548.
- Glennen, S. (in press). Speech and language guidelines for children adopted from abroad at older ages. *Topics in Language Disorders*.
- Glennen, S., & Bright, B., (2005). Five years later: Language in school-age internationally adopted children. *Seminars in Speech and Language*, 26, 86-101. Glennen, S., & Masters, G. (2002). Typical and atypical language development in infants and toddlers adopted from Eastern Europe. *American Journal of Speech-Language Pathology*, 11, 417-433.
- Glennen, S., Rosinsky-Grunhut, A., & Tracy, R. (2005). Linguistic interference between L1 and L2 in internationally adopted children. *Seminars in Speech and Language*, 26, 64-75.
- Johnson, D.E. (2000). Medical and developmental sequelae of early childhood institutionalization in Eastern European adoptees. In C.A. Nelson (Ed.), *The Minnesota symposia on child psychology: The effects of early adversity on neurobehavioral development* (Vol. 31, pp.113-162). Minnesota Symposium on Child Psychology.
- Law, J., Boyle, J., Harris, F., Harkness, A., & Nye, C. (2000). Prevalence and natural history of primary speech and language delay: Findings from a systematic review of the literature. *International Journal of Language and Communication Disorders*, 35(2), 165-188.
- Mason, P., & Narad, C. (2005). International adoption: A health and developmental prospective. *Seminars in Speech & Language*, 26, 1-9.
- Miller, L. (2005). *The Handbook of International Adoption Medicine*. New York: Oxford University Press.
- O'Connor, T.G., Rutter, M., Beckett, C., Keaveney, L., Kreppner, J.M., & the English and Romanian Adoptees Study Team (2000). The effects of global severe privation on cognitive competence: Extension and longitudinal follow-up. *Child Development*, 71, 376-390.
- Pallier, C., Dehaene, S., Poline, J., LeBihan, D., Argenti, A., Dupoux, E., & Mehler, J., (2003). Brain imaging of language plasticity in adopted adults: Can a second language replace the first? *Cerebral Cortex*, 13, 155-161.
- Pollock, K., & Price, J. R. (2005). Phonological skills of children adopted from China: Implications for assessment. *Seminars in Speech and Language*, 26, 54-63.
- Roberts, J., Pollock, K., Krakow, R., Price, J., Fulmer, K., & Wang, P. (2005). Language development in preschool-aged children adopted from China. *Journal of Speech Language & Hearing Research*, 48, 93-107.
- Rutter, M. & The English and Romanian Adoptees Study Team (1998). Developmental catch-up and deficit following adoption after severe global early privation. *Journal of Child Psychology and Psychiatry*, 39, 465-476.
- Scott, K., Roberts, J., & Krakow, R. (2008). Oral and written language development of children adopted from China. *American Journal of Speech Language Pathology*, 17, 150-160.



First Steps

**Indiana First Steps**  
**Early Intervention System**  
**Provider Update Newsletter**  
**May 2009 Volume 3, Issue 1**



First Steps

---

**New Progress Report Mandatory May 1, 2009**

You should be now using the new Progress Report for children you serve. Remember, they are due at the beginning of the 3<sup>rd</sup>, 5<sup>th</sup>, 9<sup>th</sup>, and 11<sup>th</sup> month. Check with your local SPOE to see what the SPOE Procedures are for progress reports. You may find these forms both in PDF and Rich Text format at: <http://fswc0.tripod.com/> Click on Provider Progress Reports.

***Directions for completing the new Progress Reports***

The progress reports are due to the SPOE/Service Coordinator at the beginning of the 3<sup>rd</sup>, 5<sup>th</sup>, 9<sup>th</sup> and 11<sup>th</sup> month. Below are instructions on how to complete each field in the form. Once the form is complete, you must save the document and can name the file for easy retrieval for example: Jane Smith 3Q.

The form states: "Please submit electronically by saving and emailing to the SPOE office and to the Service Coordinator." You should send to your local SPOE office following their specific procedures for submitting progress reports. All SPOEs do things a little different so if you need clarification of who/where to email the information, contact your service coordinator.

If you are added to the plan, you are still responsible for adhering to the same timelines as the other team members for progress reports. For example: If your specialty is added at the 6-month review, you will make your first progress report at the 9 month date. You should mark this as the 9 month report like other team members.

**Child's Information:** This is quite self-explanatory by the fields available. If the child has an adjusted age, please fill it in. You may list the ICD-9 code in this area.

**Report Date:** This should be the date you complete the form.

Please mark which report period you are commenting on for the child.

**Family Information:** Please list the information in the fields. For kids with multiple household addresses, please list the primary parent.

**Provider completing this report:** This is your contact information.

**Team Information:** Please list all team members. You may include email addresses under "Other Team Members" if you would like. Be sure to include the physician.

**IFSP and Service Delivery Information:** List the IFSP date and your frequency as listed on the IFSP. "New Authorization for this reporting period...?" This refers to 30 day start date. If your specialty was added after the initial or 6 month, you should comment on when you first saw the child.

**Number of completed visits:** per quarter reporting

This is true for Number of missed visits. Make-up visits can only be during the same week of scheduled visit. For example: Family calls to cancel on Tuesday due to child being sick. You can visit on Thursday the same week. You would note this in this area.

**Review of progress report with family:** This will be a future date. You complete the report on 4-2 and your next visit is 4-9. You will list the 4-9 date and reflect your review with the family on your Face-to-Face sheet. “Left a copy and reviewed the 3<sup>rd</sup> month progress report with family during therapy session.”

**Outcome Review:** Please list the outcome. You may paraphrase. You have about one line for typing. (More space cannot be added to the PDF, however, with the rich text format, you have unlimited space.) You should only be commenting on outcomes where your discipline is listed and circled on the outcome page. For example: If you are a DT, you would not be listed on an outcome about feeding issues.

**Outcome Progress:** Check the box that is appropriate for the child’s progress towards achieving the outcome.

**Narrative:** You may write a narrative discussing the three specific skills or you may list the skills then write a short narrative to include any additional information you feel is needed. You have a limited field of @600 words. The field in the rich text is unlimited. It is suggested you only write information as it pertains to the outcome. Any additional information may be listed under additional notes. Please be sure you use family friendly terms that all team members will understand.

**Next Steps:** Comment on what you feel should happen next by marking the appropriate box.

**Additional Notes:** You have an additional four lines to add more notes in the PDF format. This can be used to complete your narrative if needed.

**Provider/Date:** This is where you will type your name and date. You should only do this on the last outcome page. For example: if you are writing a report that includes 2 outcomes, you may only “sign” the last page. Print off after saving and sign your signature in ink to the last page and keep for your records. (You will keep the original of each progress report in the child’s working file.)

Send completed progress report electronically to all team members. You may mail a copy of the report to the physician.

## **Offering Advice to Families**

Please be very cautious when offering advice to families. You should not be offering your opinion about immunizations, diagnosing children, or children’s diets such as the Gluten Free Diet. Please refer the families back to their Primary Care Physician about these issues.

## **Annual Credentialing**

When submitting your annual credentialing grid, please make sure your trainings do not overlap from one credentialing year to another. You may submit training with the date of one month before your annual credentialing date. This will allow you to use any training you accrued after you annual packet has been submitted to the CRO for processing. Please send in your credentialing information 4 weeks before your credentialing date to allow for the CRO to process. You may not use training before the one month cut off date. For example: Your annual credentialing date is 6/01/2009. You send in your packet to the CRO on 5-1-09. You may use trainings you attended from 5-1-2008 to 5-1-2009. You may not use training from before 5-1-2008 for your 2009 date. If you have additional questions or concerns, please email the First Steps website.

## Prorating Experience for Credentialing

Please make sure you are prorating your experience for credentialing purposes correctly. This is the chart from the First Steps Personnel Guide 2-2009. Please follow these guidelines:

### Birth to Three Experience

**\*You must prorate if you work only part time in First Steps.**

- 1-10 hours per week- .25 points
- 11-20 hours per week-.5 points
- 21-30 hours per week- .75 points
- 31-40 hours per week- 1.0 point

CSC Covansys will also be adhering to these guidelines when processing initial and annual credentialing packets.

When using trainings/conferences for your specialty, make sure they are appropriate for the birth to three population First Steps serves. If the training covers a wider age group, you may only use a portion of the training hours. Typically, half the training hours would be appropriate in this case. For instance, you attend training on billing codes for 6 hours. You serve birth to three and children over three, you may only claim 3 hours of the training for your First Steps credentialing.

## New Personnel Guide

Please take some time to review the new First Steps Personnel Guide. It is posted on the First Steps website under "What's New?" We are **no longer** enrolling Developmental Therapy Associates into the system as providers. DTAs that enrolled prior to our CRO transition were grandfathered into the new CRO system as a specialty.

## Diagnosis codes/ICD-9 Codes

Please remember to use the most appropriate code when billing. This can be a code you got directly from the primary care physician, a new diagnosis the family has received, code listed on the IFSP or the Physician's Health Summary. Using the appropriate code for your specialty will assist the family in getting TPL to bill their insurance company properly.



**First Steps**

## **First Steps Bulletin**

**Original Date 4-1-1997**

**Updated Date: 4-16-09**

(Effective Date :) 4-16-09

**Topic: Early Intervention Co-Treat  
Practices and Reimbursement**

**Bulletin Number: 04162009**



**First Steps**

When two providers plan and provide service together, for an individual child simultaneously, questions have emerged regarding how these services should be billed for reimbursement. This approach to services is often termed transdisciplinary and may be used as an intervention approach on an infrequent or frequent basis, depending upon the nature of the outcomes and needs of the individual child and family. This co-treatment may also be conducted in terms of providing family education and support related to individual therapies.

When two early intervention therapists work directly with a child and/or family together, they may each bill for one-half (1/2) of the total session time at their rate of reimbursement, taking into consideration the differential for off versus on-site service delivery. This policy is consistent with the reimbursement policy of the Indiana Medicaid Program, and is consistent with the historical billing practices under the grants/contracts system for First Steps Services.

However, with the use of Eligibility Determination Teams (EDT) throughout Indiana, two early intervention therapists may work directly with the child and family together and each bill for the total session time at their rate of reimbursement for their specialty if this form of treatment is approved by the IFSP team members including the Lead EDT member. This form of co-treatment must be approved prior to the first treatment session with the child and family.

*Please retain this First Steps Bulletin for future reference. If you have questions about this document, please send any questions to [Firststepsweb@fssa.in.gov](mailto:Firststepsweb@fssa.in.gov).*



**First Steps**

## **First Steps Bulletin**

**Original Date:** July 1, 1997

**Updated Date:** 04-16-2009

**(Effective Date:)** 04-16-2009

**Topic:** Procedure for Providers When Changing Enrollment Status due to Employment Change

**Bulletin Number:** 04162009



**First Steps**

### **Procedure for Providers When Changing Enrollment Status due to Employment Change**

This is to provide clarification on the process of provider enrollment status change (employment change) for providers and the subsequent actions/procedures required by the local SPOE office. If a provider changes employment status, they are required to report this change to the SPOE and/or service coordinator as soon as the change in status is known. The provider is also required to provide a 10 day prior written notice for the family to be notified of the change (or greater than 10 days if the notice is provided to the family's service coordinator) so the family is adequately notified and can complete the process for change in service provider. Changes relevant to this issue are:

- a provider changes employment from one agency/entity to another or,
- enters into private practice, and/or
- changes their provider enrollment discipline, or
- the provider is withdrawing their enrollment as a provider with the CRO, or
- a provider changes their enrollment to utilize an EIN (Employer Identification Number) from their SSN - For this type of change, providers must notify the SPOE so any new auths can be generated under the correct enrollment with the CRO.

In these instances, changes to the provider's authorizations in the SPOE database, as well as a child's IFSP will need to be made. These changes ensure that the provider and the services delivered are accurately reflected on the IFSP, and to prevent reimbursement difficulties for providers. These changes should also be made in such a way that allows for seamless service delivery for the family.

- The service coordinator is responsible for notifying the family of the change, as well as completion of paperwork associated a change in service
- The service provider shares their clinical recommendations with the team
- The service coordinator works with the family to identify a service provider and makes the appropriate modifications to the IFSP
- **Current authorizations for the provider's services (effective prior to the employment change) are terminated effective upon completion of services by that provider under the original enrollment status.**

**Topic:** Procedure for Providers When Changing Enrollment Status due to Employment Change

**Bulletin Number:** 04162009 (Page 2 of 2)

If the family chooses a new service provider, the service coordinator facilitates the process to notify the new provider of the referral and any paperwork that is associated with the selection of this new service provider in a timely fashion in order for the SPOE to enter new authorizations for the new provider. The service coordinator should also notify the previous provider of the change in a timely manner to avoid confusion about who is authorized to provide the service.

When a provider changes their employment status (as defined above), a family may elect to have the same provider continue to provide services after:

- the family has had their options reviewed with them
- the provider is confirmed to be available under the new enrollment status to serve the family and the service coordinator has verified this information
- the family has been fully informed of their options and decides to continue service with the provider

**In this situation, the SPOE will need to enter new authorizations for the provider under their NEW enrollment status in the SPOE database in a timely fashion so the provider can appropriately be authorized to provide services to the child under their new enrollment status and avoid any reimbursement difficulties with the CRO.**

**\*\*Authorizations MUST correctly reflect onsite or offsite location designation in order for the provider to be reimbursed correctly.**

*Please retain this First Steps Bulletin for future reference. If you have questions about this document, please send any questions to [Firststepsweb@fssa.in.gov](mailto:Firststepsweb@fssa.in.gov).*



**First Steps**

## **First Steps Bulletin**

**Original Date:** 7-1-2004

**Updated Date:** 4-16-09

(Effective Date:) 4-16-09

**Topic:** Early Intervention Direct Service Provider Matrix Guidelines



**First Steps**

**Bulletin Number:** 04162009

### **Early Intervention Direct Service Provider Matrix Guidelines**

The purpose of the provider matrix is to provide information to families allowing an informed selection of providers based on the needs of the family and child.

The matrix page should be viewed similar to a resume and include experience, training/certifications and education that can be verified. Experience must be professional experience that is comparable to the current position of the provider. Upon request, the provider must be able to submit verification for experience listed on the matrix.

**Misrepresentation of information on the matrix may be viewed as grounds for dis-enrollment from the First Steps program.**

The provider matrix is to be limited to experience, training and qualities important in selecting a provider. Comments must be professional and non-discriminatory. Comments relating to marketing or that do not relate to the individual qualities and training of the provider is not to be included on the matrix.

In order to maintain the integrity of the provider matrix, the Bureau of Child Development Services is requiring that providers adhere to the following procedures.

#### **Matrix Maintenance and Update Procedures:**

- The provider/provider agency must update individual provider matrix pages at a minimum of monthly or more often as needed. Comments and/or experience may be changed as deemed necessary.
- Availability should reflect the total number of available slots that the provider anticipates in the county/zip codes listed.
- The provider should list the counties and/or zip codes in which the provider is available to provide services. Counties and zip codes may be added or removed as availability in the county changes.
- Providers who list themselves as available must make every effort to provide services when selected. Only in those instances when the provider's availability changed with limited time to update the matrix, will be acceptable to not accept a referral.

- Providers may not discriminate based on race, social or economic status in listing zip codes available to provider service.
- Only experience in the field in which the provider is currently providing service is to be listed as experience. Experience should be calculated on a full time basis. Experience that was not full time should be pro-rated according to the Personnel Guide. Experience that is relevant, but not in the field of service may be listed in the comment section.
- Certifications and trainings may be listed in the comment section.  
The provider/provider agency assumes responsibility to ensure that the individual matrix pages are accurate and up to date.

### **Presentation of the Matrix**

- Families are to be made aware of the online provider matrix site.
- Intake and Service Coordinators are to have hard copies of the matrix for families to review.
- Intake and Service Coordinators should review with families the type of information provided in the matrix and how to determine if a provider is available.
- The family should be provided with information on providers who are available, as well as those who currently do not have openings.
- The Intake and Service Coordinator should discuss with families those qualities important to the family. Consideration should be given to specific days, hours that services should occur, experience with a specific diagnosis, assistive technology, and other qualities that would be meaningful to the provision of service.
- Other providers working with the family may also discuss with the family qualities to look for in a provider.
- Families are not to be provided with anecdotal, hearsay information, or personal opinion on the selection of a provider.
- Providers working with the family **may not** recommend another provider.  
Provider selections and/or changes, other than Service Coordinator changes, must go through the acting Intake/Service Coordinator. Service Coordinator changes must be facilitated through the Service Coordinator Supervisor at the local System Point of Entry (SPOE).

Providers who do not maintain their matrix page according to these procedures or whose page contains inaccurate information may be placed on Probation or dis-enrollment from the First Steps system.

Persons, who are aware of or concerned about the integrity of a provider's matrix page, should notify the cluster Local Planning and Coordinating Committee (LPCC) Coordinator. If the issue cannot be resolved, notification to the Bureau's First Steps Program Consultant will be sent by the Cluster as a concern.

*Please retain this First Steps Bulletin for future reference. If you have questions about this document, please send any questions to [Firststepsweb@fssa.in.gov](mailto:Firststepsweb@fssa.in.gov).*

## UTS FSCT Updates

As a First Steps provider you are required to attend one First Steps Core Training (FSCT) each year. The FSCTs are developed to provide baseline early intervention competency training for service coordinators and direct service providers. There are both face-to-face and distance learning options. Upcoming opportunities are listed below.

### **Distance Learning (limited to 60 participants —courses reopen monthly)**

FSCT- Direct Service Provider Refresher Course

FSCT- Providing EI Supports and Services in Everyday Routines, Activities, and Places

FSCT - A Family-Centered Approach to Procedural Safeguards

FSCT - Service Coordination Refresher Course

### **Face-to-Face FSCT Opportunities**

5/8/2009, 7/22/09 Evansville & 8/26/09 Indianapolis —FSCT - Using the AEPS to Develop Strategies for Therapy Sessions

5/12 & 13/2009 & 8/6 & 7/09 Indianapolis—AEPS Full 2-day Training

5/15/2009 Evansville, IN & 7/24/09 Indianapolis—FSCT - Home Visiting

6/18/2009 Indianapolis, 9/10/09 Bloomington & 9/25/09 Ft. Wayne—FSCT - The Paper Trail – A Guide to First Step Provider Documentation

5/19/09 Indianapolis, 8/28/09 Valparaiso & 9/18/09 Indianapolis— FSCT - Understanding Diversity within Families

Check the UTS website for training dates and registration: <http://www.utsprokids.org>

## A Message From Prevent Child Abuse Indiana

*By Sandy Runkle, MSW, Director of Programs*

Being able to recognize and address the issue of child maltreatment can be complicated. There are several types of child maltreatment, including physical abuse, neglect, sexual abuse, and emotional maltreatment. Included under those categories would be lack of supervision, medical neglect, educational neglect, verbal abuse, permitting a child to watch adults engaging in sexual behaviors...and the list goes on. Unfortunately we cannot begin to cover the full gamut of child maltreatment in just a few words, but we can provide you with some basic guidelines on what to look for, and how to report.

Some of the more obvious signs of maltreatment would be unexplained bruising, especially on areas that are not prone to bruising. For instance it is common for children to get accidental bumps on their “boney prominences”, such as knees, elbows, shins, and forehead. It would not be common however, to have bruising on the more “fleshy” areas, such as the face, buttocks, calves, or thighs. One thing we would caution though, is that it would not be common for an infant or pre-toddler to have bruises, even on their boney prominences, as they are not yet mobile and bumping into things or falling. Remember the old saying “we don’t bruise ‘til we cruise”. So again when we are talking about bruising, we are speaking of *age-appropriate* injuries. There may be other physical signs as well, such as welts, burns, fractures, lacerations or abrasions, hemorrhages burns by cigarettes or immersion, or oral injuries (perhaps from force feeding).

Neglect may come in many forms. Essentially, it is when a child’s basic needs for food, clothing, shelter, medical, education and supervision are not being met. Again, the signs may include (but are not limited to) severely underweight (for no medical reason), being left alone (especially if they are not developmentally ready...regardless of chronological age), torn or inappropriate clothing for the weather, not receiving appropriate medical attention, and not receiving an education (including not being home-schooled appropriately).

## A Message From Prevent Child Abuse Indiana (continued)

Neglect can be the most challenging to identify (how dirty is *too* dirty in terms of a house or a child), so if there is a question, it is better to report the concern, and let the Department of Child Services determine if the situation doesn't meet the legal standards of Minimum Sufficient Level of Care.

With regard to sexual abuse, the signs again may not be obvious, so if there is ever any reason to suspect a child is being sexually abused, it should be reported immediately. The Department of Child Services and/or law enforcement will determine what further evaluation (including medical) is necessary. Some signs *may* include: aggressive, overt sexual behavior; detailed drawings pictures of people with genitals or vagina; descriptive, pre-mature knowledge of explicit sexual acts, or they may actually report that sexual abuse is occurring. There may be physical signs, such as a venereal disease or injuries to the genitals or rectum, but those signs would need to be evaluated by a medical professional. Remember though, even if physical signs are not present, it does not necessarily mean a child is not being sexually abused. It is important to note that there is also "non-contact" sexual abuse, which includes allowing children to watch pornography, sending sexual content to a child through the internet or through other means, or exhibitionism.

Emotional maltreatment is just as detrimental as other forms of maltreatment, but it can be very difficult to investigate and to substantiate. It usually takes a therapist or physician to be able to substantiate emotional maltreatment. It does not mean, however, that it should not be reported. Some ways a child can be emotionally maltreated is through excessive name calling, not receiving appropriate psychological care, threats and intimidation, and/or excessive berating.

As we have mentioned, it is important to report any suspected acts of child maltreatment, and to allow the professionals to evaluate and investigate the allegations. In fact, it is the law to report even if you have "reason to believe" that a child is a victim of child abuse or neglect. In Indiana, *every person* is a mandated reporter. Reports can be made anonymously, but with any report, it is important to provide as much detail as possible. Include anything you may know about the child or the situation, e.g. names, where the child is located, what you saw, heard or documented, etc. The more detail you can provide, the better the chances are that the situation can be investigated and perhaps substantiated. To report child abuse, you may call 1-800-800-5556, 24 hours a day, 7 days a week. Please know that if you make a report *in good faith*, you are free from liability, meaning someone cannot then sue you for making the report, even if the report is unsubstantiated.

### Indiana Child Abuse and Neglect Data

- 2007 Deaths: 36
- Top Characteristics of Maltreatment
  - ◇ Family or Marital Discord/Violent Relationships
  - ◇ Lack of Knowledge/Parenting Skills
  - ◇ Substance Abuse
- 2006 Child Abuse Reports:
  - ◇ Total Reports = 84,707 children reported in Indiana
  - ◇ Substantiated or Indicated Reports = 20,857 children in Indiana
- Substantiated Reports By Type:
  - ◇ Neglect 64.6%
  - ◇ Sexual Abuse 21.4%
  - ◇ Physical Abuse 14%
- 2006 Child Fatalities By Age:
  - ◇ 53 Children in Indiana
  - ◇ 66% were 0-3 years of age
  - ◇ 33% over 3 years of age



# Child Abuse Laws in Indiana

## Juvenile Code:

- Encourages effective reporting of suspected or known incidents of child abuse or neglect
- Provides each county with an effective child protection services
- Provides children and families with rehabilitative services
- Establishes a centralized statewide child abuse registry and an automated child protection system

## Definitions:

Child abuse or neglect refers to a child who is alleged to be in need of services (CHINS). The complete text of the CHINS law. <http://www.ai.org/legislative/ic/code/title31/ar34/ch1.html>

## IC 31-34-1 A child is in need of services if before the child's 18th birthday:

- The child's physical or mental health condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent/guardian/ custodian to supply the child with necessary food, clothing, shelter, medical care, education, or supervision.
- The child's physical or mental health is seriously endangered due to injury by the act or omission of the child's parent/guardian/custodian. An omission is an occurrence in which the parent/guardian/custodian allowed that person's child to receive an injury the parent/guardian/custodian had a reasonable opportunity to prevent or mitigate
- The child is the victim of a sex offense under the criminal citations incorporated into the CHINS definition
- The child's parent/guardian/custodian allows the child to participate in an obscene performance
- The child's parent/guardian/custodian allows the child to commit a sex offense
- And needs care, treatment, or rehabilitation that the child is not currently receiving and that is unlikely to be provided or accepted without the coercive intervention of the court.

This definition includes a child with a disability that is deprived of: 1) nutrition necessary to sustain life ; 2) medical or surgical intervention necessary to remedy or ameliorate a life threatening medical condition if the nutrition or medical or surgical intervention is generally provided to similarly situated children with or without disabilities

## Religious Beliefs/Provision of Medical Treatment:

When a parent/guardian/custodian fails to provide specific medical treatment for a child because of the legitimate and genuine practice of the parent/guardian/custodian's religious beliefs, a refutable presumption arises that the child is not a child in need of services because of such failure. However, this presumption does not prevent a juvenile court from ordering, when the health of the child requires, medical services from a physician licensed to practice medicine in Indiana. The presumption does not apply to situations in which the life or health of a child is in serious danger.

## Use of Corporal Punishment:

Nothing in the Juvenile Code limits the right of a person to use reasonable corporal punishment when disciplining a child if the person is the parent/guardian/custodian of the child. In addition, nothing in this chapter limits the lawful practice or teaching of religious beliefs.

## Reporting:

Any individual who has reason to believe that a child is a victim of child abuse or neglect must make a report. In agencies in which there are established reporting protocols, the report may be made to the individual in charge or another designated agent, who also becomes responsible to report or cause a report to be made. This does not relieve individuals who make a report to another staff person of their own obligation to report directly to child protection services or law enforcement unless a report has already been made by the agency liaison. Anonymous reports are accepted. Failure to make a report can be a Class B misdemeanor.

## Child Abuse Laws in Indiana (continued)

The complete text of the mandatory reporting law. (IC31-33-5-1)

<http://www.ai.org/legislative/ic/code/title31/ar33/ch5.html#IC31-33-5-1> . The complete text of the failing to report law.(IC31-33-22-1) <http://www.ai.org/legislative/ic/code/title31/ar33/ch22.html#IC31-33-22-1> . The complete text of the false reporting law. (IC31-33-22-3)

<http://www.ai.org/legislative/ic/code/title31/ar33/ch22.html#IC31-33-22-3>

### Immunity from liability:

Any person, other than the accused, who reports child abuse or neglect or is involved in the investigation or disposition of child abuse or neglect reports is immune from criminal or civil liability, unless the person acted maliciously or in bad faith. The complete text of the immunity from liability law. (IC31-33-6-1)

<http://www.ai.org/legislative/ic/code/title31/ar33/ch6.html#IC31-33-6-1>

### Confidentiality:

All reports made to CPS are confidential and will only be released to CPS workers, police, prosecutors, doctors, or other authorized personnel. The complete text of the confidentiality law. (IC31-33-18-4)

<http://www.ai.org/legislative/ic/code/title31/ar33/ch18.html#IC31-33-18-4>

### Child Protection Services:

Each County Office of Family and Children must establish a CPS, which will be the primary agency responsible to receive, investigate or arrange for investigation, and coordinate the investigation of all reports of known or suspected child abuse or neglect. CPS must:

- Provide protective services to prevent a child's exposure to further incidents of child abuse or neglect. CPS must provide or arrange for, coordinate, and monitor the provision of services to ensure the safety of children. Reasonable efforts must be made to prevent a child's removal from the home
- Cooperate with and seek and receive cooperation of appropriate public and private agencies and programs providing services related to prevention, identification or treatment of child abuse or neglect

---

## Additional Training Opportunities

---

### Infant Toddler Specialists of Indiana Institute

**Theme:** "The Power of Play"

**Date:** Tentatively scheduled  
August 19, 20 & 21, 2009

**Location:** IUPUI Student Center

**Time:** 2 Full Days

**Structure:** 2 Tracks: Track 1 primarily for Practitioners who work directly with Infants, Toddlers and their Families and Track 2, primarily for Administrators, Trainers, Researchers, Policy-Makers, and Students



### IIDC Summer Training Building A Foundation for Success

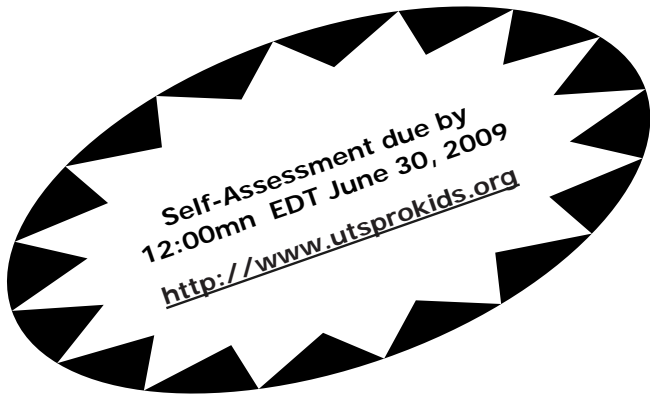
On-line June 19 - August 14, 2009

CEUs and/or IU Graduate Credit available

Register by June 1, 2009

<http://www.iidc.indiana.edu/ecc/Content/SI2009-FlyerFill.pdf>

UTS Programmatic Training  
ProKids, Inc.  
6923 Hillside Ct.  
Indianapolis, IN 46250



## TRAINING ANNOUNCEMENT

**“Promoting Young Children’s Participation in Activities and Routines through Adaptation and Assistive Technology Interventions” by Pip Campbell, OTR, Ph.D.**

**June 12, 2009**

**Ft. Benjamin Harrison, Indianapolis, IN**

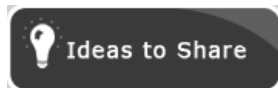
**\$40 - lunch provided**

**Register at <http://www.utsprokids.org>**



Looking for a great training that will provide you with information you can use immediately with the children/families you serve. Adaptation and Assistive Technology (AT) interventions can help children participate even when they don't yet have typically needed skills. This session will show a system for deciding when to use adaptations/AT, provide multiple examples of devices and strategies, and provide resources to assist professionals to identify AT so that children can perform 4 functional abilities: communicate, move around their environments, use their arms and hands, better socialize and can participate more effectively in 12 typical activities and routines (e.g., mealtime; playtime; outings). Click on the Tots N Tech webpage below for ideas and resources on AT and adaptations.

Dr. Campbell began her work as an occupational therapist with children with severe and multiple disabilities. Since that time, she has directed numerous externally funded research, training, and demonstration projects that have developed models of intervention for infants, toddlers, and school-age students with disabilities with a focus on promoting family-centered practices and including children in activities and routines of everyday life at home, in school & child care, and in the community.



**More adaptation and assistive technology resources are available at:**  
**<http://www.asu.edu/clas/tnt/>**