**Is Early Intervention Truly Universal and Beneficial?**

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**Abstract**

Early Intervention was created through Part C of IDEA in order to provide services and assistance to children between birth and three years of age who are presenting with developmental delays or who have been identified as being at a greater risk of developing developmental delays or disabilities. Early Intervention aims to provide services and support for the child and their family with the hopes that this will help to diminish the need for services in the future through the educational system and Part B of IDEA. It also hoped that through these supports families will be less inclined to turn to institutionalization for assistance and relief. Universal accessibility and broad eligibility was the goal of Part C of IDEA. Unfortunately this ideal has not necessarily been the case of best practice. There are numerous barriers that stand in the way of Early Intervention Services from being universally accessible and beneficial to all children who may have or be at risk for developmental delays and disabilities. This paper aims to identify and investigate three perspectives of barriers to the overall accessibility and usefulness of Early Intervention. The first is the accuracy of the assessments utilized in order to determine eligibility, the competence of pediatricians and primary care providers in regards to early intervention and making referrals, and lastly the impact on socioeconomic and minority status on accessing services. These perspectives will then be analyzed and their ethical implications discussed. Policy recommendations include providing more informative training to those that are in the position to make referrals and offer services. In order to combat these barriers and actively work towards the ideals of Part C of IDEA.

**Introduction**

The Individuals with Disabilities Education Act, also known as IDEA, was first enacted in 1975 and was known as the Education for All Handicapped Children Act (Dragoo & Library of Congress, 2018). The purpose of this act was to offer free and appropriate public education for those children with a developmental disability and in need of additional support. Note the presence of the term “public”. This is important as private education is very costly, and is not universally accessible. The goal of the act was to provide universal education, or in other words to make education accessible universally to all children despite the presence of a developmental delay or disability. Cost is a very large roadblock and reducing or eliminating cost goes a long way in ensuring universal access.

When the Act was first established, it focused primarily on children older than three or four years old; those who were enrolled in elementary school were the target demographic. This was a great beginning, but it left out significant demographics- the children who had not yet reached school age, those who were three years old and younger. The IDEA that we are familiar with now includes children from birth and continues until the age of 21. Increasing the age range of eligibility was extremely beneficial to those who have children that are presenting with either a developmental delay or disability, outside of the original catchment demographic which was school age children. Transitioning into the school system, as well as out of it, was a cumbersome task and often difficult to navigate. The changes to IDEA assisted in addressing these transitional periods, making them less challenging. Greater supports are to be considered a necessary tool to greater success. This paper aims to provide more information on IDEA; more specifically Part C which outlines Early Intervention Services and the benefits of these services for children, their families and the society that we live in as a whole. This paper will dive into who is receiving services, what is necessary in order to be considered eligible for services, the reality of the referral process, the role played by our healthcare system and the quantity, variety, and quality of services provided by Early Intervention agencies. Part C of IDEA aimed to be inclusive, and universally attainable and beneficial. Unfortunately, these ideals may not be the reality of Early Intervention, which is precisely what this paper aim to explore further.

**Literature Review**

**Developmental Assessments Utilized for Eligibility Determination**

During the reauthorization of IDEA, in 1986, Part C was added and extended its services in order to also support children between birth and three years of age who have a developmental delay or disability and provide them with services (Dragoo & Library of Congress, 2018). This change allowed for early detection of developmental disabilities in infants and toddlers. Early detection allows for early intervention, possibly reducing the need for the utilization of services later on. In addition, this allowed families to gain the support needed to better care for and meet the needs of their child, hopefully reducing the need or desire to seek out institutionalization (Dragoo & Library of Congress, 2018). The specific service that is offered to these children and their families is Early Intervention, often referred to as EI. The main requirement of Early Intervention is to provide each child and family with a unique and individualized plan in order to meet their specific needs. Children that are eligible for Early Intervention services under IDEA are children who are identified as having a developmental delay, have received a medical diagnosis or have a high likelihood of developing developmental delays later on down the line (Dragoo & Library of Congress, 2018). This idea of a developmental delay is not abstract or subjective, rather it is objective, specific and often determined utilizing developmental screenings.

There are a variety of developmental screening tests available that can be utilized in determining whether or not a child has any developmental delays. Three of the more popular developmental screening tools are the Developmental Profile II (DP-II), Denver-II (DO-II) and Battelle Developmental Inventory Screening Test (BDIST). The first tool DP-II has five different categories that it observes: physical, self-help, social, academic and communication. These categories were normed for children between the ages of 0 and 9 ½. This test is administered through a parental report along with child observation of specific behaviors. DP-II provides a developmental age when subtracted from the actual age which shows whether or not a child is advanced, average, borderline or delayed in their development. Unfortunately, there are some shortcomings of the DP-II. When the DP-II was normed, it was limited to children in the geographic location of Washington and Indiana. Additionally, only “Blacks and Whites'' were utilized (Glacose & Bryne, 1993). However, DP-II is often used in health-care settings as a developmental screening tool because of its reasonable administration time of ten minutes, its optional direct administration option, and the variety of scores it offers providing program eligibility scores (Glacose & Bryne, 1993).

The second test that is often utilized when determining eligibility is the Denver-II. This is the newer and more updated version of the Denver Developmental Screening Test-Revised often referred to as DDST-R. This developmental screening had been standardized in 14 countries and translated into over 40 different languages (Glacose & Bryne, 1993). Similarly to the DP-II, the Denver-II also utilizes a combination of parental report, direct elicitation and observation. DP-II provides a single score placing an individual in any of the following categories: abnormal, questionable, untestable, or pass on the following domains: fine motor-adaptive, personal-social, and gross motor. Unfortunately, Denver-II mirrors DP-II’s shortcomings by being normed in a limited geographic location. The population utilized for standardization was solely in Colorado, a limitation along with the lack of validity testing by the authors was a concern (Glacose & Bryne, 1993).

Battelle Developmental Inventory Screening Test (BDIST), is the third often utilized developmental screening tool. The BDIST has seven subsets that it measures, which are personal-social, adaptive, fine motor, gross motor, expressive language, receptive language and cognitive skills. Due to the ability to utilize BDIST when determining eligibility, it is very popular and used often with special educators (Glacose & Bryne, 1993). Unlike the previous two developmental screening tests, the BDIST takes at least 30 minutes and sometimes longer with older participants. The BDIST was standardized on a nationally representative sample; however, there were rumors that the inventory overproduced failing scores to its younger participants leading the authors to calibrate their norms (Glacose & Bryne, 1993).

The DP-II, DO-II and BDIST are the three most utilized developmental screening tools, which makes it very important that they are accurate. For this reason, Glacose and Bryne (1993) conducted a study in order to examine the accuracy of these three developmental screening tests. The results of their study showed that the academic scale of the DO-II was rather unsuccessful and did not identify many of the students who were in fact having difficulties. Fortunately, the DP-II was more sensitive and better able to identify children with developmental delays and disabilities. This being said, though the DP-II was more successful than the DO-II when grouping the questionable passing scores, the DP-II still failed to identify approximately half of the children with disabilities. When the opposite approach of grouping questionable failing scores, the results tilted in the opposite direction identifying more children with disabilities than accurate. Of the three developmental screening tests discussed in this paper, the most successful one utilized is the BDIST. However, it is not without its flaws, and inaccuracies do occur. In order for it to be the most useful and accurate, the 1.5 level was recommended to be the most utilized cut off as it resulted in more accurate detection of children presenting with a developmental delay or disability (Glacose & Bryne, 1993).

Developmental screening tools are utilized in order to determine eligibility for services under part C of IDEA. For this reason, their accuracy is extremely important. If the developmental screening tool does not catch a child with a developmental delay or disability, that child is not eligible for services, leaving them and their family without the necessary supports and services that they may need. This may lead to a more difficult transition into the school system and navigate part B of special education services. If the screening tool misidentifies children as having a developmental delay or disability, this has many negative implications. Early Intervention services were developed to provide services to all eligible children, which is not possible when eligibility is skewed due to a lack of representation when standardizing the tool or when the tool being utilized lacks reliability and validity.

**Pediatrician Competence and Awareness of Early Intervention**

The very first step that needs to be taken in order to receive Early Intervention services is the completion of a referral. Referrals are made to specific Early Intervention agencies on behalf of a child and their family. Once the referral has been completed, the agency can make an attempt to contact the family and arrange to determine if the child is, in fact, eligible for services. Referral sources vary, and truthfully can come from just about anyone. However, common referral sources are the child's parent/guardian, their pediatrician or primary care provider, the department of child and family services, or a family friend. One of the more common referral sources, and arguably one of the more impactful referral sources, is the pediatrician or primary care provider. Pediatricians and primary care providers are highly regarded and respected; they typically have the respect and trust of the child's family. It is also often assumed that pediatricians and primary care providers have a wealth of knowledge regarding child development and have the skills necessary to identify possible delays and diagnosable developmental disabilities. This being said, pediatricians and primary care providers are on the front lines and have a very important role in referring children and their families to Early Intervention services when appropriate.

Becoming a doctor requires extensive schooling and training. Specifically, when becoming a pediatrician, you typically undergo a pediatric residency where you are trained and mentored by pediatric residency training directors and experts in the field. Edwards (2018) researched the role that these mentors play when educating future pediatricians on Early Intervention and the services that they provide. She sent out a survey to the Pediatric Residency Training Directors the list of which was available through the American Medical Association website. The survey aimed to determine the Pediatric Residency Directors' understanding of Early Intervention, the role they feel they play in earlier referrals, and lastly, their perceived adequacy of training efforts. Unfortunately, most participants reported having minimal knowledge of Early Intervention Services, feeling unfamiliar with Part C of IDEA (Edwards, 2018). This lack of awareness and understanding of Early Intervention held by the Residency Training Directors removes any likelihood that they are educating future pediatricians on Early Intervention Services, their benefits, or the referral process. Early Intervention has been proven to be very successful; however, their success relies on them being utilized. This lack of awareness gets passed down to the pediatric residents as they absorb the information that they are given, focusing on the things that had the greatest emphasis during their residency. Unfortunately, this perpetuates the cycle of lack of familiarity and utilization of Early Intervention Services diminishing the likelihood of impactful referrals.

A gap is seen between identifying a developmental delay in the primary care setting and starting Early Intervention Services (Conroy et al., 2018). It is reasonable to think that the information above may have an impact on this unfortunate observation. It should be noted that pediatric and primary care practitioners' responsibility is not to conduct Early Intervention evaluations or screenings, but instead to refer the children and their families to Early Intervention Services and assist them in making a valuable connection with Early Intervention Services. Conroy (2018) saw this gap and felt it important to embark on a quality improvement study with the following objectives: a better system in order to encourage families to connect with Early Intervention, create clear referral pathways per specific Early Intervention agencies, and lastly a system in order to track referrals after the fact in order to determine the families that are failing to connect with Early Intervention. Conroy (2018) hoped to ensure that the agencies would evaluate most families referred to these Early Intervention agencies. Through concrete changes, such as creating an electronic referral system that allowed for direct and accurate referrals to Early Intervention agencies improved the communication between the primary care facility and the Early Intervention agencies. Creating an Early Intervention registry allowed for follow up when barriers and difficulties arose for the family (Conroy et al., 2018). The effort shown through this quality improvement study is ideal. Hopefully, other primary care facilities will utilize this information to make changes and allow for better communication with Early Intervention agencies, decreasing the gap in identifying developmental delays and the referral process for Early Intervention services.

Though, at times, it may be difficult to accept disparities in the medical field, and pediatricians are not an exception. Overall it is highly recommended that pediatricians screen for autism spectrum disorder in all children. The hope is that early screening will allow for early detection. Identifying autism spectrum disorder early on allows for earlier interventions; similarly to other developmental delays and disabilities, early detection, and early intervention is key. Intervening early on allows for better development in the future, a large motivation for the American Academy of Pediatrics to recommend universal screenings for all children (Wallis et al., 2020). This being said, though encouraged to screen all children for autism spectrum disorder and other possible developmental delays, a disparity still exists between those children who have received this diagnosis and the children who have received interventions such as Early Intervention in minority children (Wallis et al., 2020). Wallis et al. (2020) completed their study to better understand this disparity and shed light on the unfortunate situation. It was found that though a majority of the children associated with this large primary care network were receiving developmental and autism spectrum disorder-specific assessments. However, the number of referrals to Early Intervention, along with other developmental supports were rather low (Wallis et al., 2020). The rates of Early Intervention referrals differed based on sex (male or female), family’s primary language spoken in the home, developmental presentations, socioeconomic status, and race. The reason behind these differences was not clear; however, what was clear was the lack of equity in regards to Early Intervention referrals after an autism spectrum disorder diagnosis or the determination of a developmental disability or delay. It is extremely important that pediatricians and the facilities they work for are ensuring that they are evaluating and aware of their implicit biases and are consistently working towards equity in all aspects of their work. However, it is especially important when considering the well being of children. These pediatricians should be champions of these children, actively working against their implicit biases to ensure that they are being referred to Early Intervention, as opposed to acting as a barrier to receiving these services. Pediatricians are placed on the same pedestal as other healthcare providers, and it is presumed that they are all-knowing and can do no wrong. Realistically this is far from the truth; pediatricians and other healthcare providers are still individuals at the end of the day, individuals that are flawed and capable of making mistakes and unknowingly operating off their biases.

Early Intervention services are not limited to children diagnosed with a developmental diagnosis. To be eligible for Early Intervention services, you must be considered eligible, and eligibility is given based on any current developmental delays, diagnosis, and specific risk factors. This broad categorization of eligibility exists to allow for more interventions early on to prevent future needs for services. Tang, Feldman, Huffman, Kagawa, and Gould (2012) decided to look into neonatal follow-up programs in California and their referral practices. For the infants that are a part of these neonatal follow-up programs, a majority of them would most likely be eligible for Early Intervention Services as they are currently presenting with developmental delays or concerns for possible developmental delays, hence the need to be a part of the neonatal follow-up program. This being said, not every infant associated with this program was referred to Early Intervention Services. Through their work, Tang, Feldman, Huffman, Kagawa, and Gould (2012) found that after the first follow-up appointment, many of the practitioners prescribed to the school of thought that more time was needed and that things would improve with more time and without intervention. High-risk infants or those that had failed their developmental screening did not receive a referral for Early Intervention services. The researchers thought that referral rates would most likely increase after the second follow up visit when things did not improve independently and without intervention. However, the proportions for the number of infants not referred after their first follow-up visit remained the same even after the second follow-up visit, despite possible lack of progress (Tang, Feldman, Huffman, Kagawa, & Gould, 2012). The lack of referrals after the second follow-up visit was even more disheartening because, as the child aged, their window of opportunity for Early Intervention Services decreased along with the potential for impactful interventions and beneficial developmental growth. By not intervening and providing an Early Intervention referral, pediatricians in this case directly stood in the way of these infants and their families from receiving beneficial services and support.

**Racial Disparities in Accessing and Utilizing Early Intervention**

Racial disparities have been clearly identified and documented through Early Intervention and have an impact on several levels. The first place where racial disparities begin is within the home of families in need of Early Intervention services for their child or children who are presenting with developmental delays or disabilities. Early Intervention is uniquely a voluntary program; families are not mandated in any way to engage and utilize services and can terminate services at any time. This being said, the family buy-in is incredibly important. Magnusson, Minkovitz, Kuhlthau, Caballero, and Mistry (2017) conducted a study where they worked to gain a better understanding of the beliefs of African American and Hispanic Mothers who are considered to have a low socioeconomic status in regards to developmental delays and Early Intervention. For their study, they conducted in-depth interviews with willing mothers who utilized one of the two urban pediatric primary care clinics used in this study. These interviews led to several themes that could be considered impediments on the mothers seeking services. The mothers described being able to notice if their child was delayed by comparing them to other children around. However, many noted that children age and develop at different rates and possible delays did not bring out major concerns. Where there were concerns mothers, felt comfortable relying on their own social networks as opposed to seeking out other services or utilizing suggestions made by their pediatrician, though not due to lack of trust. When Early Intervention was considered, there just seemed to be other social and financial needs that took precedence. Accessing services was also difficult; information was either confusing or felt inaccessible (Magnusson, Minkovitz, Kuhlthau, Caballero, & Mistry, 2017). If and when mothers decided to engage or participate in Early Intervention, it seemed due to external pressure or perceived pressures and not because they truly wanted to or saw the possible benefits for their child. This forced engagement tended to feel like an inconvenience, and the mother was still not engaged in a way that would be beneficial to either them or their child, reducing their likelihood of remaining in Early Intervention (Magnusson, Minkovitz, Kuhlthau, Caballero, & Mistry, 2017). One way in which to decrease this disparity, and to see greater levels of minority children involved in Early Intervention, would be to educate the mothers and families. This could be done by engaging them in a conversation about the needs and benefits of these services, providing them with information on how these services can be beneficial and supportive while giving clear and concise information on how to actually access these services.

Minority children are typically disproportionately underrepresented in Early Intervention (Morgan, Farkas, Hillemeier, & Maczuga, 2012). This is seen consistently, with many contributing factors. Having family engagement and buy-in is one of those factors; however, this is not the only one. Being appropriately referred to Early Intervention services by your pediatrician or primary care provider is also a factor that contributes to underrepresentation in Early Intervention when these providers are disproportionately making referrals, or in other words, not referring minority children for services. By 48 months, minority children were not only disproportionately underrepresented in Early Intervention, but they were also not being evaluated by professionals in regards to communication, attention, or learning problems at levels comparable to their white counterparts (Morgan, Farkas, Hillemeier, & Maczuga, 2012).

Without question, there are racial disparities in Early Intervention. Confusion may lie in how and why these disparities exist, but consistently minority children are underrepresented in Early Intervention from the time of referral, eligibility, and in the receiving of services. Additionally, time progression plays a role in these disparities. Feinberg, Silverstein, Donahue, and Bliss (2011) found that at nine months, only 9% of children received Early Intervention services that were eligible to do so. Though this percentage was low, it was noted that there were no racial differences or disparities when looking at the services received. In comparison, at 24 months, 12% of the children that were eligible received services; sadly, black children at this age were five times less likely to receive services. These results indicate that disparities grow and develop over time (Feinberg, Silverstein, Donahue, & Bliss, 2011). The reasoning behind this disparity remains unclear. Be that as it may, a trend was identified. It appears that greater racial disparities occurred in children's receipt of services that were related to whether or not they were receiving Early Intervention Services based on a perceived developmental delay or a medical diagnosis or medical condition (Feinberg, Silverstein, Donahue, & Bliss, 2011). This thought that services and disparities exist due to diagnosis is one that was also looked into by Javalkar and Litt (2017), who found that those children who had a developmental delay as opposed to a diagnosis that were partaking in Early Intervention Services were less likely to receive the services that they need, and would be more likely to abandon services altogether despite still being eligible to receive services. Unfortunately, the families of these children eligible due to a developmental delay instead of a diagnosis also had greater levels of being dissatisfied with services. In comparison, those children and their families who were receiving Early Intervention services due to medical diagnoses were generally more satisfied and had their needs met through services provided by Early Intervention (Javalkar & Litt, 2017).

Early Intervention services represent an umbrella under which a variety of services are provided. These different services include speech therapy, physical therapy, occupational therapy, music, and art therapy, along with many other services. Enrolment in an Early Intervention agency opens the door to many different possibilities and supports. Racial disparities in Early Intervention Services continue to vary along with the number of services received. Black non-Hispanic children were less likely to receive physical therapy in comparison to their white peers, and if they did, the intensity of the therapy they received was considerably less. (Khetani, Richardson, & Mcmanus, 2017). Differenciences in socioeconomic status also play a role in disparities in services offered by Early Intervention. Those families with larger incomes were able to access physical therapy along with occupational therapy with greater intensity than those with lower incomes. The work done by Khetani, Richardson, and Mcmanus (2017) also found a difference between those who had public insurance compared to those who had private insurance. The families that had private insurance received more intensive speech therapy. This was a curious discovery as Early Intervention is a free service that is able to be accessed regardless of health insurance and at no cost to the parent as an attempt to alleviate discrepancies based on socioeconomic status; unfortunately, the disparities still exist despite these efforts.

**Analysis**

The goal of Part C of IDEA was to provide services that were universally accessible; the first place where this falls short is with the utilization of developmental screenings in order to determine eligibility. Unfortunately, these tests are far from perfect and oftentimes will either under identify or over-identify, both of which are problematic. When a developmental delay or disability is not appropriately identified, that child and their family are considered to be ineligible for Early Intervention enrolment, meaning they do not receive the services that they need. Losing out on services can have several consequences; the strain of caring for a child with a developmental disability can be very difficult on a primary caregiver. This results in making day to day life extraordinarily difficult. Additionally, developmental delays and disabilities have the ability to progress without intervention, and a small delay can lead to something far more detrimental to the health and well being of the child. When considering the future of these children who did not receive Early Intervention, their need for special education when entering the school system may be greater than if they had received services. One of the goals of Part C of IDEA was to alleviate some of the demands of special education by providing services early on; this is no longer possible when children presenting with a developmental delay or disability are not receiving appropriate Early Intervention Services. It may be difficult to see a downside to an assessment that overall identifies developmental delays or disabilities where there may not be any; though stigmatization has diminished, receiving news that your child is not performing at a level expected is still oftentimes very difficult to hear. Placing this burden on the family is cruel and possibly detrimental. Additionally, providing services to those who do not qualify could be great, as these services are not harmful. However, it is impractical as resources are costly and limited. Providing these services to those who would not otherwise be eligible could lead to a financial burden on the Early Intervention agencies.

In order to go through the eligibility process, a child must first be referred for services. Unlike school-age children, those between birth and three years of age may not be seen by other adults such as educators, counselors, etc. instead, oftentimes, these young children spend a majority of their time at home with their primary caregivers who may or may not be aware of the presence of a developmental delay or disability and what that could mean for their child. In fact, recognizing a delay does not necessarily mean that the primary caregiver would know where to turn to access services and supports. For this reason and others pediatricians and primary care physicians are a substantial source for Early Intervention referrals, or at least they should be. Unfortunately, the literature highlighted how little pediatricians and primary care physicians know about Early Intervention and the referral process. Though they were aware of the presence of a developmental delay or disability, many pediatricians and primary care physicians took the "wait and see" approach, hoping that with time development would either improve or stabilize. However, this contradicts the goals of Early Intervention, which are to get in early and provide support at the onset of delayed development. The spirit of the referral is as important as the referral itself. On many occasions completing the paperwork or making mention of the existence of Early Intervention was not enough. Families and caregivers needed and truly deserved more from their pediatricians and primary care physicians. Without true information and engagement, it made it difficult for the families to understand and move forward with the referral process. This is a large shortcoming, leaving many children and families without the necessary resources and opportunities.

The final hindrance discussed impacting Early Interventions' goals of being universally accessible, utilized, and beneficial is the vast amount of disparities that exist due to race, socioeconomic status, and reason for referrals. Those who were from lower-income households were less likely to receive services, and the intensity of the services they received was not at the same level as those with higher incomes. Black non-Hispanic children received fewer referrals and received fewer services. Those who were eligible for services due to a developmental delay as opposed to a medical diagnosis were often dissatisfied with the services and prematurely withdrew from the program. This boils down to in many different ways children who were not considered to be white received less than those who were in regards to Early Intervention and the services that they provide. It is difficult to make an argument for Early Intervention being universally accessible and utilized when such a large demographic is so grossly underrepresented. In order to be truly successful in being universal, Early Intervention needs to become culturally competent and aware of the unique needs of non-white children and their families, especially when navigating through developmental delays and disabilities and those unique challenges. Race and culture play a very large role in parenting and also engagement in social support systems.

**Ethical Implications**

The value of children seems to be truly universal. One would be hard-pressed to find a person who disagrees with the importance of ensuring the well-being of a child. This being said, Early Intervention aims for an ideal that is not only honorable but also necessary. They have the goal of providing services to children in order to ensure that they are able to grow and develop safely through additional supports and therapies that they may need. Early Intervention is also unique in the fact that it understands and honors the concert that is nature and nurture and how the two are intertwined. Early Intervention does not isolate or diminish the biological influences at play and works hard to work within the natural component. Unlike Part B of IDEA, where an Individualized Education Plan (IEP) is utilized, and the focus remains solely on the child, Early Intervention utilizes a different and more holistic approach. It is understood that children do not function in isolation but instead through and with their family and primary caretakers. This being said, Part C of IDEA, Early Intervention, utilizes an Individualized Family Service Plan (IFSP). The idea of this plan is to incorporate the developmental goals of the child and the needs of the family, and how they interact together.

The ethical implications of Early Intervention when it operates under its universal ideals are extraordinarily beneficial. Children and families are able to meet their needs, grow, develop, and interact beautifully. Unfortunately, this is not the case, and Early Intervention is not shielded from the realities of the world, removing the possibilities for imperfections. The ethical consequences of its shortcomings can not be ignored as they impact our society in numerous as well as long-lasting ways.

The lack of resources in the public school system is something that has plagued the country for quite some time now. This lack of monetary resources stretches to special education services as well. There seems to be a consistent increase in needs without an appropriate and adequate increase in funds. As an attempt to alleviate this financial strain Part C of IDEA was created with the hopes that intervening early when developmental delays first begin to appear would allow for less need and service, later on, therefore also decreasing the need and utilization of Part B of IDEA. This school of thought is realistic and beneficial. Early Intervention allows children to grow and develop adequately with greater supports early on.

When utilizing healthcare services, it is understood that preventative measures are beneficial; they prevent patients from having to come back for more invasive, timely, and costly procedures. For example, receiving support in eliminating a smoking or drinking habit will help reduce the possibility of lung cancer or liver failure, respectively. The push for a healthy diet and regular exercise is coupled with the assurance that by doing so, you ward off the possibility of heart failure and a host of other medical conditions. Healthcare providers are ethically responsible for sharing this insight and providing support in assisting their patients to reach these goals. Early Intervention operates under the same basic principles. Medical professionals have the ethical responsibility to identify possible developmental delays and provide appropriate referrals and guidance in navigating as well as accessing these additional supports. Not doing so or not doing so efficiently and effectively can lead to children developing greater developmental delays and disabilities or an increase in developmental deterioration. The consequences of this lack of universal support and understanding in the medical community can be very harmful and long-lasting. The ethical implications of this are not ones to be ignored or overlooked.

Children are not solely financial investments or biological beings. They exist socially in our world and do so within a family structure. As previously mentioned numerous times throughout this paper, Early Intervention focuses not solely on the child but on the family as a whole. Providing support for the family allows for the child to develop socially and for the family to survive what is often attributed to being a difficult and troublesome time. Supporting a child with developmental delays or disabilities can be extremely marginalizing and difficult. Part C of IDEA also aims to reduce the institutionalization of children who are presenting with a possible developmental delay or disability. All children have value and contribute light to our society. It is important that our society operates as though this is the case, by not overlooking children with developmental delays or disabilities, and providing them with the support that they need in order to live fulfilling lives.

Investing and supporting all of our children is our ethical responsibility as human people. As our children continue to grow and develop, they begin to engage more in our society and the world at large. The saying that children are our future is not simply a feel-good quote. It holds truth and Merritt. Ensuring their safety and well-being is our duty and responsibility. Access and utilization of Early Intervention Services should be universal. It should offer its support and services to all children regardless of their race or socioeconomic status. By neglecting the health and development of our children both physically, mentally, emotionally, and socially we neglect the endless positive possibilities for our future. It is not enough for Early Intervention services to exist; they must be universally inclusive, universally accessible, and free from biases. Essentially, Early Intervention should operate as it was written, and within its ideals, the ethical implications, if it continues to fail to do so, are truly concerning and disheartening, leaving many children without what they need to flourish.

In summary, the ethical importance and considerations of Early Intervention operating within its ideals are paramount. It has an impact on the financial strain and burdens placed on our government as well as the school system. Unfortunately, the school system, including special education, has minimal budgets, and in the long run, when utilized appropriately, Early Intervention can help alleviate that strain. Our healthcare system is oftentimes reactive; we typically will go and see doctors when we are sick, or something is wrong. However, preventative care is extremely important and possible. Early Intervention is one of the ways that healthcare providers can work towards preventative care by taking the initial step in referring to a child and their family to Early Intervention Services. It should be considered unethical for healthcare providers to ignore or not refer children with possible developmental delays and disabilities because, in doing so, they perpetuate the likelihood of a developmental delay or diagnosis and further medical needs down the line as well as familial strain, which has a host of ramifications. The family structure is often admittedly a fragile one. The struggles and demands of supporting a child with developmental delays or disabilities are taxing and can oftentimes leave a family broken. Early Intervention works in providing support so that these family units can not only remain intact but hopefully thrive. Investing in our children and their overall health and well-being is not solely an investment in them and their families but in humanity as a whole as children are our present and, most importantly, our future.

**Policy Recommendations**

There is not a single all-encompassing policy that could remedy these failings and shortcomings when it comes to Early Intervention. One of the main reasons why this is the case is because the problems that occur are not, in fact, localities, but instead are widespread and far-reaching. The three perspectives discussed in this paper are not isolated branches; they work in conjunction with one another. Solving the disparities and shortcomings of Early Intervention will need to be a collaborative effort.

Healthcare has the opportunity to implement several new policies that will benefit pediatric patients. Providing pediatricians and primary care providers with the necessary information on Early Intervention through training and educational opportunities could be extraordinarily beneficial. It is clear through the research that pediatricians are not familiar enough with Early Intervention Services to consistently make appropriate referrals when necessary. Lacking the knowledge in the process is detrimental to their patients and acts as a potential barrier for these children to receive services. Pediatricians are often looked at as trusted advisors, the people that those caring for children turn to when they have questions or concerns in regards to their child and their overall wellbeing. That being said, without the necessary information and a complete understanding of Early Intervention, it is almost impossible to encourage families to seek out and or consider these services seriously.

Healthcare providers also hold the responsibility to be culturally aware and competent. A factor that influences the underrepresentation of minorities in Early Intervention is the understanding, interests, and buy in of minority mothers. More can be done on behalf of the pediatric facilities that these mothers utilize. The goal should be to interact with these mothers in a meaningful way that provides useful information on the purpose and benefits of Early Intervention Services. Additionally extra supports can be created in order to assist in the navigation of accessing Early Intervention Services. This responsibility is one that is shared between healthcare providers, Early Intervention agencies, and the community as a whole. Development of workshops, and fairs, and the like could be impactful in creating a positive and meaningful dialogue that leads children with developmental delays and disabilities along with their families to Early Intervention Services.

Once the connection is made between family and Early Intervention, the work does not stop there. In order to receive services, a child must be considered eligible for services. Despite many misconceptions, a diagnosis is not required in order to receive Early Intervention Services. Developmental screenings are done, such as the Battelle Developmental Inventory Screening Test (BDIST), in order to identify the presence of a developmental delay. The presence of a developmental delay or being considered to be at risk for developing a developmental delay or disability are what determines whether or not a child and their family are eligible for services. Unfortunately, as previously discussed, these tests are flawed and do not always provide accurate results. This being said, utilizing a wide variety of testing or other considerations in order to determine eligibility should certainly be under advisement. The goal of Early Intervention relies on its namesake; the idea is to provide interventions early on in order to prevent the need for services in the future while promoting appropriate growth and development among our children. Ideally, Early Intervention in the future would be available to all children between birth and three years of age regardless of whether or not they are currently presenting with a developmental delay, while still having additional and more specific services to those who are facing those challenges. However, until then, scrutinizing the eligibility process and the developmental screening tools utilized would be an acceptable first step.

Racial and socioeconomic disparities and underrepresentation have been a consistent theme. Even when families were connected and were receiving Early Intervention Services, disparities continued in the services that they received in consistency along with intensity. It is important to note that the differences observed were adjusted for the legitimate need for additional supports and services. That being said, more should be done in regards to ensuring that minorities and lower-income households are receiving the same quality and quantity of services as their white non-Hispanic and higher-income household peers. How this is done may differ, but a nice place to begin could be internal restructuring—taking a look at how services are decided and what efforts are made when interacting with families from different backgrounds. Often gaining greater insight into a problem illuminates ways in which the problem can be addressed. Early Intervention agencies should be required to self evaluate and identify biases that exist in their agency and develop action plans in order to address them.

**Summary**

This paper first takes a look at the Individuals with Disabilities Education Act, also known as IDEA and how that came about, and the population it originally aimed to support, which was school age children. IDEA has since grown to encompass individuals with developmental delays from birth to 21 years of age. The focus of the paper was Part C of IDEA, which specifically outlines Early Intervention services that are offered to children from birth to three years of age who present with a developmental delay or disability or are considered to be at a greater risk for developmental delay or disability. The services are outlined, along with the goal of Part C, which is to provide services to all those who are eligible at no cost. Open and universal accessibility was the ideal behind Early Intervention.

Though this is how the act was written, the truth is that this was not the case when it came to practice. Three barriers were identified as standing in the way of Early Intervention being universally accessible to eligible children and their families. The first barrier was the determination of eligibility. The tools utilized in order to determine whether or not a child was eligible for services were flawed. These developmental screenings often inaccurately evaluated the child, especially minority non-white children. In order to combat this, it was suggested that different developmental screening tools be utilized in order to determine eligibility for Early Intervention, or perhaps stepping away from relying so heavily on these tools that do not always provide accurate information. Adjusting these instruments so that they may be more accurate is also something that should be considered; however, assessment tools often vary in their reliability and validity, often carrying their own biases.

Referral sources were also investigated, more specifically, those referrals coming from pediatric and primary care facilities. Most families utilize these offices, and they are equipped and able to identify the presence of developmental delays and disabilities. For this reason, they are often referral sources for Early Intervention Services. However, the research shows that they tend to fall short when it comes to this responsibility in a variety of ways. First, pediatricians and primary care providers do not seem to be as knowledgeable in Early Intervention as one would assume. Many reported being unfamiliar with services and the referral process as a whole, turning to fellow staff members with questions. This, in turn, limited the number of referrals being made and the number of children presenting with a developmental delay or disability who were able to access these resources. Pediatricians and primary care providers also delayed reaching out to Early Intervention in hopes that developmental delays would resolve or improve on their own without intervention. This lack of knowledge and understanding also transferred to families when referrals were made, leaving caregivers to feel hesitant and unlikely to move forward in seeking out services. Pediatricians and primary care providers have a unique relationship with their patients and the families of their patients, one that is often held in high regard. It is important that they are knowledgeable about Early Intervention, the services they provide, and the referral process as a whole. It would behoove these facilities to make a greater effort in educating their staff on the role of Early Intervention and the benefits they offer to their patients. Developing working relationships with their local Early Intervention agency would also improve communication and increase the likelihood of successful referrals and program enrolment. Bridging this gap between pediatricians and primary care facilities and Early Intervention agencies should be paramount.

Lastly, the disparities in representation and services provided for non-white children and low-income households needed to be addressed. These disparities existed throughout assessments in order to determine eligibility, the referrals made by pediatricians and primary care providers, as well as in services received from Early Intervention. The reasons behind these disparities and the gross underrepresentation of minority children in Early Intervention need to be further investigated. However, work can begin now to rectify these discrepancies in care. It is important that both Early Intervention providers and pediatric and primary care facilities are doing the work necessary to become more culturally competent by realizing that adjustments may be necessary, for example, when working with different cultures and with individuals with different socioeconomic backgrounds.

The development of Part C of IDEA was remarkable. The fact that families are able to receive support and services such as speech and language therapy, physical therapy, and occupational therapy is extraordinary. The unique approach of offering services to the family as opposed to solely the child has far-reaching benefits. However, as a society, it is our responsibility to continue to question and criticize these social programs, holding them accountable for the promises that they have made. More can and needs to be done in order to ensure that Early Intervention is living up to its ideals to provide quality and universal services to children and their families who may be presenting with a developmental delay or disability or are considered to be at a greater risk. In doing so, we will be able to continue to uplift our children, allowing them to reach their full potential.

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