Speech-language pathologists (SLPs) currently find themselves working with an increasing population of children who have experienced either caregiver neglect or fetal alcohol spectrum disorder (FASD) (Sokol, Delaney-Black, & Nordstrom, 2003). Working with these children can present unique challenges as, in addition to the typical special education team, the child will often be served in the child welfare system. One such challenge is understanding how changes in public law affect child welfare service delivery, especially in regard to young children who are experiencing prenatal alcohol exposure or maltreatment within the home setting. Also, these families often present with complex histories and cultural perspectives. It is imperative for SLPs to have an understanding of these families’ complex needs and the role that the social welfare system plays in the collaborative intervention process. To this end, we provide a brief history of the U.S. child welfare system and offer an overview of the current welfare system. We then examine the collaborative roles that SLPs, special education services, and others may play with children who have been maltreated or who may have FASD.

FASD and neglect have been defined previously within this forum. In general, we apply the medical definition for FASD, which is a condition resulting from prenatal exposure to alcohol caused by maternal alcoholism or heavy drinking (including episodic or “binge” drinking during pregnancy. FASD is diagnosed based upon four criteria:

1. growth retardation, (that is, below the tenth percentile for weight, height or head circumference at some point during development)
2. characteristic facial dysmorphia, including absent or indistinct philtrum (groove in the upper lip), thinned upper vermilion (lip), and shortened palpebral fissures (eye openings)
3. damage to the central nervous system, manifested as developmental delays, and mental retardation and cognitive and/or behavioral problems
4. evidence of maternal drinking during gestation. (Coles, 2003, p. 1)
Neglect is defined as a “failure to provide for a child’s basic needs” (National Clearinghouse on Abuse and Neglect, 2004, p. 1).

To begin, we provide a case study to frame the issue presented. Tamara, a 7-year-old girl attending first grade, is currently diagnosed with FASD. She was referred for a special education evaluation during kindergarten due to concerns regarding attention and hyperactivity. Her teacher also reported that Tamara did not use language to problem solve with her peers (e.g., sharing markers at the art table). The individualized education team, along with Tamara’s mother, agreed that services were needed to promote both behavioral self-control and language use under the service labels of other health impaired and speech and language. Simultaneous to problems being noted at school, neighbors had also reported concerns regarding not only Tamara, but also her mother, to Child Protective Services (CPS). Tamara had been observed drinking from her mother’s beer on the porch. Neighbors also reported that Tamara often arrived at their homes unattended at suppertime and asked if she could have a bite of food. CPS began a formal investigation and filed formal neglect charges. CPS then ordered home-based family therapy with the support of a clinical social worker and a home health worker to teach parenting and home keeping skills. The mother also was ordered into an alcohol treatment program.

The initial individual educational plan team convened to determine the goals for Tamara and included an invitation to the clinical social worker as approved by the parent. Participants in the team included a special education teacher, an SLP, a general education teacher, the parent, a social worker, and an administrator. The critical need determined by the school personnel for Tamara was to increase her ability to stop and listen when cued by an adult. Tamara rarely attended to adult initiations of conversation or directions in the classroom, as is often noted in children who are experiencing neglect. Research has suggested that these children will often avoid adult interactions in order to avoid confrontational situations (Coster & Cicchetti, 1993). This avoidant interactional pattern may be in part a cause of Tamara’s low receptive language index (standard score results of 45) on the Clinical Evaluation of Language Fundamentals—4 (CELF–4; Semel, Wiig, & Secord, 2003). The team felt that Tamara needed to be engaged visually first before she could process situations receptively. As a result, a collaborative self-control program was set up that could be implemented at school and could also be taught to the mother during home visits and therapy sessions by the social worker.

Second, in order to increase Tamara’s vocabulary for requesting basic needs in her environment, the SLP agreed to provide classroom-based therapy for Tamara to model the language skills needed in the classroom. Sample communication goals included to request help or assistance from the teacher or a peer, request to receive a desired object for play or instructional use, greet the teacher upon entering the classroom, and establish eye contact with others during conversation. These initial goals were targeted to increase Tamara’s understanding of reciprocity in communication in order to support cognitive development of behavioral regulation (Coster & Cicchetti, 1993). The SLP also agreed to create a vocabulary and phrase book to send home with Tamara so both her mother and the social worker could reinforce skill development at home. Vocabulary included a set of feeling words to promote her mother’s ability to recognize and accept Tamara’s feelings. Specific phrases included “I’m afraid right now,” “I’m hungry,” and “I need a hug.” Finally, the social worker planned to provide individual mental health sessions with Tamara’s mother in order to guide her understanding of the developmental needs of her daughter.

CPS shared during the meeting that the family currently needed forms to request a free and reduced breakfast at school, as limited finances were available. Finally, the team agreed to meet 1 month before the mother’s neglect hearing to discuss progress and possible changes needed to the plan. This initial glimpse into Tamara’s needs illustrates the numerous concerns that may occur when working with children either with FASD or who are experiencing some form of neglect. Each member of the team brings to the table a distinct mission. It is important that SLPs have a clear understanding of these partners’ roles when designing a comprehensive intervention plan.

CHILD WELFARE

The child welfare system in the United States is currently charged with both prevention and treatment for children who are experiencing maltreatment. Childhood maltreatment, for the purpose of this article, is “the physical and mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18. It is perpetrated by a person who is responsible for the child’s welfare under circumstances which indicate that the child’s health or welfare is harmed or threatened” as provided by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) (U.S. Department of Health and Human Services, 2003).

Within this population is a group of children whose traumatic history begins in utero, that is, children who are exposed to the negative impact of maternal alcohol use, resulting in FASD. FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These consequences may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications (Jacobson & Jacobson, 2002). The term FASD is not intended for use as a clinical diagnosis; it refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopmental disorder, and alcohol-related birth defects (Wattendorf & Muenke, 2005). Each year, as many as 40,000 infants are born with FASD, costing the nation approximately $4 billion (U.S. Department of Health and Human Services, 2005).

The impact of maltreatment and FASD in children is reported in the literature in all professions including health care, counseling, education, and speech-language pathology, regardless of country of origin. The global impact of FASD across industrialized nations is estimated at 6,000 disability adjusted life years. Within the United States, more than 2,000 of the 12,000 children who are born annually with FASD experience severe medical concerns as a result of maternal consumption of alcohol (Brailion & DuBois, 2005; H President and Fellows of Harvard College, 2004). The cost is estimated in the billions in the United States collectively upon social services, health care, specialized educational needs, incarceration, and lost potential wages of those impacted. In addition, the cost is magnified when combined with all children experiencing forms of maltreatment, with 2003 statistics indicating more than 2.9 million referrals and 900,000 substantiations of neglect (President and Fellows of Harvard College, 2004). Most devastating is the fact that both maltreatment and FASD are preventable.
HISTORY OF THE U.S. CHILD WELFARE SYSTEM

The United States, which once pioneered strategies to prevent child abuse, now spends more money fighting child abuse than any other industrialized country, and also has the highest rate of child abuse in the industrialized world (Lindsey, 2003). Throughout its history, the U.S. child welfare system has evolved according to changing beliefs and attitudes of how to best protect and care for abused and neglected children (Halpern, 1999). The first initiatives by the U.S. federal government in the 1800s were focused not on welfare toward the child but rather in protection of society from children who were homeless and perceived as vagrant (Stevenson et al., 1996). During the early 1900s, government interventions on behalf of children were characterized more by practical concerns about meeting children’s physical needs than by concern about the negative impact of abuse and neglect on children’s development. As public awareness about child abuse grew, however, so did awareness of the larger issues concerning physical and emotional neglect. These harms include those occurring as a direct or indirect result of children’s environmental systems. Awareness resulted in the initial Child Abuse and Treatment Act of 1974, which was amended and reauthorized several times, most recently by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) (U.S. Department of Health and Human Services, 2003).

This Act brought forth initial mandated reporting of neglect processes and a broadened focus of the child welfare system, including financial support for children in poverty and training and services for families to prevent further abuse or neglect. The Child Abuse Prevention and Enforcement Act (CAPEA; 2000) was initiated because of concern about inadequate responses to child maltreatment. This was, in part, a response to a 1999 Report to Congress on the impact of substance abuse on child protection systems (as cited in CAPEA, 2000). The U.S. Department of Health and Human Services indicated that most studies concluded that parental substance abuse was a contributing factor in between one third and two thirds of children with substantiated reports of abuse or neglect.

Internationally, neglect is defined broadly as a failure to care for a child; interestingly, only 46% of the 64 countries responding to the World Perspectives on Child Abuse Survey (6th ed.) include physical discipline, that is, hitting a child with the hand or an object to cause physical pain, as a potentially abusive practice that should be monitored (International Society for Prevention of Child Abuse and Neglect, 2004). A majority of these countries established policies and tracking systems regarding neglect only within the past 5 years (International Society for Prevention of Child Abuse and Neglect, 2004). As mandated reporters of potential abuse and neglect, SLPs need to be aware of these terms. Also, for professionals who work with immigrant families, it is important to note that these families will have varying views regarding childrearing practices and the role that government plays in monitoring such practices (See Westby, this issue, for discussion).

OVERVIEW OF CURRENT CHILD WELFARE SYSTEMS

Over the span of the last few decades, the makeup of the family in the United States has shifted greatly. Today, SLPs serve students from traditional families as well as from single-parent families and extended families. It is crucial, therefore, that SLPs employ responsive practices that promote safe and stable homes (Delgado-Rivera & Rogers-Adkinson, 1997). Further, students who live in residential or foster placements and students who are transient are becoming increasingly more common on SLPs’ caseloads. Understanding the environmental influences that shape children is a key factor to developing collaborative interventions that focus on holistic and systemic change.

Two theories, family systems theory and ecological theory, impact the promotion of safe and stable homes and are entrenched in the structure of the child welfare system (U.S. Department of Health and Human Services Children’s Bureau, 2000). Family systems theory is validated via the work of Ackerman (1959), Jackson (1965), Minuchin (1974), and Bowen (1978), and is currently used in family counseling and therapy (Fingerman & Bermann, 2000; Olson, 2000). Family systems theory assumes that emotional and behavioral problems of individuals are maintained through patterns of interaction within the family (Davis & Malone, 2001). The goal of intervention, therefore, is to evaluate and change these patterns of behavior and to help the family interact more effectively. In a system of interactions, the actions of one person (e.g., the father) can affect the responses of another person (e.g., the mother). These actions and responses can be further influenced by the presence or absence of a child with FASD.

Ecological theory, originally advanced by developmental psychologist Bronfenbrenner (1979), emphasizes the multiple, independent environmental systems in which children develop. The behavior of individuals and families are seen as a function of their adaptation to the demands of the broader context (Epstein, 1989). In this theory, the most important ecologies for children are “systems” that contain direct relationships that children have with caring adults. The first systems layer, the microsystem, contains the factors within a child’s immediate environment. Tamara’s home and first-grade classroom are considered her microsystem. The mesosystem encompasses the interrelations of two or more settings in which the developing child actively participates (Bronfenbrenner, 1979). For example, the mother’s trust in the SLP affects her decision to use or not use the vocabulary and phrase book with Tamara at home. The exosystem consists of environments that do not involve Tamara as an active participant, but in which events occur that affect, or are affected by, what is happening in her setting. The child welfare system can be seen as part of Tamara’s exosystem because it is an environment that is external to Tamara and her family but that also affects them through deciding whether parental custody will be maintained.

The SLP must recognize that communication among the three systems is critical. In school, the SLP is part of the child’s microsystem; in dealing with the family, the SLP is part of the child’s mesosystem; and if the SLP must report to the courts regarding the child, he or she becomes involved with the exosystem. The approach to intervention under the ecological model includes strengthening the interactions between the family and other systems in the community that are integral parts of the decision-making and intervention process. From an ecological theoretical perspective, the child with FASD is viewed as an indirect influence to which the individual and family system endeavors to adapt. The child’s interactions do affect the interactions of other people within the system such as when the neighbors intervened on Tamara’s behalf. The family, therefore, is an interactional system with the potential for creating and/or modifying interactions and optimizing individual development. Both ecological theory and family systems theory assert that family is...
the most fundamental factor influencing the lives and outcomes of children. For the SLP, it is key to understanding the flow of these systems as services are provided within these contexts.

Family systems theory and ecological theory interact when social services must make decisions with the aid of the courts as to placement, as illustrated in the case of Tamara. Although federal legislation places an emphasis on preservation of the family structure, birth families do not always provide optimal homes for children with FASD. The ecological perspective emphasizes that if affected children can remain with their birth families, culturally sensitive parenting courses via local community support networks should occur. However, if the family situation threatens the well-being of the child, foster care may be necessary. Foster families should have specific training or be experienced with children who have FASD. This training should include how foster care families can work with all members of the child’s team, including SLPs, given the communication needs of this population.

Children of national and international minority status regardless of country of birth experience a disproportionate level of interaction with the child welfare system (Ards, Myers, Chung, Malkis, & Hagerty, 2003). Ethnicity refers to the cultural heritage espoused by the family and includes but is not limited to race or cultural subgroup. This systemic overrepresentation occurs for many reasons. First, SLPs must recognize that children in many immigrant families confront barriers to well-being and development that comparatively few children in native-born families experience (Hummer et al., 1999). Second, children in immigrant families live in households that include at least one member who is not a U.S. citizen, and as a result, the family may be ineligible for—or reluctant to seek—financial support or benefits (Hernandez, 2004). In addition, many children in immigrant families live in households that are linguistically isolated (Rogers-Adkinson, Ochoa, & Delgado, 2003). Limited English language skills can make it difficult to communicate with SLPs, educators, and health and other service organizations. These language and economic barriers cause children in immigrant families to be more than twice as likely as those from native-born families to experience multiple risk factors that are critical to their development, including exposure to violence and personal victimization and neglect (Jaycox, Zoellner, & Foa, 2002). In addition, mothers experiencing these stressors are noted to have an increased rate of alcohol consumption during pregnancy.

Children of color are also disproportionately represented in the child welfare system, meaning that their relative numbers do not reflect those in the general U.S. population (The Child Welfare League of America, 2005). In many cases, they are “overrepresented” (i.e., the percentage of children of color in the child welfare system is greater than the corresponding percentage in the overall U.S. population). According to U.S. Census Data for 2000, there are more than 72,000,000 children under the age of 18 in the United States. Of these, 39% are considered to be children of color: African American/Black, Latino/Hispanic, Native/Indigenous American, Asian, two or more races, or some race excluding White. The disproportionate representation of children of color, evident throughout the child welfare services continuum, is also seen in the nation’s foster care system. According to the Adoption and Foster Care Analysis System, there were 556,000 children in foster care on September 30, 2000. Children of color accounted for 59% of these children (National Data Archive on Child Abuse and Neglect, 2003).

The overrepresentation of children of color in the child welfare system raises many questions regarding social, economic, and organizational factors that contribute to the current situation. The United States has more children living in poverty than any other industrialized nation (Lindsey, 2003). More than 20% of all children grow up in poverty, and the rates for African American and Latino children exceed 40% (Lindsey, 2003). These questions need to be addressed at every stage in the child welfare system in order to ensure that all children, regardless of their cultural, ethnic, or racial background, receive access to the appropriate services to ensure safety, permanency, and well being. Of particular concern is the manner in which the child welfare system is currently monitored and funded.

**LEGAL PARAMETERS**

In this section, we will discuss the role of child protective proceedings (CPP), sometimes called child maltreatment or abuse, neglect and dependency proceedings, when working with children who are experiencing neglect or FASD. CPPs are civil cases that are brought by a state or local government agency to protect an alleged abused, neglected, or dependent child (U.S. Department of Health and Human Services Administration, 2003). The participants in the case may include the child, the parents or other caretakers, foster parents, and state officials. The purpose of the proceedings is to determine whether the child is abused or neglected, and if so, what action should be taken. For children born with obvious dependency/willful neglect symptoms or with trace alcohol or other drugs within their system, this may occur at birth. In the most severe cases, those in which maternal toxiogenic consumption is known to be occurring during the pregnancy, most states will initiate action against the mother at that time. Community support models have also been created in an attempt to bring resources into the neighborhood and increase connections with families who are at risk (Berheimer & Keogh, 1995; Grant et al., 2004).

In some states, participation in community-centered services can prevent movement to more formal court proceedings (Stevenson et al., 1996). Typically, these models include faith-based initiatives and mentor relationships (Grant et al., 2004). Families who lose parental rights may do so temporarily, with the child placed in protective custody in foster care or some other alternative setting. In these cases, a specific treatment plan is determined to facilitate a targeted reunification. If parental rights are severed, the courts strive to keep the child with family members. Permanent foster care or external adoption are the least preferred placement options.

**Funding**

There is a significant funding discrepancy not only across all states, but also among the states over time. This variation appears to be the result of a complex array of state-specific issues (Andrews-Scarcella, Bess, Zielwski, Warner, & Green, 2004). Although caseload differences are certainly one factor in explaining the variation, there are other influences including, but not limited to, state priorities and policy choices, policy changes, court decisions and mandates, and efforts to maximize federal resources (Lambright & Allard, 2004). Several factors make the future financing of child welfare activities uncertain, including changes in state economic conditions, congressional proposals to alter federal financing, and potential restrictions on child welfare agencies’ use of nondedicated federal funds.
In 2001, the Promoting Safe and Stable Families (PSSF; U.S. Department of Health and Human Services, 2001) program was reauthorized for 5 years. The law provides $305 million a year in entitlement funds and authorizes Congress to appropriate an additional $200 million a year. The reauthorization of PSSF also amended the John H. Chafee Independent Living Program to allow Congress to appropriate up to $60 million per year in funds for education and training vouchers for youth that “age-out” of foster care and created a new program to provide mentoring for children of incarcerated parents. Yet, these initiatives still seem to fail in reducing the impact of neglect and FASD, perhaps because there is no shared theoretical construct to serve as the foundation for intervention. The problems of neglect and FASD could be addressed systemically according to the assumptions of the family systems theory.

Three of the most relevant assumptions of systems theory in general and of family systems theory in particular include (a) the input/output configuration of systems, (b) the concept of wholeness and subsystems, and (c) the role of boundaries in defining systems (Whitechurch & Constantine, 1993). In Tamara’s family, the input consists of the family’s characteristics (such as the mother’s alcoholism and related neglect) and special challenges (Tamara’s FASD, the family’s low socioeconomic status). The interaction of these personal characteristics produces the output. The second assumption is that the system must be understood as a whole and cannot be understood by examining its component parts, that is, just one or more of its members. The SLP must understand Tamara’s mother in order to understand Tamara. The third assumption is that family subsystems are separated by boundaries and that these boundaries are created by the interaction of family members with each other and by the family input in its interaction with outside influences. Likewise, the boundary between Tamara’s family and the SLP with whom they are collaborating may be different than the one that exists between the family and friends or other professionals. In the case of Tamara, the boundaries between the professionals and Tamara’s mother are fairly closed, and opportunities for various kinds of partnerships are limited.

In order to increase collaboration, the child welfare system needs to address these assumptions and reform practice to provide consistency, repetition, nurturance, predictability, and control returned to the child’s family in order to diminish the external loci of these interventions (Wolfe & Brandt, 1998). Specifically, models that emphasize multimodal family intervention with all stakeholders integrating their treatment plan have been shown to have more promise than do isolated intervention models (Goldfine & Lopez-Williams, 2005). In addition, child welfare systems should provide comprehensive assessments for all children as soon as possible to examine the impact of abuse and neglect on all aspects of development because delays in one domain will often impact function in other domains (e.g., language competence interacting with socioemotional competence) (Coster & Cicchetti, 2003; Shonkoff & Phillips, 2000). Accomplishing these objectives will require the participation, coordination, and collaboration of all stakeholders, including policymakers; family court judges; managers; child welfare workers; medical, mental health, and education professionals; foster and adoptive parents; and the parents and children themselves. Every group must examine its contribution to the development of the children served by the child welfare system and strive to provide that contribution in a manner that will promote healthy development for each child.

Collaboration

Trust is a critical component of collaboration. Stakeholders, including SLPs, educators, and mental health professionals, have opportunities for building trust when working with families of children with FASD or who have been found to be neglectful. Many SLPs may be involved in home-based treatment if the child is involved in early intervention services. Previous court involvement often creates a barrier; families may feel uncomfortable with professionals visiting their home because it is linked to the concept of social services monitoring. In order to develop family members’ trust, SLPs must make their plans clear with families.

Maintaining confidentiality also is important, as the records of a child with FASD will contain highly sensitive information. The Family Education Rights and Privacy Act (FERPA; U.S. Department of Education, n.d.) requires professionals to treat information pertaining to children as confidential and to disclose it only with the consent of parents or guardians, as FERPA explicitly permits, in order to benefit the child.

Positive communication is another important element to developing partnerships with families and professionals. To communicate effectively, professionals need to reflect on and develop their own interpersonal skills and tailor these communication strategies to be consistent with family preferences. One way to do this is to listen empathetically to the family and to other stakeholders. Ask if other group members would be interested in brainstorming service options. Similarly, all members should be respectful of cultural diversity. When differences do arise, members need to rely on culturally responsive strategies such as translating written and oral communications for families with limited English proficiency.

IMPLICATIONS IN SPECIAL EDUCATION

In addition to the social welfare system and its role in providing services to children in families experiencing neglect or FASD, the special education system may also be a primary service provider for these children. The special education team will most likely require an SLP, special educator, and, depending on severity of impact of FASD, occupational and physical therapists. Finally, for children who are experiencing neglect, a counselor or social worker may be included in the team.

Children who are born with severe cases of FASD may be identified at birth if they experience alcohol withdrawal or if they have pronounced facial distortion and microcephaly. Microcephaly refers to a small head circumference (small brain at about 2–3 SD below the mean) (Chen, Maier, Parnell, & West, 2004). In these cases, referral may occur simultaneously to both social services and special education early intervention programming. Early intervention is key to reducing the impact of FASD or neglect (Loocke, Conry, Cook, Chudley, & Rosales, 2005) and is believed to prevent secondary disabilities or the need for long-term care. Unfortunately, the needs of children who are born with less apparent cases such as learning disabilities rather than prominent mental retardation as a result of FASD may not be evident until the school years.

For children whose needs for special education are not evident until they become school age, a referral for special education services will be initiated. This may be met with resistance by some parents who have learned to be wary of external intervention due to previous
involvement of the social welfare system. School-aged children are typically assessed in areas that are of concern to the referring party. It is important that a speech-language assessment occur for these children regardless if communication was noted as the primary concern at the time of referral due to the overlap of language needs in children presenting with other disorders (Rogers-Adkinson & Hooper, 2003). Further, a large number of children with FASD are misdiagnosed with attention deficit hyperactivity disorder (Streissguth, 1997). This can be a coexisting condition with FASD, but basic issues and deficits with both disorders cannot be untangled until FASD is ruled out or confirmed. It is also important to note that not all children with FASD will qualify for special education services. These children may come forward in the universal screening process as implemented in the new response to intervention (RTI) model incorporated in the Individuals with Disabilities Education Improvement Act (IDEIA) (Mallard, 2004). But, unless SLPS are included in the screening and intervention process under RTI, these children may continue to have unmet needs (Graner, Faggella-Luby, & Fritschmann, 2005) and to experience chronic underachievement.

For children with a history of maltreatment, referrals often occur due to the resulting emotional scars and subsequent behavioral manifestations displayed by the child, such as classroom disruptions and aggression toward self or others. This often results in services being provided under the emotional/behavioral disorders category. At other times, such as in cases of children experiencing extreme physical abuse and possible shaken baby syndrome, a resulting cognitive delay or traumatic brain injury could result in special education services being required.

**ROLES FOR SLPS WITH CHILDREN EXPERIENCING NEGLECT**

SLPs need to provide ongoing services to children who have experienced maltreatment and FASD in tandem with other educational and mental health personnel. Current research (Halpern, 1999; Hernandez, 2004; Hooper, Roberts, Zeisel, & Poe, 2003) has indicated a clear interaction between the factors of neglect and poverty, and similarly in children with FASD and language delays. The pattern of impact has been similar in these groups with expressive language development of primary concern during early childhood intervention (Rogers-Adkinson & Rinaldi, in review). Abstract communication skills such as understanding sarcasm or indirect commands, and pragmatics, such as understanding peer body language during social interactions, have also been noted as areas of need during middle childhood and adolescence (Jacobson & Jacobson, 2002; Rinaldi, 2003). In addition, pragmatic deficits are often noted. The most common errors include limited interpretation of nonverbal cues (e.g., rolling of eyes or crossed arms) (Harpur, 2001) and inappropriate boundary usage (e.g., sharing personal information not appropriate to the level of familiarity in work or school settings). Other patterns of communication deficits that have been noted in children who are experiencing neglect and subsequent emotional disorders include language processing (Rogers-Adkinson, 2003) and expressive and receptive delays (Benner, Nelson, & Epstein, 2002).

Critical to this need for collaborative intervention by special education and speech-language pathology is that the impairments in expressive and receptive language delays appear to increase in severity over time rather than remain static (Hooper et al., 2003; Nelson, Benner, & Rogers-Adkinson, 2003), with a 20% increase of language concerns being noted in a sample of children with emotional disorders between the elementary and secondary populations (Nelson et al., 2003). The services are best provided in the classroom in a team teaching/intervention model that promotes natural language use in the social context of the classroom (Hyter, Rogers-Adkinson, Self, Friederich-Simmons, & Jantz, 2001).

Specifically, these children, even if in special education, most often participate primarily in the general education classroom. Hyter and Self (1999) pointed out that as SLPs work in increasingly more inclusive service delivery models, it is important to remember that the child, family, teacher, and classroom are all part of a “delicately balanced system” (p. 395) that requires SLPs to focus on teaching students to transfer social communicative skills into naturalistic contexts. This collaborative system expands for children with FASD or those who are experiencing abuse or neglect because a mental health provider also will often be supporting social skills and other emotional development. Children who are experiencing maltreatment and neglect are often at risk for repeating this cycle and require substantial therapeutic support over different developmental periods of their life in order to reduce this likelihood. In this area, the SLP will often assist in pragmatic skill development as well as in developing a vocabulary of feeling words for use in multiple situations. Specifically, intervention should include helping the child understand the relevance of comments to the topic at hand because children who are experiencing neglect or abuse often will link seemingly unrelated thoughts and ideas during a conversation (e.g., portraying a movie scene as a real experience to compensate for lack of experience with a topic). This area has the most potential for conflict across the team as the triad of speech-language pathology, education, and mental health often may employ contradictory interventions. For example, returning to Tamara, she has often violated social boundaries with her neighbors when requesting food. This behavior was useful for her in that she was then “found” to be in need of protective care. Yet, pragmatically, these behaviors are no longer useful or acceptable now that intervention is in place. In addition, there may be a social-interaction experience connected to going to others’ homes for food. Tamara needs another tool for gaining social acceptance in others’ homes, such as learning to ask a neighbor child to play outdoors. Finally, the team must clarify how and when skills are useful for Tamara. The SLP may be systematically reinforcing all initiations to interact due to Tamara’s reticence, yet the mental health practitioner may be teaching Tamara skills for avoiding her mother when she is drinking or that she should reduce her communication attempts during this time.

Also, Harpur (2001) asserted that a multifaceted team is necessary to design comprehensive services for children with FASD. Lifelong needs should be considered and include not only school-based services but community services as well (Grant et al., 2004). This becomes increasingly important during adolescence due to risks for use of alcohol and other drugs and other high-risk behaviors within this population. Youth with FASD are currently 40% overrepresented in juvenile corrections (Malbin, 2004). In addition, many children who are adjudicated demonstrate delays in both expressive and receptive language (Zabel & Nigro, 1999). The SLP must address these risks so that communication delays do not exacerbate interactions with law enforcement.

Another area of collaboration that is unique to this population is with the court system through CPS. All members of the multidisciplinary team can expect to compile reports regarding progress during treatment to the court system. Typically, the monitoring judge expects
a one-page summary of goals, progress related to these goals, and any resistance or high motivation by caregivers or the child during therapy/intervention sessions. This sharing of information is important for families who are awaiting possible reunification or to further other permanency planning on behalf of the child because these clinical judgments aid in projecting ongoing risk for the child within the family. This collaborative role must be taken seriously because termination of parental rights can occur. When responding to the courts, all participants need to feel that they were ethically responding in the best interest of the child.

**FINAL CONCERNS**

It is critical that this disenfranchised group of children experience appropriate treatment and intervention. Although the goal of the child welfare system is to protect children, many child welfare interventions—such as investigation, appearance in court, removal from home, placement in a foster home, and so forth—may actually reinforce the child’s view that the world is unknown, uncontrollable, and frightening (Wolfe & Brandt, 1998). Accomplishing these objectives will require the participation of all stakeholders, including policymakers; family court judges; managers; child welfare workers; medical, mental health, and education professionals; kinship; foster and adoptive parents; and the parents and children themselves. Every group must examine its contribution to the development of the children who are served by the child welfare system and strive to provide that contribution in a manner that will promote healthy development for each child. Only through collaborative interventions that focus on holistic and systemic change will children who are experiencing maltreatment and FASD be able to fully develop their potential and thrive as adult members of society.

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