Barriers to Accessing Services for Young Children

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This study investigates barriers to accessing services for children under age 3 presenting with language delays and behavioral difficulties, including language barriers for Spanish-speaking families. Using a telephone script, researchers called 30 agencies in Los Angeles County, including regional centers (the state network of Part C agencies for children with developmental disabilities), mental health centers, and schools, requesting services for a 2-year-old child. Outcomes of calls were compared by agency and by language of call (Spanish or English). Regional center calls resulted in an appointment 90% of the time, whereas schools and mental health centers were significantly less likely to link callers with services. Calls in Spanish revealed language access barriers, with fewer than half of Spanish-speaking callers to schools and mental health agencies obtaining an appointment. The study indicated barriers including basic access (e.g., reaching a live person; response in the home language), and obtaining appropriate appointment or referral.

Keywords: early intervention; access; underrepresentation; language barrier; mental health

Parents attempting to access services for a young child may face numerous barriers. These barriers may be particularly pronounced when children have varied areas of difficulty that do not fit clearly into one service system (Wesley, Buysse, & Tyndall, 1997), and when parents speak a language other than English (Weinick & Krauss, 2000). As a result, there are often delays in the process of linking young children with early intervention, which can adversely affect children’s development and response to intervention (Kasprzak et al., 2012; Wiggins,

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Baio, & Rice, 2006). In addition, difficulty accessing care can negatively affect families’ confidence in the service system and comfort in seeking help in the future. This preliminary study explores the process of seeking an evaluation for a young child with typical symptoms of concern—language delays and tantrums—to determine what barriers may be encountered by parents and the likelihood of obtaining appropriate services. The study focuses on Los Angeles County, a large, ethnically and linguistically diverse urban setting, as a model for understanding how access to a complex service system may be experienced by families. 

Co-Occurrence of Language Delays and Disruptive Behavior in Young Children

Two concerns commonly reported by parents of young children are language delays and disruptive behavior, and the two are often interrelated. Speech and language disorders are the most common developmental disabilities in the United States, with estimated incidence for preschool children ranging from 3% to 15% (Downey et al., 2002). The 2003 National Survey of Children’s Health (NSCH) found that more than 50% of parents who reported concerns about their children’s language development also had concerns about their children’s behaviors (Long, Gurka, & Blackman, 2008). A study of Head Start children found that those who exhibited behavior problems were more likely to have language deficits in comparison to peers without behavior problems (Kaiser, Hancock, Cai, Foster, & Hester, 2000).

Early intervention has been shown to improve outcomes for young children with developmental risk factors, as well as for children with early signs of conduct problems (Dawson, 2008; Guralnik, 1998; Jones, Daley, Hutchings, Bywater, & Eames, 2008; Karoly, Kilburn, & Cannon, 2005; Webster-Stratton & Taylor, 2001). Thus, listening to parental concerns and linking children as quickly as possible with early assessment, diagnosis, and intervention are vital to the healthy development of young children.

“No Wrong Door” to Service System

In an ideal service system, appropriate referral and linkage is provided to families regardless of which agency a parent contacts first. This “no wrong door” concept was first articulated by the U.S. Department of Health and Human Services’ Center for Substance Abuse Treatment (CSAT; 2000) in reference to the need for individuals with co-occurring substance abuse and mental health problems to receive appropriate care or referral regardless of which service system they contact first. The concept has since been applied to a variety of service systems in which coordinated service access is essential to good care. In the case of young children, the frequent co-occurrence of developmental and behavioral challenges means that parents may seek help from a range of types of agencies, including those providing developmental, educational, mental health, or medical services. Ideally, parents seeking help from any agency within the system will obtain information and referral to the most appropriate agency to address the child’s needs.

Gaps in Service Delivery

In reality, studies have documented significant gaps in service delivery indicating that many young children with developmental delays and/or mental health concerns do not
receive services prior to the age of 3 years. For example, in the Early Childhood Longitudinal Study–Birth Cohort, which included more than 8,000 children, Rosenberg, Zhang, and Robinson (2008) found that the prevalence of developmental delays was about 13% in 24-month-old children; however, only 10% of the children with delays were receiving early intervention services. In the general U.S. population, only 2.7% of children aged birth to 3 years are receiving Part C early intervention services (Kasprzak et al., 2012); this indicates significant underutilization of services compared with the numbers of children with developmental delays identified by Rosenberg et al. Recent studies indicate that fewer than half of children with mental health problems receive treatment (Kataoka, Zhang, & Wells, 2002; Merikanges et al., 2010).

The process from identification to intervention has multiple steps, with many potential barriers along the way: (a) public awareness/screening, (b) identification, (c) referral, (d) intake, (e) eligibility determination, and (f) enrollment in services (Shapiro & Derrington, 2004). Kavanaugh, Gerdes, Sell, Jimenez, and Guevara (2012) noted that the step from referral to intake is the step least studied in the process; in their study of more than 2,000 children under the age of 30 months, only two thirds of children who failed a screening and were referred for early intervention services actually received an intake. The present study focuses on the step from referral to intake, where several potential barriers may occur. Language barriers may prevent appropriate screening of referrals. Agency staff conducting screenings may not be knowledgeable about the problem presented or services available. Parents might not know what information is pertinent when requesting services. Services may be denied before an intake is completed because of “narrow screening” (Harbin, 2005), in which the intake screener focuses only on the specific problems served by their agency or first mentioned by the parent rather than looking more broadly at the child’s needs. Representatives from one system may determine that a child is not eligible, yet disregard problems that might qualify for services within another system. Any one or combination of these barriers might affect access to services even before the eligibility process formally occurs.

Service barriers can lead to a delay between parental concern about a child’s problems and professional diagnosis and treatment. For example, among young children with autism spectrum disorders (ASD), significant gaps have been documented between the age of first parental concern and first ASD diagnosis (Brookman-Frazee, Baker-Ericzen, Stadnick, & Taylor, 2012; Wiggins et al., 2006). Parents of young children in early intervention programs reported in focus groups that they spent hours on the phone attempting to locate services (Wesley et al., 1997). As well, parents have reported confusion about the service system and not knowing where to seek help (Brookman-Frazee et al., 2012; Bussing, Zima, Gary, & Wilson Garvan, 2003; Wesley et al., 1997). “Lack of information” and “lack of available services” were cited as the most frequent barriers to obtaining help (Betz et al., 2004). Parents need assistance in navigating systems (Freedman & Boyer, 2000).

**Service Barriers for Latino Families**

Latino families may face additional barriers to accessing appropriate assessments and interventions. Delgado and Scott (2006) found among a large sample of young children at risk for developmental disabilities that young Latino children were less likely to be referred
for services than non-Latino children. Similarly, the Surgeon General’s report on mental health care for ethnic minority children found lower representation of Latino children on mental health caseloads compared with their population rates (U.S. Department of Health and Human Services, 2001).

In a survey of Latino families (Yu, Nyman, Kogan, Huang, & Schwalberg, 2004), one quarter of parents reported language as the chief barrier to accessing health care. Flores and Tomyan-Korman (2008) found that children of non-English-speaking families interviewed through the National Survey of Children’s Health reported poorer access to medical and dental care than English-speaking families; language was perceived by these families to be a greater barrier than lengthy waitlists, lack of medical insurance, inadequate finances, or transportation. Weinick and Krauss (2000) explored reasons for racial and ethnic differences in children’s access to care; even after controlling for health insurance and socioeconomic status, the differences persisted. However, controlling for language eliminated the disparities, suggesting that limited English-language skills present a significant disadvantage for Latino families in accessing care for their children.

Given that 16.3% of all Americans were Latinos in the most recent U.S. census (U.S. Census Bureau, 2011), language and cultural barriers are likely to affect a significant number of families trying to access service systems. Pavri (2001) discussed the importance of culturally sensitive approaches to reduce barriers faced by families from non-majority cultural and linguistic backgrounds when accessing early intervention services. Recommendations included improved communication among different service-system professionals, case-management assistance to navigate systems, and recruitment of bilingual professionals from diverse backgrounds.

**Service System Organization**

Although developmental and behavioral problems frequently co-occur, many states have different service systems and funding streams to address different types of problems (e.g., depending on whether the problems are viewed as primarily developmental, educational, or mental health related; Lutterman, Berhane, Phelan, Shaw, & Rana, 2009). Therefore, parents whose children present concerns in more than one area may have particular difficulty knowing where to start when attempting to access services.

The service system for children with developmental or behavioral problems includes several access points depending on the particular symptoms of concern, the child’s age, and available funding. According to the U.S. federal law, children with disabilities or delays are served by the Individuals with Disabilities Education Improvement Act (IDEA, 2004). Depending on their age, they are served by either Part B—Assistance for Education of All Children with Disabilities (aged 3 to 21)—or Part C—Infants and Toddlers with Disabilities (age birth to 3; IDEA, 2004). Across states, Part B services are administered by the State Education Agency (SEA), but the administration of Part C services varies widely by state. IDEA Part C includes a mandate that the lead agency develop a comprehensive Child Find plan that includes collaborating with primary referring agencies to identify children who may be eligible for services (Dunst, Trivette, Appl, & Bagnato, 2004).

Local education agencies administer special education services for children with disabilities. Although school services for typically developing children generally begin in kindergarten, children with disabilities may be eligible for special education services at age 3, or
even younger for certain low-incidence disabilities. Under the Child Find mandate of IDEA, school districts are required to identify all children, aged birth through age 21, with disabilities (IDEA, 2004) and link them to special education or early intervention services.

Finally, young children with behavioral or emotional problems may be eligible for mental health services through the public mental health system or by providers who accept private insurance. Low-income children with mental health needs may receive services through the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT), a mandatory federal program providing physical and mental health services that functions as the Medicaid program for children aged birth to 21 years (Health Resources and Services Administration, 2010). Children covered by Medicaid are entitled to mental/behavioral health screenings and services (Powell, Fixsen, Dunlap, Smith, & Fox, 2007).

**Purpose of Study**

The present study was designed to simulate the process that parents of young children experience when they attempt to navigate the service system, so as to identify barriers and opportunities for linkage. Although other studies have documented that parents of young children and non-English-speaking parents have problems accessing services, the specific experience of families as they seek to work their way through the process from seeking help to actual linkage with an appropriate agency has not been studied previously. This study seeks to determine (a) for parents of a child under age 3 with language delays and disruptive behavior, whether the Child Find process leads to appropriate assistance regardless of which service system (developmental disability, education, or mental health) is first contacted, and (b) differences in the ability to obtain an appointment for Spanish-speaking compared with English-speaking parents. To control variables related to child characteristics and the parent’s style of seeking help, the research team in this study used a telephone script to ensure that all requests for help from each agency followed the same protocol.

**Method**

**Service System Context for the Study**

This study was conducted in Los Angeles County, an ethnically diverse county of over 10 million people. California has the largest number of Latino families in the United States (U.S. Census Bureau, 2011), and Latinos make up over 47% of the population of Los Angeles County (U.S. Census Bureau, 2010). Therefore, the setting provides an opportunity to examine access to services for Spanish-speaking families.

In California, IDEA Part C is administered at the state level by the Department of Developmental Services (DDS) and locally through the regional center system. Regional centers are a network of 21 independent private nonprofit agencies that contract with DDS to provide Part C services. Regional centers function as the Child Find lead agency and are required to partner with other agencies, such as schools, to ensure that children in need of Part C early intervention services are identified. In turn, the Child Find mandate requires that schools refer young children who may have disabilities to regional centers for further assessment and determination of eligibility.
In Los Angeles County, the Department of Mental Health (DMH) administers EPSDT mental health services through directly operated programs, as well as contracts with community agencies. Agencies contracting with DMH are mandated to offer evaluation and intervention to children with Medicaid insurance who have mental health needs.

Sample and Participant Selection

Data collection involved researchers following a telephone script to request services for a young child from three types of service agencies. The sample of agencies called included elementary schools, mental health centers funded by DMH, and regional centers. Ten agencies within each category were chosen from across the geographic area of Los Angeles County, resulting in a total sample of 30 agencies. Los Angeles County was divided into eight Service Planning Areas (SPAs) in 1993 by the Board of Supervisors, for purposes of planning, service coordination, and data sharing by major county departments serving children and families. Researchers and funding agencies use the SPAs to organize data profiles, ensure sampling of the full geographic and ethnic makeup of the county, and conduct strategic planning. Therefore, the sampling method for the current study used the SPAs as an organizing structure for sampling agencies that would represent the geographic and ethnic diversity of the region.

To select the mental health centers, the Los Angeles County DMH website was used to obtain a provider list for each SPA. From that list, all agencies that provided outpatient services to children with Medicaid insurance were selected. A random number generator was used to select one agency from each of the eight service planning areas. One additional agency was randomly selected from each of two service areas with the most children’s providers, for a total of 10 mental health agencies.

To select the schools, the local school district school-finder website was used to identify the elementary school serving the address nearest the mental health center that was chosen above. There are seven regional centers in Los Angeles County, so all seven were included in the sample. To provide a larger sample, one regional center from each of three adjoining counties was added.

Measure

The Access to Care Telephone Script was designed for the present study. The research team included a parent of a child with complex special needs who has experience attempting to access services (the fifth author); this author assisted in designing a telephone script that mimics the kinds of questions that parents are likely to ask. Using the telephone script, a researcher presented herself as a parent requesting help for her son. The caller described her son as a 2.5-year-old boy with tantrums (occurring multiple times a day, including hitting his mother and running away from his mother in public places) and language delays (the child only says single words, does not combine words, and most people outside the family do not understand what he says). The caller then asked for help for her child and responded to any questions asked based on answers provided in the script. If asked about insurance, the caller indicated that the child had Medicaid insurance. If the agency staff confirmed that the child could receive services there, the caller requested an appointment. Following the call,
the researcher documented the outcome of the call (e.g., an appointment was offered or they were given an alternative referral).

**Procedures**

All telephone calls were made by two researchers (the second and third authors, a clinical social worker and a clinical psychologist) who are fluent in English and Spanish. Each researcher called 15 agencies in English (5 mental health centers, 5 schools, and 5 regional centers). After the phone call was complete, the other researcher waited 2 weeks before calling the same agencies in Spanish. Therefore, each of the 30 agencies received one call in English and one call in Spanish from the two different researchers, with all calls following the same telephone script. If no one answered the phone at a given agency, the caller left a message. If there was no response to the message, the caller tried two more times (on different days) to obtain a live person. The script included standardized instructions for responding to typical questions from the agency. In addition, the researchers consulted regularly to ensure consistency in responses.

Additional follow-up calls were made any time that a call ended with a referral to another agency. In those cases, the researcher called the agency to which they were referred, using the same language (English or Spanish) as the original call, and used the same telephone script to attempt to obtain an appointment with that agency. If that agency gave another referral, the researcher then called that agency, and so on. This process continued until the researcher either obtained an offer of an appointment or received no further referrals. The purpose of the calls to the referred agencies was to determine whether a parent following the complete chain of referrals from a given call would eventually obtain an appointment for an evaluation or services.

Because the study involved deception (people answering the phone at agencies were not informed that the caller was in fact a researcher and not a parent), an opt-out procedure was followed to give all the agencies who were contacted the opportunity to remove their data from the study. The study method was approved by the Institutional Review Board and the Consumer and Community Advisory Board of the host institution. After completion of the phone calls, a letter describing the study methodology and a summary of findings was mailed to the director (or principal, in the case of schools) of all agencies who had been contacted for the study. Agency directors or principals were told how to contact the lead author to request to “opt-out” of the study by having data from their agency removed. Two agency directors contacted the researcher in response to the letter to request recommendations for providing optimal service. No agency requested to have their data removed from the study. Thus, the results presented represent data from 100% of the agencies contacted.

**Results**

**Outcome of First Call**

The outcome of calls was defined as “adequate” if both of the following criteria were met: (a) the caller reached a live person within three calls and (b) the call resulted in an
offer of an appointment (even if there was a wait list to actually make the appointment), instruction to walk in to the agency to meet with a staff person, or a referral to another agency. Calls that did not meet one or more of the criteria were rated as “poor.”

Based on the definition above, 45 out of the 60 initial calls (75%) were “adequate,” with 28 calls (47%) leading to an appointment and 17 (28%) leading to a referral. For calls rated as “poor,” in five cases (8%), a live person could not be reached by phone in three tries on different days; in seven cases (12%), a live person was reached but did not provide assistance in either obtaining an appointment or giving a referral; and in three cases (10% of Spanish calls), the person answering the phone hung up because he or she could not speak Spanish nor locate a person to speak Spanish to the caller. A chi square test comparing adequacy of the calls by agency found no significant difference in adequacy of first calls between the regional centers (90%), schools (70%), or mental health centers (65%), \( N = 60 \), Fisher Exact \( p = .147 \) (ns), ES = 0.48. Adequacy of calls was compared by language and indicated no statistically significant differences, \( \chi^2(1, N = 60) = 2.05, p = .152 \) (ns), ES = 0.26. Calls in English were adequate 80% of the time, and those in Spanish were adequate 63% of the time. For these analyses, power may have been too low to detect significant differences between agencies or by language; a larger sample might have detected statistically significant differences. However, further analysis of the data separated by language indicated that there was sufficient power despite the small sample to detect differences in the interaction between agency and language.

When comparing language separately by agency, it was found that all agencies had exactly the same number of adequate calls in English (80%). However, the agencies differed significantly when called in Spanish, \( N = 30 \), Fisher Exact \( p = .038 \), ES = 1.22. In Spanish, the regional centers had more adequate calls (100%) than either the schools (60%) or the mental health centers (50%).

**Ability to Eventually Get Help**

To further evaluate whether parents would eventually be able to get an appointment at an appropriate agency, all referrals were called. As outlined under Procedures, in cases where a referral was offered, the same caller contacted the new agency referral using the same language (English or Spanish) as the original call and following the same phone script. If that agency also offered a referral, the same caller called that agency as well. Calls continued in this manner until the caller was either offered an appointment or received no further referrals.

Overall, in 36 of the 60 calls (60%), the caller was able to eventually obtain an appointment after exhausting all referrals given; Table 1 provides specific call outcomes. There was a significant difference in outcome by agency, \( N = 60 \), Fisher Exact \( p = .001 \), ES = 1.67. If the regional center was contacted first, 90% of the calls resulted in an appointment. However, if a school or mental health center was contacted first, only 35% or 55% (respectively) of calls resulted in an eventual appointment.

In the case of schools, the majority of calls in which a live person was reached resulted in a referral (70%), most often (85%) to another school phone number such as the school district or a private preschool number. Only two callers to schools (20%) were provided with a referral to a regional center. Out of 14 total referrals by the schools, only 7 (50%) resulted in an offer of an appointment. Problems in linkage included referrals to a wrong
number, referrals to a private preschool that did not offer assistance, and referrals to the special education office that resulted in parenting advice given over the phone but no offer of appointment for an evaluation or preschool placement. In the case of mental health agencies, 77% of callers who reached a live person obtained an appointment (or were put on a wait list for an appointment), 23% were referred to other mental health agencies, and two of those referrals led to an appointment. No callers to mental health centers were offered a referral to a regional center.

There was no significant difference regarding the final outcome for calls in English (19/30 adequate = 63%) versus Spanish (17/30 adequate = 57%), $\chi^2(1, N = 60) = .28$, ns, ES = 0.036. However, when comparing language separately for each agency, differences between agencies depending on call language were identified. In English, there was no significant difference between agencies in the number of adequate calls; $N = 30$, Fisher Exact $p = .249$. In contrast, in Spanish, the agencies differed significantly, $N = 30$, Fisher Exact $p = .003$, ES = 2.13. In Spanish, the regional centers had significantly more calls resulting in an eventual appointment (100%) than either the schools (30%) or the mental health centers (40%).

Discussion

This exploratory study illustrates a number of barriers for parents attempting to obtain services for young children with developmental and/or behavioral difficulties and suggests directions for system improvement. According to the Child Find provisions of IDEA, states are required to develop a system for linkage such that children with special needs are connected with appropriate services. In the case of young children with behavioral and developmental concerns, a number of agencies are mandated to provide assessment and services. In California, the regional centers administer the IDEA Part C early intervention program, and are mandated to develop linkages with other agencies serving young children. In addition, through EPSDT, children with Medicaid are mandated to receive health screening (including mental health and developmental needs) and linkage to services. This study indicated that if a parent directly contacts a regional center, he or she appears to be well-served by the system in terms of linkage to the intake and eligibility-determination
system—that is, our data suggest that as long as a live person responds to the phone call, parents calling regional centers are routinely offered an appointment to determine their children’s needs and eligibility for services. This linkage system was seen to work equally well for parents calling in English or in Spanish (the most common second language in California). Because the regional centers are the early intervention provider for California, this finding suggests that when parents of children with developmental delays call the “right” agency first (i.e., the agency mandated to provide early intervention in the state), the system works well in terms of ensuring that an intake is provided.

In contrast, this study suggests that if parents seek services directly through the public-school system or through publicly financed mental health agencies serving children with Medicaid, linkage is much less likely to occur. In the case of schools, staff answering the phone most often referred parents to another school resource, either a special education office for the school district or a private preschool. However, these referrals did not lead to successful linkage, and there appeared to be no clear direction for school staff regarding what type of referral should be provided to parents. Because the regional centers serve as the primary Part C early intervention provider for this age group, it was surprising that only 2 out of 14 referrals from schools were directed to a regional center. In most cases in which linkage failed, the caller was simply told that his or her child was too young, but the person answering the phone was not aware of other options (such as early intervention) for younger children. In the case of mental health agencies, about half the calls resulted in an offer of an appointment (or to be put on a wait list for an appointment) at that mental health center. When callers were referred out (most often because the agency called did not serve children under age 3 years), they were never referred to a regional center. The pattern of referrals suggests that agency staff most often refer to another similar agency (i.e., schools refer to other schools; mental health agencies refer to other mental health agencies) rather than referring to the Part C provider. Therefore, the Child Find mandate to ensure that other child-serving agencies are aware of and link families to regional center early intervention services seems not to be implemented effectively in this large urban setting.

The study also found that callers face significantly greater barriers when they are monolingual Spanish-speaking, compared with English-speaking callers. Examination of access by agency and language revealed that regional centers consistently provided appropriate access to Spanish-speaking callers. However, fewer than half of calls in Spanish to schools and mental health agencies resulted in successful linkage. This finding corroborates results of other studies that found that Spanish-speaking families face particular barriers to accessing services (Flores, Abreu, Olivar, & Kastner, 1998; Yu et al., 2004). Whereas those studies used survey data about parents’ recollection of their experiences in seeking help, this study was unique in documenting the actual experience of callers attempting to access services in Spanish. It was particularly notable that 20% of schools and 10% of mental health agencies sampled in the study did not have a Spanish-speaking staff person or an interpretation service available to talk to a caller, despite the high percentage of Spanish-speaking families in Los Angeles.

Policymakers have advocated for a more integrated system of care for young children so that those found not eligible for services in one system are nonetheless linked with appropriate resources (Kavanaugh et al., 2012). Powell et al. (2007) noted that the lack of universal screening for challenging behaviors means that many young children with significant mental health needs are not identified; when these children are identified or their parents...
seek help, the complex array of service agencies with different eligibility criteria, entitlements for services, and services available mean that many families fail to connect with appropriate care. Indeed, our study indicated that the recommended “no wrong door” to service access is not in place for young children in this urban setting.

Several limitations should be considered in interpreting the present findings. First, calls were made by researchers rather than actual parents. Although a parent of a child with complex needs designed the script, it may be that actual parents would have responded differently than the trained callers.

The study was conducted in Los Angeles County, and results may not generalize to other communities that have a different organization of service systems and different cultural populations. The study was limited to three types of agencies, whereas there may be additional access points that parents would be likely to contact and that would lead to different outcomes. In particular, the first point of contact for many parents may be physicians such as pediatricians or family practitioners. However, if a physician determines that a child’s developmental or behavioral difficulties require intervention, he or she is likely to refer parents to agencies such as those contacted in this study. Therefore, the findings provide guidance that could be useful to physicians in identifying the most appropriate agency for first referral when parents raise concerns about their young children. Another limitation is that the study focused on one method of service access, direct request via telephone. It is not known how these findings would generalize to other methods of access, such as walking in to an agency, searching for information on the Internet, or direct referral from a service professional. In addition, it is not known which of the agencies studied would be most likely to actually receive direct requests for help from parents.

The choice of a 2.5-year-old as the target child may have created ambiguity regarding the best agency to provide service. Because a child this age has limited time remaining in the early intervention system and is on the cusp of eligibility for preschool special education, agency staff members may have been unsure which agency would be the most appropriate for referral. It is encouraging that the regional centers did offer intakes even though the child was almost beyond the age for early intervention. However, schools may have been more likely to refer to special education services due to the child’s age. Therefore, the findings from this study may not generalize to children of different ages and presenting problems.

A final limitation is the small sample size of the study, which may have limited power. In particular, the number of schools and mental health agencies was small relative to the total number of these agencies in the county. However, given that results were found that were of statistical significance and practical meaning, and the entire County of Los Angeles was sampled, the small sample did not preclude meaningful findings. In particular, the large effect sizes for the differences by language at schools and mental health centers indicated a robust and meaningful difference in the experience of Spanish-speaking compared with English-speaking callers.

There are implications for system change arising from the study findings. First, many parents are likely to face barriers when seeking help for their young children, and these barriers may lead them to give up before obtaining services. In the case of Spanish-speaking parents, in this study, about half the calls did not lead to an appropriate appointment; this suggests that many young children may not receive help when their problems are at an early stage and most amenable to early intervention services. Second, many staff
members handling phone calls at child-serving agencies do not have training or access to resources needed to successfully link young children to early intervention services.

The findings of this study suggest the need for staff training and service-system changes to reduce barriers to accessing services for young children and improve the Child Find process. Recommendations include a centralized referral system, public education about the service system, commitment to quality customer service on the part of public-serving agencies, and directions for further research.

First, a centralized referral system to link parents with services for young children may best address the identified problems, given the complexity of the service system. If one centralized agency had staff persons trained to assess key eligibility factors before providing linkage, families would be more likely to be routed to the appropriate agency earlier in the process. In addition, a centralized referral system would enable more efficient access to staff persons speaking a range of languages or using interpretation services. In Los Angeles County, the 211 Information and Referral telephone service recently launched a Developmental Screening Project with the goal of conducting high-quality developmental screenings for young children and then providing referral and linkage to publicly available services based on the results. Although no published outcomes of the project are yet available, the project may prove to be a promising approach to addressing some needs raised in this study.

Second, even if a centralized referral system is in place, concentrated effort is needed to inform the public, health care providers, and agencies about the centralized system so that parents are directed there. Public information campaigns often focus on raising awareness about a particular problem without necessarily providing information about how best to find help. An example of a model program that may lead to better access is the Learn the Signs Act Early campaign (Centers for Disease Control and Prevention, 2012), which includes (a) public information for parents about early signs of developmental problems with recommendations to contact the child’s physician and the early intervention system; (b) information for physicians about developmental screening and referral, including free materials for waiting rooms and handouts for parents; and (c) information for early-childhood educators.

Third, agencies serving the public are encouraged to evaluate their access points from the perspective of individuals seeking service and to strive to create family-friendly and accessible entry into services. In more than 25% of the calls in the present study, the caller either could not get through by telephone even after three attempts, or the person answering the call hung up due to language barriers. It is recommended that agencies serving the public ensure adequate staffing to answer phones or return calls in a timely way and make use of telephone interpretation services to supplement staff members who may not speak the languages of all callers.

Finally, further research is needed to evaluate the effectiveness of these outreach programs on actual linkage of young children and families to needed services. To expand the work begun in this study, additional studies could focus on the following: (a) evaluating barriers to access from the agency’s perspective, (b) identifying successful methods of improving language access for non-English-speaking parents, (c) implementing a program-improvement project to address the barriers identified in this study and evaluating its effectiveness, (d) replicating the findings with children of different ages and presenting problems, and (e) expanding the sample to include other regions of the country to compare access barriers and solutions in different service systems.
References


