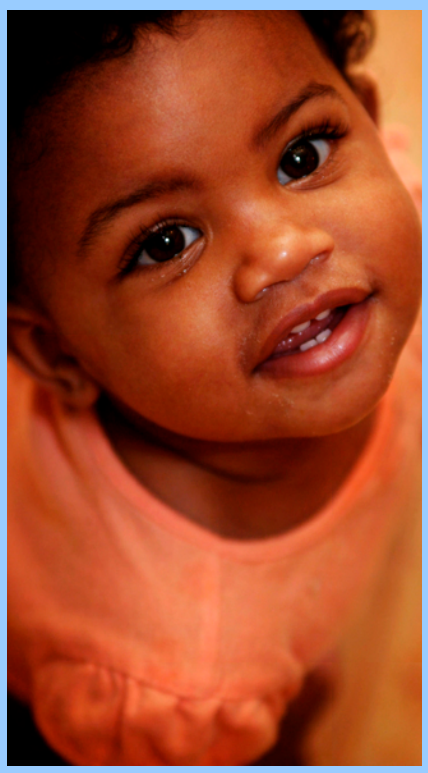
Infant/Toddler

Development, Screening, and Assessment



National Infant & Toddler Child Care Initiative

U.S. Department of
Health and Human Services

Office of Child Care
Administration for Children and Families

Infant/Toddler Development, Screening, and Assessment is one of three infant/toddler modules created to support consultants working in child care settings, especially those who have not had education or training specific to infants and toddlers in group care. These modules were designed to complement training offered to early childhood consultants through the National Training Institute at the Department of Maternal and Child Health, University of North Carolina at Chapel Hill.

The infant/toddler modules, which also include ***Relationships: The Heart of Development and Learning*** and ***Infant/Toddler Curriculum and Individualization***, provide content on early development and quality child care policies and practices for consultants working in child care settings serving children ages birth to 3 years. As the modules do not focus on developing consultation skills, they are not intended to be used as stand-alone trainings. They should be incorporated into training that also addresses the critical skills and process of consultation.

Information about the National Training Institute for Child Care Health Consultants can be found at *http://nti.unc.edu/* or by contacting the program at the following address:

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Infant/Toddler Development, Screening and Assessment

LEARNING OBJECTIVES

Upon completion of this module, child care consultants will be able to:

- Describe factors that affect infant/toddler development and identify resources for reference on developmental milestones.
- Discuss how the integrated nature of infant/toddler development affects overall growth and development.
- Describe their state's professional development system supports for infant/toddler caregivers and how they can be accessed.
- Define the difference between observation, screening, and ongoing assessment and the key components of each process.
- Discuss the importance of coordinating referrals with the family and other care providers, such as medical and dental homes, therapists, and additional child care providers.
- Identify key aspects of the state Part C/Early Intervention system for infants and toddlers with disabilities.
- Discuss the importance of involving families in the process of observation, screening, and assessment.

Infant/Toddler Development

INTRODUCTION

The purpose of this module is to provide child care consultants with information that will support their work with individuals and child care programs serving infants, toddlers, and their families. The module includes:

- A brief overview of infant/toddler development.
- Information on how infant/toddler caregivers can nurture infant/toddler development.
- Discussion of how programs can involve families[1] in recognizing and promoting their child's development.
- Information on how infant/toddler caregivers know how infants and toddlers are developing (observation, screening, and assessment).
- Ideas about what to do when development is not proceeding as expected.

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WHAT THE CHILD CARE CONSULTANT SHOULD KNOW

An Overview of Infant/Toddler Development

The development that occurs from birth to 3 years provides the foundation for subsequent development across domains. Although it is common practice to discuss early development within discrete domains, the number and labeling of these domains is not standardized and varies considerably depending on the field in which the discussion occurs. But discussions of development typically include some combination of the following domains:

- Physical
  - Growth and health status
  - Sensory
- Motor
  - Fine motor
  - Gross motor

[1] In this module, *family* refers to adults who have primary responsibility for parenting a child and/or other family members who may be routinely involved in the child's life. Family can include biological parents, foster parents, adoptive parents, grandparents, legal guardians, and others.

- Cognitive
  - Approaches to learning
- Communication/Language
- Social/Emotional (including mental health)

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The Developmental Continuum and Appropriate Expectations

Infant/toddler development proceeds in a predictable sequence: infants crawl before they walk, babble before they talk, and so on. But when each developmental milestone is achieved varies from child to child. A primary task of child care consultants will be to guide caregivers' awareness of infant/toddler development and of the age range that may be considered typical for the emergence of key developmental indicators. Awareness of the age range of infant/toddler development is important to:

- Ensure caregiver competence in observing infant/toddler development.
- Know when referrals should be made to the state's Part C/Early Intervention system (discussed in the Red Flags and Referrals section) and other systems.
- Support individualized curriculum planning to meet each child's developmental needs.

Infant/Toddler Development Is Integrated Across Domains

Development not only occurs on a continuum with expectations that overlap age ranges but also is integrated across domains. For example, language development requires intact cognitive skills to construct conceptual frameworks and physical development to coordinate the necessary oral-motor response. Language also greatly relies on social interactions — relationships that are meaningful and include significant language exchanges. Similarly, cognitive development does not result from neurobiological development alone, although neural connections are necessary to allow sensory inputs to reach the brain. For example, Piagetian theory supports the notion that infants construct an understanding of the world by coordinating sensory experiences (such as mouthing, seeing, and hearing)

with physical and motor actions (such as crawling). In other words, infants gain knowledge of the world and develop conceptual frameworks from the physical actions that allow them to explore their environment.

This integration of development across domains has implications for the overall course of a child's development. A developmental disability or delay identified in any one area will affect other developmental domains as well. For example, a child with vision impairment would not able to visualize the environment, likely impacting motor development. Or a child with cerebral palsy may be less likely to physically engage with and explore the environment in a way that will support overall development. These sensory and motor deficits may affect the young child's base of experience for cognitive and language development because of limited opportunities to explore the environment.

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Infant/toddler caregivers need core knowledge of the infant/toddler developmental continuum, tools, and procedures for conducting developmental screening and ongoing assessment. They also need to be aware of systems for referral if a developmental concern emerges. The consultant may be called upon to link programs with accessible resources that will provide them with this basic information.

How Caregivers Can Nuture Infant/Toddler Development

Nature vs. Nurture: It's Not Either/Or, It's Both

Scientists agree that human development is shaped by both nature (biology) and nurture (experience) (National Research Council, 2000). Research supports that the interaction of nature and nurture has the greatest influence on early development, with long-lasting effects on every developmental domain throughout childhood.

Because a nurturing environment is a critical factor in infant/toddler development, it is important for caregivers to be aware of their responsibility for nurturing the development and learning of infants and toddlers in out-of-home care. The act of nurturing infant/toddler development can occur in many ways, including:

- Warm, responsive relationships.
- Provision of healthy and safe environments.
- Caregiver competence.

Infants, toddlers, and their families are nurtured when relationships are healthy, environments are safe, and caregivers understand how to support the learning and development of infants and toddlers.

Warm, Responsive Relationships Nurture Infant/Toddler Development

"Human relationships, and the effects of relationships on relationships, are the building blocks of healthy development" (National Research Council, 2000, p. 27). Relationships, and the interactions that occur through relationships, embody the nurturing that supports development.

Parent/Caregiver Collaboration in Promoting Development

Early care and education programs have a great opportunity to actively and appropriately promote development. A key aspect of supporting and promoting child development is an effective, positive relationship between the parent and the infant/toddler caregiver. A principal task of this relationship is bidirectional communication about the child and his or her development. While the importance of this level of communication cannot be understated, multiple realities of the field offer challenges that can make it difficult. A key role of the child care consultant is often that of promoting effective communication between programs and parents and problem solving around some of the challenges.

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Communication between parents and caregivers occurs informally at daily arrival and departure and formally in intentionally planned meetings in the child care setting or on home visits. Parent/caregiver communication about the child's development is critical to the process of individualizing the child's curriculum. In this process, parent and caregiver work together to establish "where the child is." This process is discussed more completely in Module 3 in this series: ***Infant/Toddler Development: Curriculum and Individualization***.

Although relationships are not the focus of this module (see Module 1 ***Relationships: The Heart of Development and Learning*** for a full discussion), they are central to all development that occurs throughout infancy and toddlerhood. For example:

A child's emerging sense of self and emotional security is nurtured through warm, responsive, consistent relationships with primary caregivers.

Both the communication process and language are learned through listening to and interactions with adults.

Motor development occurs when relationships with others and the opportunities that ensue encourage a child to move and manipulate objects.

The absence of relationships, as evidenced by research on children raised in orphanages, can lead to significant negative effects on a child's health and physical development (National Research Council, 2000, p. 257).

Development Can be Nurtured Through Healthy and Safe Environments

Health and safety are primary considerations in child care settings because infants and toddlers are vulnerable to experiences that may negatively impact their overall well-being. The most evidence-based information on health and safety for young children is *Caring for Our Children*, developed by the American Academy of Pediatrics (2002). Designed for child care providers, parents, health professionals, licensors, and policymakers, this health and safety manual includes the latest information to inform caregiver health and safety practices. Child care consultants should also be familiar with the health and safety licensing regulations for their states, accessible online from *http://nrc.uchsc.edu/STATES/states.htm.*

Creating and maintaining a safe environment for young children requires thoughtful planning and care. Although it is beyond the scope of this module to fully address health and safety, Box 1 lists important procedures for child care consultants to support when working with programs serving very young children. Box 2 highlights key components of a health and safety policy.

BOX 1

General health and safety practices may include but are not limited to:

- Medication administration and storage.
- Daily health checks conducted at the beginning of each day.
- Admission and readmission after illness, including inclusion/exclusion criteria.
- Health evaluation procedures on intake, including physical assessment of the child and other criteria used to determine the appropriateness of a child's attendance.
- Managing children with communicable diseases.
- Injury prevention and managing children with injuries.
- Tracking communicable illnesses and problems that arise in the care of children with communicable illnesses.
- Staff, parent, and volunteer training on illness and injury prevention.
- Communication with families and health care providers in the event of illness or injury.
- Practices for emergencies that require medical care within an hour.

Source: American Academy of Pediatrics (2002).

BOX 2

Health and safety policies and procedures should include information on:

- Ensuring that young children have a medical and dental home.
- Oral health procedures.
- Nutrition and physical activity procedures.
- Developmental surveillance and screening procedures.
- Evaluating the safety of play equipment.
- Background screening of all staff.
- Procedure for recognition of child abuse and neglect.
- Disaster preparedness.
- Medical and dental emergencies.
- Rapid response emergencies (e.g., choking).
- Conditions of short-term exclusion and admittance.
- Medication administration and storage.
- Immunization and well-health checks for children and staff.
- Contacting families in the event of an emergency.
- Safe sleeping practices.
- Record-keeping and reporting.
- Staff training on health practices.
- Hygiene/sanitation practices (e.g., hand washing, diapering, toileting).
- First aid kits.
- Contacting the Poison Control Center at 800-222-1222.

Sources: American Academy of Pediatrics (2002); Fiene, R. (2002).

In addition to the resources mentioned at the end of this section, numerous checklists and systems exist that include high quality standards for the health and safety of infants and toddlers. The following is a partial list of such systems:

- Infant/Toddler Environmental Rating Scales – Revised Edition (ITERS-R)
- Family Child Care Environmental Rating Scale – Revised Edition (FCCERS-R)
- National Association of the Education of Young Children (NAEYC) Early Childhood Program Standards and Accreditation Criteria
- Head Start Performance Standards

ACTIVITY I: Comparing Health and Safety Standards

This activity may be used to support both consultant's and caregiver's familiarity with standards of care. Use the Internet links to state child care licensing standards (*http://nrc.uchsc.edu*) and Caring for Our Children (*http://nrc.uchsc.edu/CFOC/*) to compare standards on the following key aspects of infant/toddler health and safety.

Health and Safety Indicator Standard(s)	Caring For Our Children Standard(s)	State Licensing
Staff-to-child ratio for infants		
Staff-to-child ratio for toddlers		
Daily health checks		
Frequency of diaper checks		
Oral hygiene		
Back-to-sleep policies		
Exclusion standards		
Sanitization of toys		
Safety checks of play equipment		
Procedures for reporting abuse and neglect		
Immunization requirements		
Emergency evacuation procedures		
Documentation for injury		

Development Can Be Nurtured by Competent Infant/Toddler Caregivers

Staff who are knowledgeable in the fundamentals of child development are better prepared to nurture the development of very young children. Professional development systems for early care personnel should be accessible, address the needs of adult learners, and based on a clearly articulated framework. They should include a continuum of training and ongoing supports, with defined pathways that are tied to licensure and lead to qualifications and credentials.

The professional development and quality initiatives described in Table 1 can provide support to improve the quality of infant/toddler care. It could be useful to discuss each of these initiatives as they apply to your state with peers, infant/toddler programs, and caregivers.

TABLE 1

Infant/Toddler Quality Support Initiatives

Infant/Toddler Credential (ITC)
Any combination of requirements (training, courses, experience) when considered together, translate to formal recgnition of individuals who work with infants and toddlers in child care programs.

Core Knowledge and Competencies (CKC)
CKC define what infant/toddler caregivers should know (knowledge) and be able to do (competencies) to work successfully with infants and toddlers.

Infant/Toddler Early Learning Guidelines (ELG)
ELG describe expectations about what children should know (understand) and do (competencies and skills) across different domains of learning.

Infant/Toddler Specialist Networks (ITSN)
ITSN are trained early childhood professionals who provide support to the professionals and caregivers who provide early care and education to infants and toddlers.

Infant/Toddler Child Development Associate (CDA) Credential
A national credential based on criteria that documents the comptency of child care providers working in infant/toddler settings.

Higher Education
College-level coursework that is accessible to caregivers, leading to 2- or 4- year degrees and advanced degrees.

Articulation of Early Childhood Programs
"The transfer of professional development credentials, courses, credits, degrees and student performance-based competencies from one program or institution to another, ideally without the loss of credit" (LeMoine, 2009).

Financial Incentives and Support
Financial support may include increased compensation through programs such as T.E.A.C.H. Early Childhood Scholarships or state-based scholarships.

Coaches, Consultants, and Mentors
Professionals who work in child care settings to support the development of knowledge and skills of infant/toddler caregivers.

Quality Rating and Information Systems (QRIS)
Define standards for incremental levels of quality across a range of categories, and establish systems for rating and improving the quality of child care settings. (NITCCI, 2008)

THE ROLE OF THE CHILD CARE CONSULTANT

The child care consultant should:

- Observe the program for evidence that caregivers have ready access to information on infant/toddler development. Are there wall charts or posters with such information visible? What other resources are available?
- Review program practices to determine if developmental milestones are identified within tightly defined age ranges that allow for typical variations within development but still alert providers to possible delays.
- Review program policies on health and safety, the environment, and routine practices to ensure key points are addressed.
- Discuss professional development opportunities that support infant/toddler caregivers' knowledge of infant/toddler development.
- Be knowledgeable about the presence or emergence of infant/toddler initiatives (e.g., infant/toddler specialist networks, early learning guidelines, core knowledge and competencies, infant/toddler credentials within the state.

Where to Find More Information

American Academy of Pediatrics, American Public Health Association, & National Resource Center for Health and Safety in Child Care and Early Education. (2002). *Caring for our children: National health and safety performance standards: Guidelines for out-of-home child care programs* (2nd ed.). Elk Grove Village, IL: American Academy of Pediatrics and Washington, DC: American Public Health Association. Also available from http://nrc.uchsc.edu

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National Infant & Toddler Child Care Initiative. (2007). *Infant/toddler early learning guidelines*. Washington, DC: NITCCI. Retrieved June 3, 2008, from *http://nccic.org/itcc/PDFdocs/itelg.pdf*

National Infant & Toddler Child Care Initiative (2008). *QRIS Issues Meeting White Paper: Including Infants and toddlers in quality rating and improvement systems.* A project of the U.S. Department of Health and Human Services, Office of Family Assistance, Administration for Children and Families, Child Care Bureau. Retrieved December 29, 2009 from *http://nitcci.nccic.acf.hhs.gov/resources/AFF_whitepaper%2004%2030%2009%20(2).pdf*

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U.S. Dept. of Health and Human Services, Administration for Children and Families, Office of Head Start (2004). *Head Start Performance Standards*. Retrieved December 29, 2009 from *http://www.acf.hhs.gov/programs/ohs/*

Web Sites

American Red Cross, *www.redcross.org*

The Council for Professional Recognition's Child Development Associate (CDA) credential, *http://www.cdacouncil.org/default.htm*

Healthy Child Care America, *http://www.healthychildcare.org*

National Association for the Education of Young Children (NAEYC) Early Childhood Program Standards and Accreditation Criteria, *http://www.naeyc.org/accreditation*

National Infant & Toddler Child Care Initiative, *http://nccic.org/itcc/*

The Program for Infant Toddler Caregivers (PITC), *http://www.pitc.org*

ZERO TO THREE: National Center for Infants, Toddlers, and Families, *http://www.zerotothree.org*

WHAT THE CHILD CARE CONSULTANT SHOULD KNOW

Engaging Parents In Development, Screening, and Ongoing Assessment

Substantial research supports engaging families because family involvement results in positive outcomes for infants, toddlers, and their families. An ongoing challenge for caregivers is to develop and enhance skills that will offer young children the best possible learning experiences and opportunities in center-based settings, at home, and in the community. It is therefore essential that every effort be made to ensure that ongoing and effective communication and partnerships be established and maintained between caregivers and infants and toddlers and their families. Families provide a perspective on their child that is not readily accessible to the provider, and through which providers can gain a deeper understanding of the child's strengths and challenges. When families are equal partners in the observation, screening, and assessment processes, it ensures that strengths and needs are identified and appropriate supports are in place to individualize learning opportunities.

BOX 3

Tips to Involve Families

- Maximize daily arrival and departure.
- Acknowledge arrival or departure.
  - Share a quick but specific detail about the child's progress.
- Communicate often.
  - Regularly scheduled parent/caregiver meetings.
  - Distribute printed materials (such as a newsletter).
  - Learn from families if communication is efficient and effective.
- Offer home visits when appropriate.
- Notify families of workshops, trainings, and family-child groups.
  - Encourage family peer networking.
- Invite families to spend time in the child care setting.
- Provide resource materials and ideas for activities that families can do at home and in the community with their children.
- Recognize that family involvement is an ongoing process.
  - Learn from families about prior child care experiences and any new expectations in new child care settings.
- Acknowledge the perspective of the family on their child's strengths and needs.
- Be sensitive to the diversity in home cultures and how communication may need to be impacted.
- Host special family events throughout the year at different times of the day to accommodate a variety of family schedules.
- Be sure families are knowledgeable about curriculum and learning expectations.

Source: Harvard Family Research Project (2006).

Family/Caregiver Collaboration to Support Overall Development

A key aspect of supporting and promoting child development is an effective, positive relationship between the family and the caregiver. Engaged communication gives early care and education programs an opportunity to actively and appropriately promote the development of infants and toddlers. Caregivers can promote effective communication between programs and parents by maximizing opportunities to communicate with families.

Family/caregiver communication about the child's development is critical to the process of individualizing the curriculum. A framework for an informed observation, screening, and assessment process is created when caregivers work together with families to assess developmental strengths and needs. Caregivers and families are then able to individualize curriculum and learning expectations for each child based on their unique strengths and needs. This process is discussed more completely in ***Infant/Toddler Development: Curriculum and Individualization***, the Module 3 in this series.

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Parent/Caregiver Collaboration in Screening and Assessment

Parent participation is integral to effective screening and assessment of infants and toddlers. In keeping with the principles of screening and assessment described later in this module, information from multiple sources and settings is critical to capturing an accurate description of the child's development. The parents' perspective is helpful in gathering information about the child's activities and capacities in the home. Parents see their child in the child's ultimate "comfort zone," and thus have the advantage of observing developmental indicators that may not emerge in the less familiar child care setting.

In recognition of the importance of parent input in the screening and assessment process, some of the screening tools described in appendices C and D were designed to be completed by parents. If a program selects a tool that is not designed to be completed by parents, it remains important for the infant/toddler caregiver to work with parents in the screening and assessment process to assure that the skills and behaviors observed at the center are truly representative.

When parents are involved in screening and assessment, they become equal partners in the process. If a concern emerges about a child's development, this partnership paves the way for a discussion and decisions about the possible need for a referral. When parents are not involved in the process, they are less informed about developmental expectations and the infant/toddler caregiver's perspective of their child's progress. This lack of information establishes an "uneven playing field" and can make it difficult to discuss any concerns about the child's development.

BOX 4

Communication Tips

- Be a good listener.
- Communicate strengths first.
- Affirm that families understand the message.
- Describe behaviors rather than use labels or diagnoses.
- Allow time for families to think, process, and respond.
- Be sensitive to the emotional needs of the family.
- Ask for feedback.
- Share resource information.
- Ask questions.
- Wonder with families.

THE ROLE OF THE CHILD CARE CONSULTANT

The child care consultant should:

- Review policies and documentation of children's screening and assessment to check for parent participation in the process.

- Be available for consultation with infant/toddler caregivers around strategies to engage and communicate with families.

Where to Find More Information

Annie E. Casey Foundation, School Readiness, Culture, and Language Working Group. (n.d.). *Getting ready for quality: The critical importance of developing and supporting a skilled, ethnically and linguistically diverse early childhood workforce*. Retrieved January 25, 2007, from http://www.californiatomorrow.org/media/gettingready.pdf

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Sandall, S., McLean, M. E., & Smith, B. J. (2000). *DEC recommended practices in Early Intervention/early childhood special education.* Denver, CO: DEC.

Web Sites

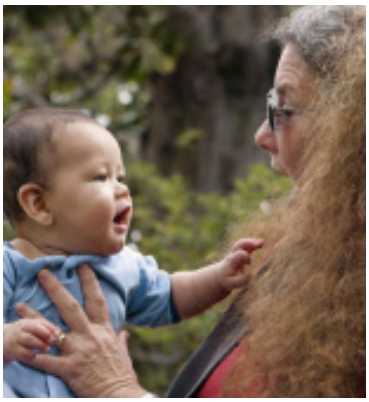
National Dissemination Center for Children with Disabilities (NICHCY), http://www.nichcy.org/

National Early Childhood Technical Assistance Center (NECTAC), http://www.nectac.org/partc/partc.asp

Vogel, C., Aikens, N., Burwick, A., Hawkinson, L., Richardson, A., Mendenko, L., et al. (2006). Findings from the survey of Early Head Start Programs: Communities, programs, and families. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Observation, Screening, and Assessment

WHAT THE CHILD CARE CONSULTANT SHOULD KNOW



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Human development in the first 3 years of life occurs with rapid changes in cognitive development, language, motor skills, and social/emotional skills. This foundation is so important that infant/toddler caregivers must be aware of each child's developmental progress. In a child care setting, knowledge of a child's development is accomplished through the key processes of observation, developmental screening, and ongoing assessment. The child care consultant can play an important role in helping infant/toddler caregivers understand the definitions, key concepts, and processes that can support understanding the developmental progress of infants' and toddlers'.

Observation

An important component of screening and ongoing assessment is observation. Observation is a process of gathering information that documents a child's growth and development. For observation to be meaningful and useful it must be objective and factual. Consultants can help caregivers understand they must document only what they see and hear when recording information about a child. Factual observations should include:

- Descriptions of actions.
- Quotations of language.
- Descriptions of gestures.
- Descriptions of facial expressions.
- Descriptions of creations.

Adjectives, such as fussy, angry, hyperactive, happy, and sad, leave interpretation to the reader, who may or may not have the same perception of these words as the observer. Learning to document accurately takes time and patience and needs to be supported by the consultant. References on this topic can be found in the "Where To Find More Information" section.

The variety of strategies used for documenting children's development are beyond the scope of this module, but the following nonstandardized methods can be implemented with basic instruction to caregivers:

- Anecdotal records or brief notes taken throughout the day that can be filed in the child's portfolio.

- The use of checklists or published developmental profiles.

- Structured observations, such as using a grid to assure that each domain is noted for each child on a scheduled basis.
- Work samples, such as examples of representative work.
- Digital photographs of developmental accomplishments.
- Parent input.
- Videotaping.

Screening and Assessment: Definition and Purpose

For the purposes of this module, discussion of screening and assessment will be limited to two key functions of early care and education:

1. *Developmental Screening* — assuring that any potential developmental concerns are identified and documented for referral to Early Intervention systems and other systems, as appropriate.

2. *Ongoing Assessment* — determining how a child is progressing across domains for purposes of planning individualized curriculum. (See Module 3, ***Infant/ Toddler Development: Curriculum and Individualization***, for a full discussion of how assessment leads to individualization.)

STOP & READ

BOX 5

An Early Childhood Dilemma: Definitions

Because of the many disciplines involved in the field of early childhood development and the diverse array of programs serving young children, there are multiple definitions and rationales for assessment. A necessary caution to individuals familiar with a specific niche in this diverse field is that the word assessment often carries different meanings in different disciplines. The actual definition or intent of the word may vary depending on the context of the speaker and the purpose for which the term is used.

At this time, there is no official agreement on terminology across fields of study or practice. Terms such as assessment, ongoing assessment, authentic assessment, informal assessment, formal assessment, and evaluation often carry different meanings in different contexts. The Web site of the Chief Council of State School Officers (see the Where To Find More Information for this section) includes many of these definitions; however, differences remain in practice and create confusion during cross-discipline conversations.

All consultants, caregivers, and other professionals in the field are urged to check their assumptions about the meaning of the word and purpose of the process when discussing the assessment of young children.

Infant/Toddler Developmental Screening

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Screening is a brief assessment "intended to identify children who are at risk for developmental problems" (Meisels & Wasik, 1990, p. 613) or to determine if a child should be referred for diagnostic assessment or evaluation. In a screening, a small number of key indicators are briefly assessed in each developmental domain. Depending on the tool, a developmental screening can be completed by the child's parent, teacher-caregiver, or other trained professional.

It is important for child care consultants to help infant/toddler caregivers understand that a developmental screening does not identify or diagnose a developmental delay. Screening tools "provide only a 'snap shot' of a child's functioning" (Early Head Start National Resource Center, n.d.). A screening offers a quick look at major developmental milestones across domains, assuring the parent or teacher-caregiver that development appears to be progressing typically. If a screening shows that a child has not achieved the milestones or indicators typical for her age, these results indicate that further assessment is needed to gain a more accurate representation of the child's development. (See the Red Flags and Referrals section.)

Child care consultants should also be aware that developmental screening is a mandated requirement in primary health care, and that infants and toddlers are recommended to have at least twelve well-child visits during their first 3 years. Consultants may support screening activities by reminding caregivers to coordinate with the family and the child's health care home. The Health Insurance Portability and Accountability Act requires parental permission for such coordination.

BOX 6

Infant/toddler developmental screening provides broad insight into:

- Physical health.
- Approaches to learning.
- Social and emotional development.
- Language and communication.
- Cognitive development and general knowledge.
- Motor development.
- Vision and hearing.
- Can raise a red flag that warrants further observation.

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Evaluating and Selecting Screening Tools

In a child care setting, the assessment of infant/toddler development (discussed in the next section) relies primarily on ongoing observation and documentation of children's behaviors and accomplishments. In contrast, developmental screening typically relies on a tool designed specifically to look at development compared to norms across domains to determine if additional evaluation is warranted.

A number of commercially available screening tools are designed for use with infants and toddlers. Both the Early Head Start National Resource Center (EHS NRC) and the National Early Childhood Technical Assistance Center (NECTAC) have prepared a comparison of the more commonly used tools (see appendices C and D for copies of these comparisons). Information on many screening and assessment tools used to measure the effectiveness of services and outcomes in Early Head Start programs is available in a downloadable document from the Office of Planning, Research and Evaluation in the Administration for Children and Families (*http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/index.html*).

Key Considerations in Selecting Standardized Screening Tools

Given the importance of screening to determine if an infant or toddler needs further evaluation to determine his developmental status, consultants can help programs understand how critical it is to carefully select appropriate standardized screening tools. Standardized tools contain the following key components (Meisels & Atkins-Burnett, 2005):

Is the tool reliable and valid?

Reliability is the measure of how consistently the tool yields the same or similar results in similar circumstances. For example, reliability measures consistency of response if two different caregivers complete a screening on the same child.

If the tool is reliable, the scores of both examiners should be similar. Validity is the measure of whether or not the tool actually measures what it is designed to measure. For example, if a tool asks a toddler to point to a picture to demonstrate vocabulary knowledge, it may be that the child's scores might actually reflect her ability to sit and point, not her vocabulary. In this scenario, the tool would not be considered valid.

Reliability and validity information should be available for any tool considered by a program. If a tool does not include this information, it should not be used, as there is no evidence that the results gained from the tool are truly representative of the child's development.

Who can administer the tool?

Some developmental screening tools can be administered by parents or infant/toddler caregivers; some require specialized training to administer. Programs should review the requirements of the tool and assess the background and training of their staff to assure an appropriate decision is made.

Is the tool normed on a population similar to the children being screened?

In the creation of a screening or assessment tool, norming is a process in which the screen is conducted on samples of children to establish test norms or levels of performance by various subgroups. For example, if a tool was normed on infants and toddlers in a white-collar, Midwestern university town, it may be an inappropriate tool for infants and toddlers from migrant families experiencing poverty. The results may not accurately represent a full range of differences among different populations of children.

Is the tool culturally and linguistically appropriate?

Knowledge of the ethnic background of the community in which you conduct a screening program is essential to selecting an appropriate developmental or social/emotional screening instrument. Because communities vary greatly in their diversity, it is important to acknowledge that an instrument that works well for one population may not work as well for another population. Many screening and assessment tools are available in two or more languages and often list the population on which the test was developed.

How long will the screening take?

If the tool is administered through intentional interaction in one sitting, the length of time required is an important consideration when screening infants and toddlers.

Does the tool cover the age range needed?

It is critical that tools cover the ages of the children being screened.

How are parents involved in the administration of the tool?

Some tools are designed to be completed by parents, some by staff with parent input. Especially in a child care setting, it is important that caregivers work closely with parents to screen the development of infants and toddlers. Therefore, tools that include a significant role for parents are crucial to an effective process.

How difficult is the tool to administer and score?

Programs will want to review the complexity of tool administration and scoring before making a decision about which tool to use. A tool that is overly difficult will present a challenge to programs and staff.

Note: A full discussion of these points can be found in Developmental Screening in Early Childhood: A Guide (Meisels & Atkins-Burnett, 2005).

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ACTIVITY II: Comparing Screening Tools

Using the resources in appendices C and D and the information in *Resources for Measuring Services and Outcomes in Head Start Programs Serving Infants and Toddlers* (http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/index.html), select five tools and analyze their effectiveness and applicability in infant/toddler programs.

Tool	Age Range Covered	Developmental Domains Addresses	Who Can Administer?	Reliability/ Validity?	Cultural/ Linguistic Appropriatness	Administration Time?

Ongoing assessment for the purpose of planning an individualized curriculum for the child should not be confused with the more formal process of assessment designed to determine the absence or presence of a developmental delay, or with a multidisciplinary evaluation to determine if a child is eligible for the state's Part C/Early Intervention program. These formal assessment or evaluation procedures will vary with individual state requirements but are typically completed by Early Intervention professionals with specialized training in assessment and evaluation. These procedures may include the use of criterion-referenced or standardized assessment and evaluation tools. Administration of these tools requires training beyond that which is typically included in professional development systems for infant/toddler caregivers.

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Beyond participation in Part C/Early Intervention, there are no nationwide systems that include developmental assessment of infants and toddlers. Child care consultants are urged to become familiar with the state systems supporting infant/toddler development in their state to assure familiarity with any additional assessment procedures that may be in place.

A chart depicting the potential connection between early care and education programs and Part C/Early Intervention for screening, assessment, evaluation, and program planning can be found in appendix B.

What Is Ongoing Assessment?

Ongoing assessment in a child care program is the process of documenting children's growth and learning through observation, for the purpose of planning appropriate activities that support the growth and development of an individual infant or toddler. Within this context, assessment can be defined as "a process designed to deepen understanding of a child's competencies and resources, and of the care giving and learning environments most likely to help a child make fullest use of his or her developmental potential" (Greenspan & Meisels, 1996, p. 11).

The Head Start Performance Standards [45 CFR Part 1304], available through *http://eclkc.ohs.acf.hhs.gov/hslc*, provide regulations for child care programs serving infants and toddlers enrolled in Early Head Start and offer a reference defining high quality for infant/toddler programs. These standards define assessment as "the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility to identify: (i) The child's unique strengths and needs and the services appropriate to meet those needs; and (ii) The resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child" (45 CFR 1304.3).

Two key concepts included in these definitions of assessment are process and ongoing. These terms indicate that assessment is not a one-time event but rather a system designed to gather information that continues over the time of a child's enrollment in the program. Given the pace of development during the years from birth to 3, it is critical that assessment be an ongoing process to assure that any irregularities in development do not go unnoticed, and that the programming designed is appropriate for each child's unique developmental profile.

BOX 7

Principles of Ongoing Assessment

The point of infant/toddler assessment is to learn more about the child, not to assign a grade or score. To ensure that the assessment process yields the most accurate information possible, assess young children in the natural context of their interactions with parents or caregivers. Early childhood research and national organizations have defined key principles for conducting assessments on young children:

- **Parents and other primary caregivers are integral to the process.** Because the goal of screening and assessment is to gain the most accurate portrait of a child's development and capacities, the voices of those most familiar with the child must be central to the process.
- **Information is most accurate when gained from multiple sources and contexts.** Assessment information is more authentic when gleaned from multiple perspectives and the various everyday settings of the child. Parents and caregivers familiar with the infant or toddler can all provide useful information contributing to a more complete view of the child's development.
- **Assessments are recurrent processes.** Infants and toddlers develop rapidly, with major developmental milestones occurring frequently throughout the early years. Especially for very young children, it is critical to implement a schedule for assessment that will assure that knowledge of each child's development is up-to-date and accurate.
- **Tasks and settings should be relevant and familiar to the child.** The tasks used in assessments should be relevant to the child's daily routines and activities and conducted in familiar settings through interactions with known and trusted adults.
- **Assessment identifies current competencies as well as upcoming developmental markers.** Assessment must use a strengths-based approach, including information that can guide caregivers in facilitating future growth and development.
- **Assessors are knowledgeable and effectively trained.** Caregivers responsible for assessing a child must have a working knowledge of child development and be trained in the process of assessment. Both staff and families should be aware of the purpose and function of any assessment being conducted.
- **Tools used for assessment should be standardized, reliable, and valid.** When using commercially prepared tools for assessment, programs should use only tools that have a high degree of reliability and validity data reported. Assuring the validity of a tool includes verifying that it is only used for the specified purpose it was designed for, and that all assessment measures are culturally and linguistically appropriate for the child and family (Meisels and Atkins-Burnett, 2005).
- **Assessment should attend to the child's functional capacities, not isolated skills.** Authentic assessments document the child's ability to use skills in a functional manner throughout everyday routines, not simply if he or she can stack blocks or string beads. This approach acknowledges the integrated nature of development.
- **Assessment should be culturally and linguistically appropriate.** Assessors should remain conscious of the child's home culture and language throughout the assessment and in the interpretation of results.

Sources: Early Head Start National Resource Center (n.d.); Greenspan & Meisels (1996); Meisels & Provence (1989); NAEYC & NAECS/SDE (2003); Neisworth & Bagnato (2000); Neisworth & Bagnato (2004).

BOX 8

Components of Infant/Toddler Ongoing Assessment

- Observation.
- Formulating questions.
- Gathering information.
- Sharing observations.
- Documentation.
- Review of the data/record.
- Family involvement.
- Culturally and linguistically relevant.

Ongoing Assessment of Infants and Toddlers: What Does It Look Like?

After helping the last child brush her teeth after breakfast, Holly scanned the room and noticed Marissa and José on a cushion in the book corner looking at a picture book side-by-side. She picked up a sticky pad and pen from a nearby wall pocket and jotted down a few notes about what they were doing. She noted that Marissa was interacting quietly with José, sharing the book (social development), vocalizing a "story," (language and communication), and turning the pages efficiently (fine motor and emergent literacy). On a separate note, she also noticed that José, who was holding the book right side up, pointed to a picture of a cow and said "Vaca" (cognitive, language, and emergent literacy).

Holly noted the date and time, and stuck the notes in a folder to be filed in each child's portfolio during nap time.

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Observations such as this example, along with the variety of methods mentioned in box 8, contribute to ongoing assessment. A good way to organize the information collected over time about a child is by making a portfolio. A portfolio is an "organized purposeful compilation of evidence documenting a child's development and learning over time" (McAfee & Leong, 2007, p. 100). With intentional selection of representative documentation, the portfolio becomes a record of what the child has done and can do, serving as the foundation for planning activities and experiences that will further support the child's development.

BOX 9

Uses of Ongoing Assessment

- Identifying the child's current abilities in order to plan individualized curriculum and activities that will appropriately support the child's development.
- Note any developmental concerns or delays.
- Documenting developmental progress.
- Planning individualized activities.
- Informing curricula.
- Producing a profile of child outcome data to inform program quality.

BOX 10

Child-Centered Practices in Screening and Assessment

- Infants and toddlers should not be separated from their family or trusted caregivers during assessment.
- Infants and toddlers should not be assessed by a person they do not know or with whom they are not comfortable.
- Assessments that are limited to areas that are easily measured, such as motor or cognitive skills, should not be considered complete.
- Formal tests or tools should not be the cornerstone of the assessment of an infant or young child.
- Child care consultants should work with programs to assure that screening or assessment does not occur without family knowledge or involvement.

Source: Greenspan & Meisels (1996).

ACTIVITY III: Using Existing Practices to Compile Portfolios

The purpose of this activity is to provide an opportunity for consultants to reflect on and discuss with their peers how to help infant/toddler child care programs use portfolios to document observations. Although this activity lends itself to group discussion, it can also be a self-reflection exercise.

As a child care consultant, you have been working with Sunshine Child Development Center. You have noticed that, although the caregivers regularly observe and intentionally plan for infants and toddlers in their care, they have no established process for documenting their observations.

How might you assist the director in establishing policies and procedures for creating portfolios as a record of each child's development, building on practices the program already has in place?

- How would you begin the conversation with the director?
- What resources could you use to discuss children's portfolios?
- What needs to be in place to support implementation?

ACTIVITY IV: Infant/Toddler Assessment — Challenges to Programs

The principles described earlier represent best practices in the assessment of young children, including infants and toddlers. The application of these principles to practice may present challenges to programs struggling with the realities of staff turnover, lack of formal training, and other staffing issues.

In a large group, facilitate a discussion of these challenges, recording the challenges on chart paper. Guide the discussion to generate conversation around how a consultant might help a program overcome major challenges.

If the discussion starts slowly, it may help to begin discussion with one or more of the following possible challenges:

- Time for staff to complete observations and documentation.
- Untrained staff with little background in development.
- A focus on what the child can't do vs. what he or she can do.
- English-only infant/toddler caregivers working with infants and toddlers whose home language is not English.
- Parent perspective not valued.

ACTIVITY V: Consulting for Quality in Screening and Assessment

The purpose of this activity is to provide an opportunity for consultants to discuss their approaches to assisting child care programs develop appropriate screening and assessment procedures and policies.

Divide participants into small groups and have them discuss the consultation approach they might implement with one of the following programs to encourage more appropriate screening and assessment. It may be helpful to provide guiding questions for the discussion, such as:

- What might be the best way to approach the director?
- How would you start the conversation?
- What are some of the key points to discuss?

Programs for Discussion

- You are asked to consult with Sunshine Early Learning Center, which has no screening or ongoing assessment process in place.
- You are asked to consult with Rainbow Early Learning Center, which has just begun serving infants and toddlers. The program's director has reassigned some of her less credentialed infant/toddler caregivers from preschool to infant/toddler rooms. She describes how they have "adapted" their traditional preschool assessments for infants and toddlers by "using the same format" as for the preschoolers, but "expecting less, because they're babies." Their rationale for this adaptation was that the infant/toddler caregivers were familiar with the procedures, and she knows it's important to have assessment as part of their overall program.
- You are asked to consult with the Wee Village Early Learning Center, which has been serving infants and toddlers for over 20 years. They use an assessment tool developed by a former lead teacher. The teachers are very comfortable with the tool and they feel the families like it. The lead teacher who developed it put their tool together by selecting items from an array of other assessments.

THE ROLE OF THE CHILD CARE CONSULTANT

The child care consultant should:

- Observe to see if program is using screening and assessment to individualize curriculum for infants and toddlers.
- Review professional development plans and link the program with the professional development activities that will strengthen skills in conducting ongoing assessment.

Where to Find More Information

Chief Council of State School Officers (n.d.). *The words we use: A glossary of terms for early childhood education standards and assessments.* Retrieved February 3, 2008 from *http://www.ccsso.org/projects/scass/projects/early_childhood_education_assessment_consortium/publications_and_products/2838.cfm*

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Red Flags and Referrals

WHAT THE CHILD CARE CONSULTANT SHOULD KNOW

Most infants and toddlers in child care settings meet developmental milestones within the typical range. But for a small percentage of children some factors in both nature (genetics, biology) and nurture (environment, interactions) can result in delays in typical development.

In some instances—for example, genetic conditions such as Down syndrome or perinatal events leading to cerebral palsy—developmental delays may be identified at the time of birth and are known at the time of the child's enrollment in the child care program. In other young children a developmental delay may not be suspected until the range for the emergence of a major milestone has passed and the skill has not developed.

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Consultants should be aware that child care is often the setting in which such observations are first made. Several factors contribute to this. First, programs carrying out developmental screenings are proactively attending to each child's development, the primary purpose of screening being to identify any potential concerns. Second, the training and education of infant/toddler caregivers in infant/toddler development provides a lens through which variations in development may be more noticeable than to parents without similar training. Finally, the infant/toddler caregiver's experience over the years with many children in a particular age range may make her very familiar with developmental markers that can highlight a potential developmental concern.

What Is a Red Flag?

Red flag is an informal term that, in this context, simply implies that some aspect of the child's development has been noticed as at risk for falling outside the range deemed typical. A red flag may be discovered during a standardized developmental screening or through the ongoing, daily interactions between the infant/toddler caregiver and child. In essence, a red flag is a signal to pay increased attention to the aspect of concern in a child's development, and to be even more intentional in documenting observations and providing opportunities for the child to acquire the skill.

Red flags may occur in any aspect of the child's development or learning. In addition to indicators that are addressed in developmental screenings, infant/toddler caregivers may observe red flags in a child's health by using a daily health check (see Standard 3.001 in *Caring for Our Children,* *http://nrckids.org/CFOC/PDFVersion/Chapter%203.pdf*, for a sample health check), or in a child's mental health by attention to infant mental health indicators (see Where to Find More

Information for this section). Most important in identifying red flags for health or mental health is for the infant/toddler caregiver to observe for the regular presence of signs or behaviors that interfere with the child's development or learning. Rare or occasional variations in child health and behavior fall within the normal course of development.

Regardless of the area of development, a red flag indicates the need for closer observation and documentation of the child's development. If the concern continues typically the child is referred.

Atypical Development: When Does a Red Flag Become a Concern?

The range for the achievement of most developmental milestones is wide. Therefore, it is not always easy to determine if a child is developing within normal limits or if there is a potential delay. Because of this, ongoing observation of the child's development and effective communication with parents is critically important. If observation, screening, or assessment indicates a potential developmental concern, the role of the infant/toddler caregiver is to maintain open communications with parents to exchange and compare information from home and program observations. If a question or concern exists, and if the parent is in agreement, the infant/toddler caregiver in collaboration with the parent should follow his or her organization's procedures for referral for further evaluation.

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Child care consultants may be called upon to assist programs in multiple ways when questions of atypical development arise. Consultants can help programs understand that it is not the role of the consultant or program to determine the presence or absence of a developmental delay, but rather to refer the child to the appropriate systems if such a concern is suspected. Consultants can also provide support if the program is seeking help on how to share and discuss emerging concerns with parents.

Communicating With Parents About Developmental Concerns

The screening process and the rationale for conducting screenings should be communicated to parents during their orientation and should become part of an ongoing discussion throughout the child's enrollment in the program.

Often parents are not prepared to handle results from a screening that may indicate a potential developmental concern. Communicating with families about developmental concerns may be less emotionally stressful if families are knowledgeable of the process before screening takes place. An ongoing, effective communication process already in place between caregivers and families can help support the discussion about screening results. Caregivers who sincerely seek out parent input and participation build a trusting relationship with families. This trusting relationship allows for questions or concerns related to the child's development to be present in ongoing communication, with both parent and infant/toddler caregiver sharing observations to further discuss or resolve any questions about the child's development.

In situations where such substantive communication and relationships are not yet in place, or where parents are less involved in screening and assessment, it may be more challenging for infant/toddler caregivers to communicate with parents regarding concerns about a child's development. Child care consultants may need to assist or coach program staff in how to invite parents into a discussion of the child's development. The following tips may facilitate this process:

- Encourage programs and caregivers to invite parents into conversation about development on a regular basis. Conversation starters include comments such as:
    - "Today I saw her _____. What are you seeing at home?"
    - "I'm noticing that she's trying to _____ (e.g., pull herself to stand). Have you noticed her trying this at home?"
    - "You must spend lots of time reading to him at home. I've noticed that he really likes books. What else does he really like to do?"
- Encourage programs and caregivers to invite parents to do activities at home that are designed to promote development. The following example points out an area needing development, without identifying it as a problem, and can involve parents in sharing in the process of promoting development.
    - "I've noticed that she's not really holding her head very steady. Today we rolled up a hand towel and put it under her chest while she was on her tummy. It really helped her feel stable and she had fun watching the other children in that position. She didn't even realize she was holding up her head! If you want to try that at home — for just a couple of minutes a time — it might help strengthen those muscles."
- Encourage programs to avoid having their first conversation with parents

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about development focus on concerns or possible problems. Such information may be perceived as negative rather than helpful and is more likely to be accepted if offered in the context of ongoing conversations about development.

- Point out that, while infant/toddler caregivers may have both experience and training in infant/toddler development, parents may lack that valuable context. Therefore, what may appear an obvious concern to a provider may go unnoticed by a parent. Parents' assertions that they have not noticed the same concern is likely based on a different context and is representative of their truth rather than a denial of the caregiver's concerns.

- Validate that hearing the "news" that their child's development may not be completely on track may be difficult for families. Rather than forcing a conversation parents are not ready to hear, the infant/toddler caregiver can spend time gently encouraging parents to participate in developmental observation or screening.

- Remind programs and staff that educating parents about developmental expectations — either through sharing developmental milestones or Early Learning Guidelines — may offer a firmer context for parents to make more discerning observations of their own or simply to better hear what the infant/toddler caregiver is communicating.

- Remind programs and staff that "being right" about their concerns (with

the parallel implication that the parent is "wrong") is less helpful to the child's development than developing a positive relationship with the parent. Sometimes it takes hearing a concern from multiple people over time to make it acceptable. The first person to bring it up is very important but may not be the person who finally succeeds in getting increased evaluation or services. This relationship will provide a more supportive context for further conversations about concerns, if they are warranted. The mode of transmitting the message also may impact the number of times it is given, as well as the form of the message. Caregivers may want to consider the nature of the parent's learning approach and tailor the concern to the learning style of the parent — auditory, visual, or kinesthetic.

- Remind programs and caregivers that in a relationship-based approach, respect is the foundation of all communication with families. Attending to the parents' ability to receive the information being communicated and maintaining a focus on mutual concern about the child's overall well-being will lay the foundation to move forward.

Above all, remind programs and caregivers that participation in further evaluation and assessment is entirely voluntary for families. Parents are not required to participate in Early Intervention, accept that there may be a developmental concern, or agree with anything the infant/toddler caregiver communicates. If the infant/toddler caregiver truly has concerns about the child's development, the most effective means of supporting that development is through a relationship-based approach with the family focused on the child's well-being.

BOX 11

Involving The Child's Medical Home

- Discuss with families and child care health consultants on how best to involve the medical home.
- A thorough medical evaluation may be performed to explore the reason for the delay.
- The child's physician may have important information, such as whether there is already a referral in the works, or if this child was a preemie and not delayed when development is corrected for prematurity.
- This is an opportunity for the child care health consultant to help a family find a medical home if they do not have one.

Source: AAP (June 2009) Personal Communication

ACTIVITY VI:

Supporting Infant/Toddler Caregiver Communication With Parents—What Would You Do?

Present the following scenario, then facilitate a discussion with the group about the role of the child care consultant. It may be helpful to use a flip chart to help the group define some of the issues indicated in the scenario. It will be important to highlight and draw distinctions between:

- Talking *with* parents vs. talking *to* parents.
- Judgment/understanding the parent's perspective.
- Concern about the child's development.

Note: The specifics of the child's development are not at issue in this scenario. The discussion should stay focused on the interactions between consultant and caregiver or caregiver and parent.

After the discussion, you can extend the activity if time allows by asking volunteers to role play a conversation between consultant and caregiver, in which the consultant coaches the caregiver in effective communication with parents when there are developmental concerns.

As a child care consultant, you are waiting to meet with the director at a center when you overhear the following exchange between two staff:

"You know… I've tried to talk to his mother several times about his development. He really should be rolling over by now, but…he just lays there and hardly even tries to move. Every time I start down that path with his mom, she just says, 'Oh, he's fine. His older brother was a late walker. There's nothing wrong with him at all.' But…I'm really worried about him. I've asked her to ask her doctor about his lack of movement but I don't think she has."

"Yeah, I know what you mean. I always have a hard time getting parents to listen when there is a problem."

The director approaches you, having also heard this exchange. You are invited to assist.

Questions to consider:

- Where do you begin?
- What do you need to know?
- What questions would you ask the concerned caregiver?
- How can you support this issue?

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Referral

As a system designed to assess the child's development across domains, Part C/Early Intervention serves as an effective referral point when a delay in development is suspected. Although less universal, many states have additional systems in place, such as a mental health or health consultation networks, which may offer further support in the critical domains of social/emotional development and health. To support infant/toddler child care settings, consultants should become familiar with the referral procedures for all consultant networks in their state. Because Part C/Early Intervention is the only system currently available in all states and is intended to support the development of infants and toddlers with disabilities or developmental delays, this section will focus on referrals to that system.

State Part C/Early Intervention Systems

Part C of IDEA (the Individuals with Disabilities Education Act) is the federal law supporting early intervention systems for infants and toddlers with disabilities in states that voluntarily participate. State participation in Part C brings the guidance of federal regulations to the state system and allows the provision of federal funds for partial support of the program. Each state develops a state plan that defines the specific parameters for the state within federal guidelines.

As a first step after referral, Part C/Early Intervention systems are designed to determine eligibility, either through documentation of an established condition such as a genetic or medical diagnosis or through evaluation. If a delay is

suspected but an established condition has not been identified, a multidisciplinary evaluation (MDE) is completed to confirm eligibility. The MDE may be followed by an assessment intended to support planning for the Individualized Family Support Plan (IFSP, the birth to 3 equivalent to an Individualized Education Plan for preschool and school-aged children eligible for Special Education services), which will guide Early Intervention services for the eligible child and family.

Child care consultants and infant/toddler caregivers should know these key facts about Part C/Early Intervention:

- A primary provision of Part C is that early intervention services are to be delivered in the child's "natural environment." Natural environments are defined as including community settings in which children without disabilities participate [20 U.S.C. 1400 Sec. 632 (4)(g)]. A child care setting is a natural environment for the delivery of Part C services as defined in the law.

- The promotion of natural environments is related to a goal of the program: that participation in Early Intervention enhance the capacity of caregivers to support the child's development. The implication is that caregivers will learn to embed intervention strategies in a child's daily routines, with the support of the Early Intervention team. For example, most intervention visits by the Early Intervention specialist or therapist should take place within the context and routines of the care room, rather than having the child pulled out of the regular context for therapies.

- With these provisions, infant/toddler caregivers can serve as important members of a child's Early Intervention team. If infant/toddler caregivers are not included in planning and implementation of intervention strategies, child care consultants can work with the program to understand Part C

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regulations and the importance of their role. Further, consultants can encourage programs to communicate their interest and willingness to function as a part of the IFSP team.

- Part C/Early Intervention programs are required to facilitate a child's transition from the Part C to Part B/Early Childhood Special Education services where appropriate, or to other services that will continue to support the child's development when he ages out of Early Intervention.

The National Early Childhood Technical Assistance Center (NECTAC) provides support to state and local Early Intervention systems and may serve as a helpful resource to child care consultants. The Part C portion of the NECTAC Web site can be accessed at http://www.nectac.org/partc/partc.asp.

Knowing When and How to Refer

A critical provision of Part C/Early Intervention is that each state determines the eligibility criteria for Early Intervention services through its state system. Child care consultants will need to become familiar with the eligibility criteria for the state they serve. There is wide variability in eligibility definitions, with some states serving children who are "at risk" for developmental delays (due to environmental or other known risk factors), and others having significantly more restrictive criteria.

It is also important for consultants to know how to access the point of entry into the state Part C/Early Intervention system, as these also vary from state to state. This information can be accessed through links to each state system on the NECTAC Web site at *http://www.nectac.org/contact/ptccoord.asp*. These links should lead to information on how to refer, as well as to the state's eligibility criteria.

The question of when to refer a child to Part C is somewhat dependent on the state's eligibility criteria. In states with broad eligibility (such as those serving children "at risk"), it may be appropriate to refer an infant or toddler with only a slight indication of a developmental concern. States with narrow eligibility criteria (e.g., "a 50% delay in development in any one domain") may not accept a referral for a child who clearly will not be eligible.

However, it is not the role of the child care program to determine the presence or absence of a delay. Therefore, if concerns are present and there is any question about whether or not a child might be eligible, a referral should be discussed with parents and made to the Part C/Early Intervention system with parent approval. In the process of screening and ongoing assessment of the infants and toddlers in their care, a child care program should maintain documentation of each child's

development, including any concerns that are noticed. With parents' permission, these can be shared with the Part C point of referral to help determine eligibility.

It is this step in the process where child care consultants may be asked to assist, either to verify concerns and support the process of deciding to make a referral, or to support a caregiver's communication with the family. Depending on the child care consultant's background and expertise, the program may prefer to have an additional layer of reflection and verification of concerns to support the process.

The child care consultant should be aware of and may be called upon to support infant/toddler caregiver understanding that participation in Part C/Early Intervention is voluntary for families. If parents are not interested in a referral for further evaluation, they have the right and authority to decline.

Multidisciplinary Evaluations

Once a referral has been accepted by the Part C/Early Intervention system, the regulations allow 45 days for completion of a multidisciplinary evaluation to determine eligibility, and the development of an Individualized Family Service Plan (IFSP) for eligible children. Evaluations for eligibility typically involve formal assessments and include information from multiple sources to help make the determination.

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ACTIVITY VII:

Connecting With Systems Supporting Infant/Toddler Development

The purpose of this activity is to help consultants provide information and resources to child care programs and caregivers about state systems that support infant/toddler development.

Using the links provided for Part C/Early Intervention information and other systems in the preceding text, complete the following for your state:

	Part C/ Early Intervention	Mental Health	Health	Others
Name of coordinator or area contact				
Lead agency				
Contact number for making a referral				
Location of closest point of entry to the system				
Eligibility criteria for services				
Other relevant information helpful to child care provider				

THE ROLE OF THE CHILD CARE CONSULTANT

The child care consultant should:

- Review program policies and/or documentation of screening to determine appropriateness of approach, including the inclusion of parent participation in the process.
- Know the point of entry for the State's Part C/Early Intervention system.
- Know the eligibility criteria for the State's Part C/Early Intervention system.
- Review policies related to the program's practice for referral if concerns emerge in a child's development.
- Review any existing practices related to the delivery of Part C/Early Intervention services within the program, and ensure that interventions are supported within the natural routines of the room.
- Support the program in ensuring effective communication between specialists, directors, infant/toddler caregivers, and family members.
- Know local contact information for Health Consultation.
- Be aware of additional existing supports, such as Mental Health Consultation.
- Be aware of state systems that integrate health, mental health, family support, prevention, and Early Intervention services.

Where to Find More Information

American Academy of Pediatrics, American Public Health Association, & National Resource Center for Health and Safety in Child Care and Early Education. (2002). *Caring for our children: National health and safety performance standards: Guidelines for out-of-home child care programs (2nd ed.).* Elk Grove Village, IL, & Washington, DC: American Academy of Pediatrics and American Public Health Association. Available from http://nrckids.org

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Web Sites

Center on the Social and Emotional Foundations of Early Learning (CSEFEL), http://www.vanderbilt.edu/csefel

Commonwealth Fund, www.abcdresources.org
Includes several demonstration models of Child Care Health Consultants helping caregiver communities begin developmental screening. This program is funded to improve child health and development.

National Early Childhood Technical Assistance Center (NECTAC), http://www.nectac.org/partc/partc.asp

National Dissemination Center for Children with Disabilities (NICHCY), http://www.nichcy.org/

Talaris, www.talaris.org
Includes an interactive developmental timeline.

Healthykids, www.healthykids.us
Includes content about health and safety in out-of-home care in a form that helps parents and caregivers improve the setting the child is in.

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APPENDICES

APPENDIX A:

Developmental Milestones of Children From Birth to Age 3

Note: This list is not intended to be exhaustive. Many of the behaviors indicated here will happen earlier or later for individual infants. The chart suggests an approximate time when a behavior might appear, but it should not be rigidly interpreted.

For the most part, behaviors appear in this chart in the order in which they emerge in children. Particularly for younger infants, the behaviors listed in one domain overlap considerably with several other developmental domains. Some behaviors are placed under more than one category to emphasize this interrelationship.

	Birth to 8 Months	From 8 Months to 18 Months	From 18 Months to 3 Years
I Learn Who I Am	**I learn about my body.** • I discover that my hands and feet are part of me. • I can move them. **I learn to trust your love.** • I feel secure when you hold me in your arms. • I feel good when you smile at me. **I learn to comfort myself.** • I may suck my fingers or hands—it soothes me. **I can make things happen.** • I can kick a mobile and make it move. • I can smile at you and you will smile back at me.	**How I feel about myself depends on how you care for me and play with me.** • I feel competent when you invite me to help you. • I feel confident in my abilities when you let me try new things. **I am showing you that my sense of self is growing stronger when I am assertive.** • I sometimes insist on things going my way. • When I say "No!" it often means I am an individual. **I am learning language about me.** • I can point to and tell you the names of one or more parts of my body. • I begin to use "me," "I," and "mine."	**Sometimes I feel powerful. But independence can be scary. I count on you to set clear and consistent limits that keep me safe.** • When I test limits, I am learning who I am and how I should behave. **I feel good about myself and where I come from when my culture is reflected in my child care setting.** • I feel I belong when you speak to me in my home language. • I feel proud when I see pictures of my family and other people like me hanging on the wall. **I sense how you feel about me. Your feelings help shape how I feel about me.** • When you respect me, I respect myself. • I tune in carefully to your tone and words when you talk about me. **Sometimes I want to be big. Sometimes I want to be a baby again. And sometimes I want to be both—at the same time. This is one of the reasons my behavior is sometimes hard for you to understand. I don't understand it myself.** • Sometimes I will walk. Other times I want a ride in the stroller. • Sometimes I push you away. Other times I want you to hold me close. It's O.K.—I still love you. **I am learning more self-control.** • I understand more often what you expect of me. • Sometimes I can stop myself from doing things I shouldn't. Sometimes I can't.

	Birth to 8 Months	From 8 Months to 18 Months	From 18 Months to 3 Years
I Learn About Feelings	**I can show you many feelings—pleasure, anger, fear, sadness, excitement, and joy.** • I smile and wiggle to show you I like playing with you. • I frown or cry when you stop paying attention or playing with me. **Sometimes I need you to help me with my feelings.** • I need you to try to understand how I feel. • I need you to protect me when I feel overwhelmed or scared. **I share my deepest feelings. I know and trust you.** • My smile is brightest for you. • I can protest strongly when I am upset. I know you will be there for me no matter what.	**My feelings can be very strong.** • I laugh and may shriek with joy when I am happy and we are having fun. • I may sometimes hit, push, or bite because I'm angry or frustrated. **I care deeply about you.** • I may smile, hug you, run into your arms, or lean against you to show my affection. • I may try to follow you or cling when you get ready to leave. • I know now when you're gone, and it frightens me. **Knowing when you will return makes me feel better and helps me learn about time.** • I am slowly learning that when those I love leave, they will return. A consistent daily schedule helps me know when things will happen.	**My feelings can be very strong.** • I feel proud of things I make and do. • I may be afraid of the dark, monsters, and people in masks or costumes. **I am learning to control my feelings.** • I am learning to use words to control my feelings. • I sometimes practice how to express my feelings when I play. **I know you have feelings too.** • I learn how to care for others by the way you care for me. • I sense when you are happy and truly there for me. It makes me feel good.
I Learn to Move and Do	**At first, my body moves automatically.** • I search for something to suck. • I turn my head when something blocks my breathing. **Within a few months, I begin to learn to use my fingers and hands.** • I put my hand and objects in my mouth. • I cam move an object from one hand to another. **Over time, I move my body with a purpose.** • I can hold my head up. • I can roll over. • I can crawl by myself. • I may even be able to stand up if I hold on to you.	**I am learning to do new things with my fingers and hands**. • I can make marks on paper with crayons and markers. • I can use a spoon and drink from a cup. **I am learning to move in new ways.** • I can sit in a chair. • I can pull myself up and stand by holding onto furniture. • I learn to walk, first with help and then alone. Sometimes I still like to crawl.	**I can do many new things with my fingers and hands.** • I scribble with a crayon or maker and may be able to draw shapes, like circles. • I can thread beads with large holes. • I am learning to use scissors. **I move in new ways.** • I kick and throw a ball. I may be able to walk upstairs putting one foot on each step. **I can handle many everyday routines by myself.** • I can dress myself in simple clothes. • I can pour milk on my cereal.

	Birth to 8 Months	From 8 Months to 18 Months	From 18 Months to 3 Years
I Learn About People, Objects, and How Things Work	**I can tell the difference between people I know and people I do not know.** • I recognize my parents' voices. • I relax more when I am with you and other people I know. **I sometimes am afraid of strangers.** • I sometimes cry if a stranger gets too close to me or looks at me directly in the eyes. **I like to be with you.** • I like to be held by you. • I like you to talk softly and smile at me. I smile and "talk" back to you. You are the most important person in my life. **I learn about how the world works.** • I like to look around and see new things. • I like to play games with you, like peek-a-boo and hide-and-seek.	**I am learning about choice and choices.** • I have favorite toys and favorite foods. • I like to choose what to wear. **I like to see and be with other children my age or a little older.** • I have fun making silly faces and noises with other children. • I do not know yet how to share but I learn though supervised play with others. **I want to be like you.** • I learn how to relate to other people by watching how you act with me, our family, and our friends. • I feel proud and confident when you let me help you with your "real work," like scrubbing the carrots. **I learn about how the world works.** • I am very interested in how the world works. • If my music box winds down, I may try to find a way to start it again.	**I am more aware of other children.** • I am aware when other children are my age and sex. • I am aware of skin color and may begin to be aware of physical differences. **I like to play together with other children.** • I may pretend we are going to work or cooking dinner. • I build block towers with them. **I am beginning to be aware of other children's rights.** • I learn I don't always get my way. • Sometimes I can control myself when things don't go my way. • Sometimes I can't. **I am becoming aware of how you respond to my actions.** • I know when you are pleased about what I do. • I know when you are upset with me. **I learn about how the world works.** • I may be able to put toys in groups, such as putting all of the toys with wheels together. • I can find a familiar toy in a bag, even when I can't see it.

	Birth to 8 Months	From 8 Months to 18 Months	From 18 Months to 3 Years
I Learn to Communicate and Relate	**I can tell you things—even as a newborn.** • I cry to tell you I need you. • I communicate through the expressions on my face and gestures. **Within a few months, I develop new ways to communicate.** • I learn to make many different sounds. I laugh. • I use my sounds, change the expression on my face, and move around to get your attention. **I learn to babble.** • I make some of the sounds that I hear you use. • Sometimes I try to imitate you. • I like you to imitate my sounds too. **I like to "talk" with you—even though I don't yet speak words.** • I may catch your eye and smile to tell you I am ready to communicate with you. • I stretch my arms towards you when I want you to pick me up.	**I communicate through my expressions and actions.** • I point to let you know what I want. • I may hit, kick, or bite when • I get too frustrated or angry. I need you to help me learn how to express these feelings in acceptable ways. **I communicate using sounds and words.** • I create long babble sentences. • I may be able to say 2 to 10 or more words clearly. **I understand more than you may think—much more than the words I can say.** • I listen to you and watch you because I understand more than just words. • I learn to look at a ball when you say "ball" in my home language.	**I have many things to tell you.** • I may know up to 200 words in my home language and sometimes in a second language. • I can tell you things that happened yesterday and about things that will happen tomorrow. **I like you to read and tell me stories.** • I especially enjoy stories that are about something I know. • Sometimes I may listen for a long time. Other times I may listen for just a little while. • Sometimes I like to "read" or tell you a story too. **I play with words.** • I like songs, fingerplays, and games with nonsense words. • Sometimes I can use an object as if it were something else. For example, I might use a block for a phone.

Note: Adapted from Caring for Infants and Toddlers in Groups: Developmentally Appropriate Practice. Zero to Three, pp. 78–79.
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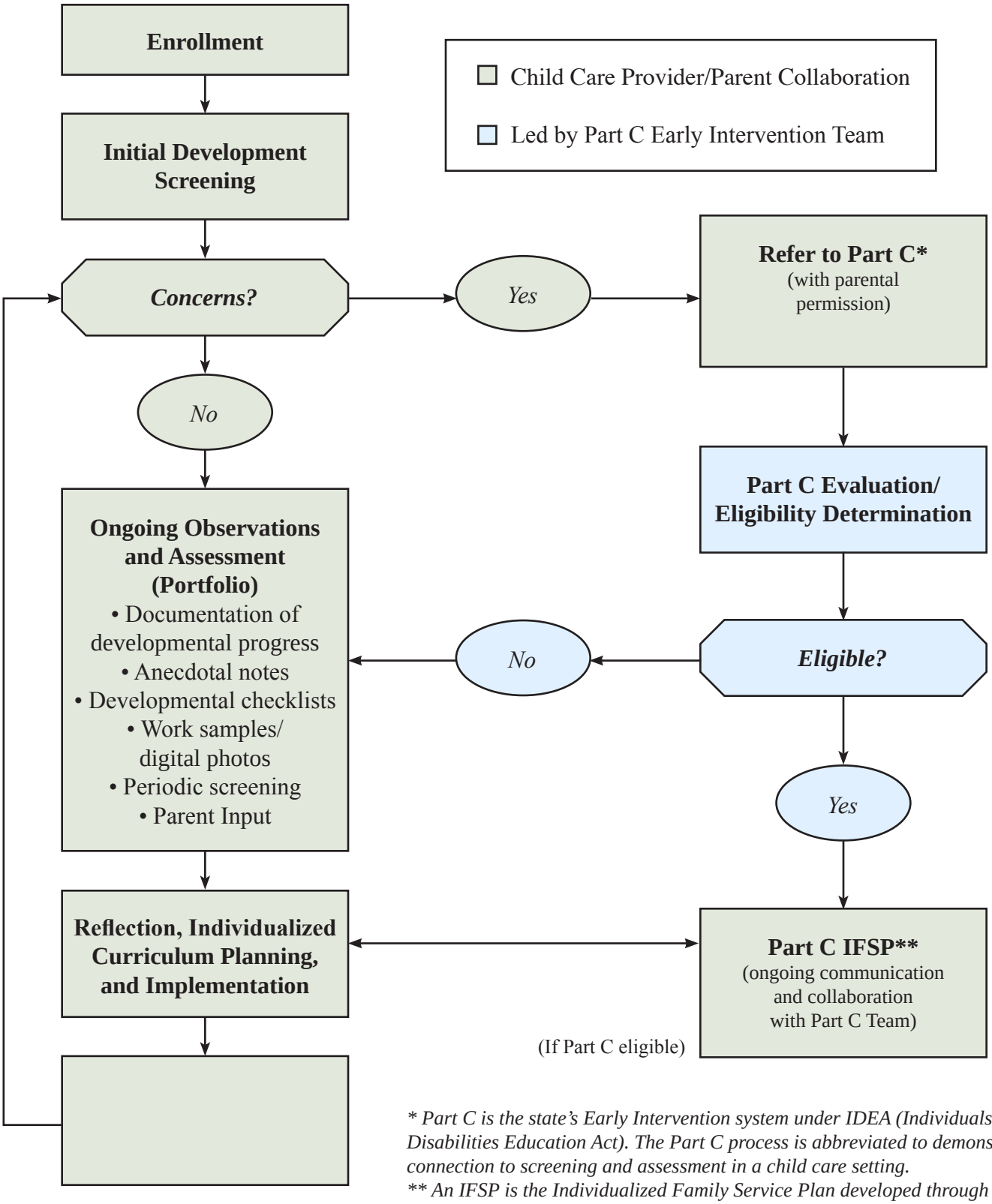
APPENDIX B:

Infant/Toddler Early Care and Education and the Part C Screening/Assessment Cycle



** Part C is the state's Early Intervention system under IDEA (Individuals with Disabilities Education Act). The Part C process is abbreviated to demonstrate connection to screening and assessment in a child care setting.*
*** An IFSP is the Individualized Family Service Plan developed through Part C to address Early Intervention priorities, desired outcomes, and services.*

Screening and Assessment Test Reviews

- Ages & Stages Questionnaire
- Denver Developmental Screening II
- Battelle Developmental Inventory Screening Test
- Birth to Three Assessment & Intervention System
- Minnesota Child Development Inventory
- Minnesota Infant Development Inventory

Each review includes a description of the instrument; information on standardization, reliability, and validity; and the potential use of the instrument. Each review is a summary of a published evaluation of the tool and references follow each review.

Ages & Stages Questionnaire (ASQ)

Age range: 4 months to 60 months
Purpose: Parent-completed child monitoring system
Publication Dates: Original Publication Date 1979, Revised 1991, 1994, 1999
Publisher: Paul Brookes Publishing Co.
P. O. Box 10624
Baltimore, MD 21285-0624

Description: The ASQ was designed to screen for developmental delays by evaluating an infant's development over time. The system consists of 11 questionnaires to be completed by the parent at 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 33, 36, 42, 48, 54, and 60 months of age. Each questionnaire contains 30 items and examines development in the following five domains: communication, gross motor, fine motor, problem solving, and personal and social development. There are three choices parents can choose from in answering questions ("yes," "sometimes," "not yet"). Each questionnaire also provides a section where parents can identify general concerns that may not be captured by questionnaire items. All items are written at a sixth grade reading level, and a Spanish version is available. There is also a video tape available that provides guidance on how the system may be used in a home visiting context. Estimated administration time is 10–30 minutes. An Administration Manual provides information on using the system and scoring the questionnaires, and guidance is offered on how one might evaluate the useful of the system in their given program.

Standardization: The sample reported in the Administration Manual is comprised of 2,008 children from the states of Oregon, Hawaii, and Ohio. The sample includes children from a variety of ethnic (Caucasian, African American, Hispanic, Native American) and socioeconomic backgrounds. However, parents from Asian backgrounds appear underrepresented. Among the standardization group, data has been gathered on typically developing infants, as well as infants at risk for developmental delay due to medical and/or environmental risk factors. In fact, from 1980 to 1988 the research sample evaluated largely consisted of infants who were deemed medically at risk.

Reliability/Validity: Both test-retest reliability and interrater reliability data on use of ASQ have been found to be fairly acceptable. Interrater reliability, in this case, refers to the percent of agreement between the parent's rating and those of a professional. Validity studies have also yielded fairly positive findings. The underreferral rate (those with a delay but not picked up by the ASQ) across the 11 age intervals ranged from 1% to 13% while

the overreferral rate (those identified by ASQ as having a delay where in fact no delay was found upon subsequent assessment) ranged from 7% to 16%. Sensitivity ranged from 38% to 90% across the 11 age intervals and specificity ranged from 81% to 90% across the age intervals.

Utility: Very few reviews have been published on the utility of this instrument. Current data on the reliability and validity of the tool suggest that it offers promise as an infant/toddler screening tool. See listing of references below for additional research data on ASQ. Please note that prior to the 1994 revision the instrument was referred to in the research literature as the Infant Monitoring System.

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Squires, J., & Bricker, D. (1991). Impact of completing infant developmental questionnaires on at-risk mothers. *Journal of Early Intervention*, 15, 162–172.

Denver Developmental Screening – II

Age range: 2 weeks to 6 years
Purpose: A screening tool to detect developmental delays
Publication Dates: 1967–1990
Publisher: Denver Developmental Materials, Inc.
P.O. Box 371075
Denver, CO 80237-5075

Description: This instrument was designed to be a quick and simple screening tool to be used in clinical settings by people with little training in developmental assessment. The test is comprised of 125 items, divided into four categories: Gross Motor, Fine Motor/Adaptive, Personal/Social, and Language. The items are arranged in chronological order according to the ages at which most children pass them. The test is administered in 10–20 minutes and consists of asking the parent questions and having the child perform various tasks. The test kit contains a set of inexpensive materials in a soft zippered bag, a pad of test forms, and a reference manual. The manual includes instructions for calculating the child's age, administering and scoring each item, and interpreting the test results.

The test items are represented on the form by a bar that spans the age at which 25%, 50%, 75%, and 90% of the standardization sample passed that item. The child's age is drawn as a vertical line on the chart and the examiner administers the items bisected by the line. The child's performance is rated "Pass," "Caution," or "Delay" depending on where the age line is drawn across the bar. The number of Delays or Cautions determines the rating of Normal, Questionable, or Abnormal.

Standardization: The original standardization sample consisted of 1,036 children and approximated the occupational and ethnic distribution of Colorado. Children with known handicaps, twins, breech or premature birth, and adopted children were excluded. The re-standardization in 1990 included 2,096 children. The demographic characteristics of the sample approximate the distribution in Colorado, which compared to the population of the

United States is an overrepresentation of Hispanic infants, an underrepresentation of African American infants, and a disproportionate number of infants from Caucasian mothers with more than 12 years of education.

Reliability/Validity: This test has been criticized for a number of inadequacies. The fit between the test items and what the test is supposed to measure has been questioned. The most serious concern has been its lack of sensitivity in correctly identifying children with developmental delays, particularly children under 3 years of age. The standardization sample is not representative of the nation as a whole, but simply presents the age at which children in Colorado are able to do a variety of tasks.

Utility: This test is widely used due to its ease of administration and scoring. The weaknesses of this test are due to its psychometric problems and the tendency to miss children with developmental delays. Moreover, the use of this test on populations other than healthy, white, upper middle class children has been questioned due to the standardization process. The DDST is intended only for screening purposes, and should not be used as an in-depth assessment of developmental functioning or to plan intervention programs.

References:

Buros, O. (Ed.). (1995). *Mental Measurements Yearbook*, (l2th ed.), pp. 263–266. Lincoln, NE: Buros Institute of Mental Measurements.

Keyser, D., & Sweetland, R. (Eds.). (1985). *Test Critiques* (Vol. I, pp. 239–251). Austin, TX: PRO-ED.

Battelle Developmental Inventory Screening Test

Age range: Birth to 8 years
Purpose: General screening for developmental delays
Publication Dates: 1984
Publisher: DLM Teaching Resources
One DLM Park
Allen, TX 75002

Description: The Battelle Screening Test is a part of a larger test called the Battelle Developmental Inventory (BDI). The full-scale BDI is designed as a diagnostic assessment. The Screening Test is designed to identify children who are at risk for delay and in need of a more comprehensive evaluation with the full-scale BDI. The Screening Test consists of 96 items in the areas of motor, communication, personal-social, adaptive, and cognitive development. Three methods of assessment may be used: administering the items to the children, observing the child in a natural context, and parent report. The manual provides adaptations that can be made for children with handicapping conditions.

Standardization: The standardization for the Screening Test is based on the data collected for the larger BDI. Eight hundred children participated and were selected according to race, gender, and geographic region according to the U.S. Census Bureau. While the total percentage of minority children for the total sample was representative of the national percentage, the sub-sample at any particular age range may be quite small (e.g., only one minority male in the age range of 12–17 months). Also, the minority children included Hispanic and African American, but did not include Asian or Native American families. Children in poverty may also be underrepresented as the authors did not attempt to control for socioeconomic status. There is no mention whether children with handicaps were included in the sample.

Reliability/Validity: Only information on the parent BDI was available. One reviewer raised considerable questions concerning the cut-off scores. In many cases (46% of the age levels), the range of raw scores separating a moderate delay (-1 standard deviation) from a severe delay (-2.33 standard deviations) was 0,1, or 2 points. For another example, a child who receives a nearly perfect score (39 passes out of 40 items) on the Motor Domain, receives a rating of moderate delay at -1 standard deviation below average. Furthermore, children whose birthdays are at the borderline of the age intervals can have identical test performance but significantly different scores.

Additional concerns with this test include the fact that the examiner must collect their own test materials, and the test can be administered differently for each child. Therefore, the normative comparisons are flawed. An examiner cannot compare the performance of a handicapped child to the norms if the administration has been altered.

Utility: Given the psychometric inadequacies of this test, the reviewers recommend that the BDI Screening Test be used only as an additional aide in assessing a child's developmental skills, and not as tool to make a decision regarding a child's placement or referral. The error rates when using the cut-off scores is extremely high. They recommend that the cut-off scores not be used in making referral decisions, and that this test should not be used with infants under 6 months of age.

References:

Buros, O. (Ed.). (1990). *Mental Measurements Yearbook* (10th ed., pp. 23–31). Lincoln, NE: Buros Institute of Mental Measurements.

Keyser, D., & Sweetland, R. (Eds.). (1985). *Test Critiques* (Vol. 2, pp. 72–82). Austin, TX: PRO-ED.

Birth to Three Assessment and Intervention System

Age range: Birth to 3 years
Purpose: To identify and assess developmental delays in young children and to design early intervention programs
Publication Dates: 1986
Publisher: DLM Teaching Resources
One DLM Park
Allen, TX 75002

Description: This is an expanded and updated version of the Birth to Three Developmental Scale. The kit consists of three spiral bound notebooks: 1) the manual for the Birth to Three Screening Test of Learning and Language Development; 2) the Birth to Three Checklist of Learning and Language Behavior; and 3) the Intervention Manual: A Parent-Teacher Interaction Program.

The Screening Test consists of a 4-page record form. The 85 test items are divided into five areas: Language Comprehension, Language Expression, Avenues to Learning (cognitive and perceptual-motor items), Social-Personal Development, and Motor Development.

The Checklist consists of an 11-page record form. The 240 test items are divided equally between these same five areas, with 48 items in each domain. Each 6-month age range has six items per developmental area.

The items for the Screening Test and Checklist were selected from existing infant assessment scales. The test materials are not provided, but a list of needed items is presented in the manuals. The manuals also describe the administration procedures and criteria for scoring the performance as "Pass," "Emerging," or "Fail."

The Intervention Manual provides an introduction and basic overview for designing an intervention program. The focus is on developing a curriculum for cognitive and language skill development with little attention to social-emotional development or engaging parents. The reviewer (see reference below) found the manual to be too superficial to use as a curriculum package or for developing an intervention program and warned that paraprofessionals should not be mislead into thinking that assessment and intervention is as simple and straightforward as the manual leads one to believe.

Standardization: Consisted of 357 children, ages 4 to 36 months, from the states of California, Tennessee, and Utah. The group was balanced for gender, and rural versus urban environment, and the manual states that an attempt was made to include children from varying ethnic and socioeconomic status but does not give any data on who was actually included. The normative tables were developed with data from the earlier standardization sample rather than the current one, but no reason is given. Furthermore, the instructions for using the norm tables are confusing and did not make sense to the reviewer.

Reliability/Validity: For the Screening Test, the manual does not provide enough information regarding reliability and validity to adequately address these issues. The reviewer mentioned the lack of standardized test materials as a limit to the ability to compare test results between individual children. No data was provided on validity studies. Similarly, the manual for the Checklist does not provide information on how the checklist was constructed or any reliability or validity data. There is no discussion of how to interpret scores.

Utility: This instrument is described as a 3-part set for screening, program planning, and monitoring progress of at-risk or delayed children. The reviewer raised concern regarding the inadequate information regarding standardization, reliability, and validity. Thus the Screening Test was not recommended as a norm-referenced test. The Checklist could have some use as a way to monitor a child's progress in a program, but extreme caution should be taken not to interpret the child's performance in a normative way (i.e., as delayed or not) until further validity studies have been done. The Intervention Manual is useful as a brief introduction or overview of the issues involved in designing an early intervention program, but many Where to Find More Information are needed to adequately address the complex needs of an early intervention program.

References:

Buros, O. (Ed.). (1992). *Mental Measurements Yearbook* (11th ed., pp.110–112). Lincoln, NE: Buros Institute of Mental Measurements.

Minnesota Child Development Inventory

Age range: 1–6 years
Purpose: Screening tool to determine developmental status
Publication Dates: 1968-1974
Publisher: Behavior Science Systems, Inc.
P.O. Box 1108
Minneapolis, MN 55440

Description: This scale is a 320-item parent-completed questionnaire. There are eight domains: general development, gross motor, fine motor, expressive language, comprehension-conceptual, situation comprehension, self help, and personal-social. There are separate forms according to age and gender. Caregivers are instructed to read each statement and check "yes" or "no" if it applies to their child. Respondents must have an eighth grade reading level to complete the questionnaire. It takes approximately 30–50 minutes to complete. This is test is designed to supplement a parent interview when questions of developmental delay have been raised.

Standardization: Items were selected on the basis of how representative it was of developmental skills, how easily observed by mothers in real life situations, descriptive clarity, and age-discriminating power. The standardization sample consisted of 796 children from Bloomington, Minnesota. The ages ranged from 6 months to 6 years. The number of boys and girls were equivalent. The authors state that "the normative group should not be considered representative of white, preschool children in general" and "the norms should not be used for children from families of lower socioeconomic status or other ethnic backgrounds."

Reliability/Validity: Limited information exists concerning reliability and validity. This test correlates well with other established measures of children's abilities (e.g., Bayley, McCarthy, Cattell). The biggest concern was with the interpretation of the scores "percent below age level."

Utility: One reviewer notes "The demographics suggest, and the authors concur, that this instrument is suited for use with white, middle-class, non-handicapped children from intact families of successfully employed fathers and unemployed mothers." This instrument is meant to supplement a parental interview and should not be the only source of information about a child.

References:

Buros, O. (Ed.). (1985). *Mental Measurements Yearbook* (9th ed., pp. 991–992). Lincoln, NE: Buros Institute of Mental Measurements.

Minnesota Infant Development Inventory

Age range: 1–15 months
Purpose: Mother's observations of her infant's development
Publication Dates: 1977–1980
Publisher: Behavior Science Systems, Inc.
P.O. Box 1108
Minneapolis, MN 55440

Description: This instrument evolved out of the authors' earlier work with the Minnesota Child Development Inventory (MCDI). Similar to the MCDI, the MIDI was designed to obtain a mother's observations of her baby's developmental functioning. It measures five domains: gross motor, fine motor, language, comprehension, and personal-social. The booklet contains 75 questions; there is one item for each month of age in each of five areas. There is no manual, and no scores are derived. The examiner determines developmental delay if the child's performance falls below the behavior of infants 30% younger.

Standardization: The standardization for this instrument is based on the standardization of the parent MCDI. Since there were no infants younger than 6 months in the sample, the placement of items in the early months is unclear.

Reliability/Validity: No information is given for this age range for either the MCDI or the MIDI.
Utility: This scale is presented as a method for involving parents in examining the development of their infant. Reviewers note that no information is provided on the psychometric properties, the standardization is inadequate, and there is no guidance on the interpretation of delay.

References:

Buros, O. (Ed.). (1985). *Mental Measurements Yearbook* (9th ed., Vol. 2, pp. 995–996). Lincoln, NE: Buros Institute of Mental Measurements.

APPENDIX D:

National Early Childhood Technical Assistance Center Screening Instruments[1]

I. Multi-domain Screening Instruments That Can Be Completed By Families Or Other Care Givers

Name of Instrument	Description	Age Range	Scores	Time Frame	May Be Administered By
Ages and Stages Questionnaire (ASQ) - 2nd Ed	The Ages & Stages Questionnaire (ASQ) system is designed to be implemented in many settings & can easily be tailored to fit the needs of many families. Clear drawings & simple directions help parents indicate children's skills in language, personal-social, fine & gross motor, & problem solving. The ASQ involves separate copy-able forms of 30 items for each age range (tied to well-child visit schedule). The measure can be used in mass mail-outs for child-find programs as a first-level screening tool to determine which children need further evaluation to determine their eligibility for early intervention or preschool services. The questionnaire can also be used to monitor the development of children at risk for disabilities or delays. Published in English, Spanish, French & Korean, other translations are in development. A video is available that demonstrates completion of the questionnaire for two children. Their family is introduced & guided through questionnaire completion by a home visitor. Viewers discover how to explain the ASQ screening process, redefine items to reflect a family's values & culture, create opportunities for child learning & development, & promote positive parent-child interaction.	Birth to 60 months	A 2 SD below the mean cut-off score is used for questionnaires at 4, 8, 12, 16, 24, 30, & 36 months A 75 developmental quotient is the cut-off for questionnaires at 6, 10, 14, 18, 22, 27, & 33 months. Scores provide guidance on which children to refer for diagnostic testing, which to provide with skill-building activities & recommend to re-screen, & which children simply to provide activities for. *http://www.nectac.org/topics/earlyid/Screeningcall/AgesandStages/sld001.htm*	~ 15 - 20 minutes, less if parents complete independently (each questionnaire takes 10-20 minutes to complete, with 2-3 minutes to score)	Parents; home visitors; other providers; professionals score the questionnaires
Child Development Inventories (CDI)	Three separate instruments [the Infant Development Inventory (IDI), Early Child Development Inventory (ECDI), & the Preschool Development Inventory (PDI)] each with 60 yes-no descriptions. Items tap the better predictors of developmental status only. A 300-item assessment-level version may be useful in follow-up studies or sub-specialty clinics & produces age equivalent & cutoff scores in each domain.	33 - 72 months; IDI for 3-18 months; ECDI for 18-36 months; PDI for 36-60 months	The ECDI & the PDI produce a single cutoff tied to 1.5 standard deviations. The IDI provides cutoffs for each of five developmental domains & illustrates both significantly advanced & delayed development.	~ 10 minutes, less if parents complete independently	The CDIs can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation.

Name of Instrument	Description	Age Range	Scores	Time Frame	May Be Administered By
The Ounce Scale	The Ounce Scale is an observational, functional assessment that can be used effectively with children living in poverty, children at risk or with disabilities, and children growing and developing typically. The Ounce Scale is organized around eight age levels and six areas of development: Personal Connections-How children show trust; Feelings about Self-How children express who they are; Relationships with Other Children-How children act around other children; Understanding and Communicating-How children understand and communicate; Exploration and Problem Solving-How children explore and figure things out; and Movement and Coordination-How children move their bodies and use their hands.	Birth through 42 months—divided into 8 intervals	The Ounce Scale has a twofold purpose: (1) to provide guidelines and standards for observing and interpreting young children's growth and behavior, and (2) to provide information that parents and caregivers can use in everyday interactions with their children.		It was designed to be used in Early Head Start programs, child care centers, Even Start programs, home visiting programs, and family child care homes.
Parents' Evaluations of Developmental Status (PEDS)	This screening & surveillance tool provides decision support & both detects & addresses a wide range of developmental issues include behavioral & mental health problems. It promotes parent-provider collaboration & family-centered practice by relying on 10 carefully constructed questions eliciting parents' concerns. PEDS identifies, using substantial evidence, when to refer, screen further or refer for additional screening, counsel, reassure, temporize, or monitor development, behavior, & academic progress. In English, Spanish, & Vietnamese with additional translations in development.	Birth to 8 years	High, moderate, & low risk for developmental & behavioral/mental health problems. A longitudinal score & interpretation form organized by the AAP's well-visit schedule remains in the medical record. Identifies when to refer, provide a second screen, counsel, reassure, temporize, or monitor development, behavior, & academic progress.	~ 2 minutes, less if parents complete independently	Written at the 4th to 5th grade level, parents complete the measure while they wait for appointments.
Temperament and Atypical Behavior Scale (screener)	Screener consists of a 15-item, single-sheet form. Only children whose scores indicate a potential problem need to be assessed with the more extensive TABS Assessment Tool.	11 to 71 months	Identifies when more extensive assessment is needed.	5 minutes	Parents

II. Multi-domain Screening Instruments To Be Completed By Assessment Team Members

Name of Instrument	Description	Age Range	Scores	Time Frame	May Be Administered By
Brigance Screens	Nine separate forms, ~ one for each 12-month age range, the Brigance Screens tap speech-language, motor, readiness & general knowledge, & for the youngest age group, social-emotional skills. All Screens use direct elicitation & observation except the Infant & Toddler Screen, which can be administered by parent report. All Screens are available in English & Spanish.	Birth to ~ 90 month	Cutoff, age equivalents, percentiles, & quotients in motor, language, & readiness at all age levels except Infant & Toddler, which provides scores for nonverbal & communication. Cutoff scores should identify at least 75% of the children who need further evaluation and 82% of those who do not. Overall scores generated at all age levels. The screens also provide criterion-referenced and norm-references scores and growth indicator scores to measure a child's progress.	~ 10 minutes/ screen	Widely used in educational settings & often administered by paraprofessionals (a video is available to facilitate learning the test). I/T screen can be done by parent report.
Denver Developmental Screening Test II (DDST-II)	The purpose of the DDST-II is to screen children or possible developmental problems, to confirm suspected problems with an objective measure, to monitor children at risk for developmental problems. Performance-based and parent report items are used to screen children's development in four areas of functioning: fine motor-adaptive, gross motor, personal-social, and language skills. There is also a testing behavior observation filled out by the test administrator. Spanish version is available.	From 1 month to 6 years of age	Child's exact age is calculated and marked on the score sheet. Scorer administers selected items based on where the age line intersects each functional area. The scorer can then determine if child's responses fall into or outside of the normal expected range of success on that item for the child's age. The number of items upon which the child scores below the expected age range determines whether the child is classified as within normal range, suspect, or delayed. Those with suspect scores are monitored by more frequent screening, while those with delayed scores are referred for further assessment.	10 to 20 minutes, on average.	Trained paraprofessionals and professionals administer the test.

Name of Instrument	Description	Age Range	Scores	Time Frame	May Be Administered By
Infant-Toddler and Family Instrument (ITFI)	ITFI is allows family service providers to gather information and impressions about a child and family and their home environment that help providers decide whether further referrals and services are needed. The areas screened include gross and fine motor, social and emotional, language, coping, and self-help. Components include a Caregiver Interview (covering home and family life, child health and safety, and family issues and concerns), a Developmental Map, a post-visit Checklist for Evaluating Concern to alert providers to areas that are or may become problems and should be monitored, and a Plan for the Child and Family.	6–36 months	Extensively field tested.	Two 45- to 60-minute sessions to conduct the Caregiver Interview and the Developmental Map; one 45- to 6-minute session to share findings and develop a plan.	Family service providers. Can be used in home visiting or center-based programs by family service providers from different fields, with varying levels of education and experience.

[1] Sources utilized include *http://www.nectac.org*, *http://www.rehab.state.tx.us/Library/*, *http://www.dbpeds.org/articles/*, *http://www.earlyonmichigan.org/articles/7-03/DevScrTools7-03.htm*, *http://www.psychcorp.com*, *http://www.newassessment.org/public/assessments/SelectTool.cfm*, *http://testcollection.ets.org/cgi/swebmnu.exe?act=3&ini=TestColl*, *http://www.wa.gov/dshs/iteip/prog8.html*, *http://www.icyf.msu.edu/publicats/z5dissem/screenng.html*, *http://www.agsnet.com/*, *http://www.brookespublishing.com/store/books/fenson-cdi/index.htm*, *http://www.pbrookes.com/store/books/wetherby-csbsdp/checklist.htm*, *http://www.pbrookes.com/tools/aeps/index.htm*, *http://www.agsnet.com/*, *http://www.pearsonearlylearning.com/OunceScale.htm*, Crais, E. (handout from 12/12-14/01 DE workshop): Assessment and intervention focused on communication skills of children birth to five; McLean, M., Wolery, M., & Bailey, D.B., Jr. (2004). Assessing Infants and Preschoolers with Special Needs (3rd ed.). Upper Saddle River, NJ: Pearson Publishers.

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