KIT

Keeping In Touch

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Educational & Developmental Intervention Services (EDIS) Personnel Development

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DEVELOPMENTAL SCREENING QUALITY PRACTICES

Resource Article

Developmental screenings provide valuable information about a child's achievement of developmental milestones at a given time. Much of this information comes from the parent and/or primary caregiver. In their 2007 study, Scarborough, Hebbeler, Simeonsson, and Spiker set out to gather caregiver descriptions of toddlers to determine what skills the children have or are missing as they enter early intervention (EI). These researchers had three primary questions:

1) How do parents describe the developmental skills of infants and toddlers entering EI?
2) Is reported skill level associated with child characteristics, such as eligibility category, age at entry to EI services, gender, and race/ethnicity; or with family characteristics, such as primary female caregiver's education, household income, and the number of adults in the household?
3) Are there predominant patterns of reported developmental skill level across developmental domains that characterize children entering EI?

The researchers sampled parents and/or caregivers of 3,338 infants and toddlers who entered EI programs nationally. The children were between several weeks and 33 months of ages with a caregiver in the household who spoke either English or Spanish. Most of the data were collected via telephone interview, with a small portion (2%) who participated via mail-in survey. The questions selected for the survey were compiled from a variety of developmental testing and screening tools (e.g., Battelle Developmental Inventory, Ages & Stages Questionnaire, Bayley Scales of Infant Development, Child Developmental Inventory, etc.) and met each of the four criteria: a) having face validity as developmental markers; b) contributing to a sequenced strand of development; c) reflecting skills of a universal, rather than culture-specific nature; and d) readily observable by caregivers in the everyday settings and activities of children. Together, 84 questions were selected and grouped according to one of four skill areas (i.e., motor, communication, independence, and cognitive), and

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ordered by developmental age. The phone interviews lasted approximately 40 minutes. Service providers at the enrolling EI program provided the children's age at entry and reason for eligibility (i.e., diagnosed condition, risk for developmental delay, established developmental delay).

Parents/caregivers reported on their child's skill level by providing one of the following responses: 1-doesn't do it at all; 2-does it, but not well; 3-does it well. The questions continued until two consecutive questions were scored as a 1-doesn't do it at all. Results suggested that children over 12 months of age experienced greater challenges with communication skills than development of motor skills as only 22% of the children were reported doing expected communication tasks well vs. 72% for motor tasks. More children entered EI programs with age expected skills in the areas of cognitive (26%) and motor (22%) than in the areas of independence (19%) and communication (17%).

Infants and toddlers with diagnosed medical conditions and those at risk for developmental delay (e.g., due to prematurity) began services at a younger age than children with developmental delay. Male children were more likely to show delays in communication than female children. Socioeconomic factors appeared to play a role in the development of motor and communication skills as fewer children from families with lower socioeconomic status were reported as having age-expected motor and communication skills than those coming from a family with higher socioeconomic status. Younger children, those entering EI before age 24 months were more likely to have age-expected communication skills than those children entering after 24 months. About half of the children (50.3%) were reported having below age-level skills in all four domains. Overall, 17.5% were reported to have age-expected skills in all domains.

The researchers point out, "Children entering EI are highly diverse with regard to their development." Some children entering EI demonstrate many age-expected skills with a delay in only one area, other children show delays in more than one area. Children with diagnosed conditions may show no delay upon entering EI, but start services early, which is the intent of IDEA Part C. The results from this study underscore the importance of developmental screenings for infants and young children as well as individualizing services for families in EI to best meet the needs of each family participating and achieve optimal outcomes for children and families.

Scarborough, A. A., Hebbeler, K. M., Simeonsson, R. J. & Spiker, D. (2007). Caregiver descriptions of the developmental skills of infants and toddlers entering early intervention services. Journal of Early Intervention, vol. 29, no. 3, pp. 207-227.

What do the data say?

How helpful have newborn hearing screenings in identifying infants born deaf or hard-of-hearing?

Even before developmental screenings, all newborns should receive a hearing screening. According to the National Institute of Health (NIH) 2-3 of every 1,000 children in the US are born deaf or hard-of-hearing. Each year in the US as many as 12,000 babies are born with a hearing loss. Prior to implementation of universal newborn hearing screenings only those infants considered at high risk were screened. Today nearly 100% of newborns are receiving this important screening.

In fact, newborn hearing screening has become a standard of care in the US and all states have established Early Hearing Detection and Intervention (EDHI). In addition, nearly all of the states have mandated newborn hearing screening programs. According to a 2005 American Academy of Pediatrics (AAP) report, 90% of all newborns in the US are screened before they even leave the hospital (Johnson, et al, 2014). Data from Centers for Disease Control and Prevention (CDC) and EHDI showed that in 2010 over 97% of newborns in the US were screened for hearing loss. In addition the CDC reported that between 1999 and 2007 the percentage of infants screened increased from 46.5% to 97% (Gaffney, et al., 2010).

The first three years of life are critical for children's development. This is the period when the brain lays neural pathways essential for processing auditory information. Accordingly, identifying hearing loss as early as possible is essential for identifying and applying treatment options to help children and their families. In fact, in 2000 an NIH study found that children with hearing loss, who received treatment early, demonstrated language skills comparative to their same age peers regardless of the degree of their hearing loss. A further study in 2001 indicated that children who were identified and received treatment before 6 months of age fared better than those receiving treatment after 6 months of age (NIH, 2010). Data from the CDC also identified that by 6 months of age 77% of children with a permanent hearing loss were enrolled in an early intervention program. Early identification and intervention is critical to helping children with hearing impairments achieve their full potential. Yet, according to Delaney & Roger (2010) there are common misconceptions about hearing loss and screening that continue to linger. One misconception is that parents will know if their child has a hearing loss; yet prior to universal screening children were identified at 2 to 3 *years* of age or later. Another persistent belief is that parents can identify a hearing loss by clapping their hands behind their child's head; yet children are masters at compensating for a hearing loss – they use visual and other environmental cues. Some also believe that the frequency of hearing loss does not justify the need for a universal screening program; yet with 2-3 infants in every 1000 live births having a hearing loss it is estimated to be one of the most common congenital anomalies. Another myth is that children younger than 12 months cannot benefit from hearing aids; yet, in fact they can and do.

EDHI has been instrumental in advancing newborn hearing screenings and helping children and families. The EDHI recommended national benchmarks include: hearing screening no later than 1 month of age, diagnostic audiologic evaluation no later than age 3 months (for those infants not passing the screening), and enrollment in early intervention no later than age 6 months (for those identified with a hearing loss).

Delaney, A. M. & Roger, A. R. (2013). Newborn hearing screening. Accessed from http://emedicine.medscape.com/article/836646-overview

Gaffney, M., Eichwald, J., Grosse, S. D., Mason, C. A. (March 5, 2010). Identifying infants with hearing loss – Unites States, 1999 – 2007. Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, 59(08), 220-223. Accessed from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5908a2.htm.

National Institute of Health (2010). Newborn hearing screening – Fact sheet. Accessed from http://report.nih.gov/NIHfactsheets/Pdfs/

Consultation Corner

From May through December 2014 we are excited to have Jantina Clifford, Jane Farrell, and Suzanne Yockelson as our consultation corner experts addressing the topic "Developmental Screening Quality Practices; Using the ASQ and ASQ-SE."

What if the parent-completed results of the ASQ are different from my observation of the child's skills?

These tools are designed to "catch" children—but what happens when providers think they have "caught" the parent? The ASQ is designed to identify children who are in need of further evaluation to determine if they might qualify for early intervention or early childhood special education services. It is not unusual for practitioners who are new to the ASQ (or any parent-completed screening tool) to question the veracity of parent report or the ability of parents to be objective and reliable observers of their child's development. Oftentimes practitioners worry that parents will "over-report" on their child's development, that is, their responses will indicate that the child is able to do more than he or she is actually capable of. If and when parent report does not "match" the professional's understanding of the child's ability or current skill level, the "disagreement" can go one of two possible ways: the parent reports a higher skill level than the practitioner believes to be true, or the parent reports a lower skill level than the practitioner believes to be true. In any case, both situations present an interesting circumstance that provides an opportunity to gather further information. Following are some guidelines and suggestions for things to consider if and when parent and professional report on a child's development differ.

First…determine the purpose of the screening (i.e., what decisions will be made upon completion) and how the parent might feel about possible implications of results. Knowing how the parent feels about the screening and possible decisions can help the provider to address any feelings of discomfort by listening, acknowledging, and providing clear and accurate information behind the purpose of the screening and the advantages of accurate results (i.e., the purpose is to identify children who need extra support to learn…the advantages of "catching" these children early are that there are free and effective services that can help children to catch up with their peers, often before they enter kindergarten or first grade. Children who need the extra support but don't receive it are prone to fall further behind).

Asking parents how they feel about their child's development and how they feel about completing the screening gives them a chance to voice their fears or concerns. They may not understand that there are services available such as early intervention, and they also may not be aware of the importance of intervening early on. Some parents may fear that that if their child is identified he or she may be labeled, or even "kicked out" of their early childhood or community program. Addressing and allaying these fears *before* parents complete the screening can help improve parent accuracy by allowing and encouraging them to freely report observations of their child's abilities and to communicate any concerns they may have.

Consultation Corner (continued)

There are at least three common issues and concerns that have been voiced by providers who are considering or are embarking upon the use of parent-completed screening tools. These include the parent's a) over-estimation of child ability, b) under-estimation of child ability, and c) hasty completion of the screening tool. Each issue is addressed further below:

Parent over-estimation of child ability

- A parent might report a child is able to perform skills that a professional does not think he/she is capable of performing. But it may in fact be that the child *is* capable of doing the skill. Children often perform differently for different people and/or in different situations or circumstances. It's important to remember this and to be respectful of the relationship being developed with the family at this early step in the family's early intervention journey. If you find yourself in this situation remember that openly doubting the parent's response may jeopardize the provider's relationship with the parent.
- Another consideration is that the parent might have misunderstood the question. Before sharing the ASQ for parents to complete ask about their comfort and confidence to complete it. If there is question make arrangements to do it together. Make time to discuss the questions that are not clearly obvious to the parent. Think also about credit given to emerging skills. With the ASQ it's possible to give partial credit for skills that are not fully integrated or developed yet.
- When there are discrepancies in parent and providers' perceptions about a child's abilities, approach it with caution as well as curiosity. The provider may need to slow down in order to move forward with the parent.

Parent under-estimation of child ability

- It's possible for a parent to report a child is not able to perform skills that a professional has observed the child perform or has good cause to assume the child can do. A parent may not have seen the child demonstrate the skill. We know that children perform differently with different people and under different circumstances. It is possible that the parent didn't expect the child to be able to demonstrate a particular ability. It is also possible that there are different cultural expectations that impact the child's opportunities to practice or demonstrate particular skills. Another consideration is that the child does not demonstrate the skill to the parent's expectation. It may too be that they desire further evaluation. And, it is certainly possible for the parent to misunderstand the question or the response options.
- Being respectful of family cultural values and beliefs and openly discussing all observations with the parents is critically important if we are to truly help the family help their child.

Hasty observation and/or completion

- Parents are busy people and may not have the time to intently observe their child. It's important to consider this reality. We know parents are rich resources of information and their responses provide valuable insight regarding a child's development. However, parent-completed tools rely on parent ability and motivation to complete. If parents are unable or uninterested in completing a questionnaire then the information provided and subsequent results are not likely to provide a good representation of the child's abilities. When parents understand and appreciate the value of developmental screening they are more likely to complete the questionnaire in a thoughtful manner (i.e., watching for or trying to elicit skills they are unsure about).
- To extend responsive support we need to be understanding about the many obligations a family may have.

On the WWW

http://challengingbehavior.fmhi.usf.edu/explore/pbs/process.htm

The Technical Assistance Center on Social Emotional Intervention (TACSEI) for Young Children's provides a useful planning tool, *6 Steps for Positive Behavior Support (PBS) that* can be used to address challenging behaviors of toddler and preschoolers in a group and/or classroom setting. The website has other interesting links such as the *Backpack Series* that includes a variety of handouts on topics such as 'Teachable Moments: How to Help Your Child Avoid Meltdowns' and 'How to Help Your Child Stop Whining' and 'How to Understand the Meaning of Your Child's Challenging Behavior.' You'll find the Backpack Series at: http://challengingbehavior.fmhi.usf.edu/do/resources/backpack.html

Continuing Education for KIT Readers

The Comprehensive System of Personnel Development (CSPD) is offering a continuing education opportunity for KIT readers.

In line with the focus on *Developmental Screening Quality Practices,* readers are invited to receive continuing education contact hours for reading the monthly KIT publications (May through November 2014) and completing a multiple-choice exam about the content covered in these KITs,.

KIT readers will receive the exam in December 2014. There is no need to register for the CEUs. Rather, if you are interested complete the exam online at www.edis.army.mil

Upon successful completion of the exam, you will receive a certificate of non-discipline specific continuing education contact hours.

KIT Newsletters
are available
online at
www.edis.army.mil

Thank you for your continued interest in the KIT.
Please share your KIT questions/ideas via email to
EDISCSPD@amedd.army.mil