THE DEVELOPMENTAL SCREENING CERTIFICATE PROGRAM:
CREATING A SUSTAINABLE MODEL FOR SCREENING PRACTICE AND
TRAINING

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Arts in Education,

Educational Psychology

By

Allie Odette Baldassari

May 2016
The graduate project of Allie Odette Baldassari is approved:

____________________________________  ______________________
Sloane Lefkowitz Burt, M.A.                        Date

____________________________________  ______________________
Joan Maltese, Ph.D.                                Date

____________________________________  ______________________
Shari Tarver-Behring, Ph.D.                        Date

____________________________________  ______________________
Joannie Busillo-Aguayo, Ed.D., Chair              Date
# TABLE OF CONTENTS

SIGNATURE PAGE ........................................................................................................... ii

LIST OF TABLES........................................................................................................ vi

ABSTRACT................................................................................................................... vii

CHAPTER ONE: INTRODUCTION.................................................................................. 1

Developmental Screening ............................................................................................ 1

Child Development Institute’s Early Learning Center ................................................. 2

Health Promotion and Prevention ............................................................................... 2

Developmental Screening ............................................................................................ 4

Workforce Development Model .................................................................................. 5

Strengthening Families Framework ............................................................................. 5

Statement of Need......................................................................................................... 6

Purpose of Graduate Project ....................................................................................... 8

Terminology................................................................................................................... 9

Preview of the Project................................................................................................... 10

CHAPTER TWO: LITERATURE REVIEW....................................................................... 11

Introduction.................................................................................................................. 11

The Importance of Standardized Developmental Screening Tools ......................... 12

Methodology................................................................................................................. 12

Parent Recognition and Responses to Developmental Concerns ............................ 15

Methodology................................................................................................................. 16

Preparation of the Manuscript...
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 4.1</td>
<td>32</td>
</tr>
<tr>
<td>Table 4.2</td>
<td>36</td>
</tr>
<tr>
<td>Table 4.3</td>
<td>37</td>
</tr>
<tr>
<td>Table 4.4</td>
<td>37</td>
</tr>
<tr>
<td>Table 4.5</td>
<td>37</td>
</tr>
<tr>
<td>Table 4.6</td>
<td>38</td>
</tr>
</tbody>
</table>
ABSTRACT

THE DEVELOPMENTAL SCREENING CERTIFICATE PROGRAM: CREATING A SUSTAINABLE MODEL FOR SCREENING PRACTICE AND TRAINING

By

Allie Odette Baldassari

Master of Arts in Education, Educational Psychology

The American Academy of Pediatrics recommends that all children should receive regularly scheduled developmental screenings (2001). The earlier a developmental concern is addressed, the better the child’s developmental trajectory. Thus, successful developmental screenings combined with early intervention will significantly improve a child’s developmental trajectory. The Child Development Institute (CDI) in Canoga Park, California has spearheaded the effort to provide pediatricians and early care and education (ECE) professionals with training in the recommended standardized screening tools for many years (Maltese, Aguayo & Chavez, 2011). This thesis project evaluates CDI’s Developmental Screening Certificate Program (DSCP) for ECE professionals. The DCSP provides ECE professionals in-service training while supporting community-based screening at CDI’s Early Learning Center (ELC). The research analyzed demonstrates the significance of implementing universal developmental screenings before children enter school, parents’ perceptions of screening, and the importance of helping families navigate the referral systems with follow-up. Seven professionals in the ECE field evaluated the DSCP training, and this thesis
explores those comments and establishes the benefits of the DCSP with suggestions for future work.
CHAPTER ONE

INTRODUCTION

Developmental Screening

The Centers for Disease Control (CDC) reports that about 16% of children have a developmental delay or disability. Only 30% of developmental delays or disabilities are identified before children enter kindergarten (Children Now, 2014); that means that 70% of children with delays entering kindergarten do so without identification of, or support for, their delay. Children who are undiagnosed are at a significant disadvantage. A delay in one domain may impact the development of other domains, and the longer a delay is left untreated, the greater the detrimental impact upon the child. Thus, it is important to identify delays and disabilities as early as possible in order to improve developmental trajectories (Nelson, 2009).

Developmental screenings are brief snapshots of a child’s development, and are generally conducted through a parent-reported questionnaire, which will lead to a further evaluation if a concern or red flag arises (Bergman, 2004). Once children are identified as at-risk for having a developmental delay or if there is a parent concern, they should be referred to the appropriate agency for a further assessment. Screenings benefit children without delays as well because even if there is no concern, it is an opportunity for conversation about what to look for and expect in a child’s development and be provided with activities to scaffold learning.

In 2001, the American Academy of Pediatrics (AAP) recommended that all children should receive standardized developmental screening as part of well-child care in their primary care settings. The AAP also stated that screenings are an “ideal
opportunity for the pediatrician to offer anticipatory guidance to the family and supporting their child’s development” (AAP, 2001, p. 192). Despite that recommendation, a study looking at the use of standardized tools for screenings by pediatricians found that more than half of pediatricians providing care to patients younger than 36 months still do not use any standardized screening tools (Radecki, Sand-Loud, O'Connor, Sharp, & Olson, 2011).

While developmental screening by pediatricians has increased since the AAP recommendation, there are still a significant amount of doctors who do not use standardized developmental screening tools (Pinto-Martin, Dunkle, Earls, Fliedner, & Landes, 2005). Current rates of detection of developmental delays are substantially lower than their estimated prevalence (Pinto-Martin et al., 2005). This suggests that children with developmental delays or disabilities are being under identified. Thus, it is important that new avenues of identification and referral are created so that identification approaches the estimated prevalence.

Child Development Institute’s Early Learning Center

Health Promotion and Prevention

The Child Development Institute (CDI) was founded in 1995 to serve the San Fernando Valley with holistic development and intervention services for young children and their families. CDI’s mission is to help all children reach their full potential by supporting the relationships and environments that shape early development. CDI also provides professional trainings to schools, teachers, and professional organizations.

A needs analysis of CDI’s service area revealed that “while nearly 75% of the families referred to CDI by our local regional center lived within 15 miles of [CDI], less
than 1% of [CDI] referrals came from one of the closest neighborhoods, Canoga Park” (Maltese, Aguayo, & Chavez, 2011). In other words, in spite of being ranked highest of the 11 service areas measured in San Fernando Valley's Community Needs Index (2013) with barriers in income, education attainment, and housing (all environmental risks for developmental delays) identification of children with developmental delays was almost non-existent (Maltese, Aguayo, & Chavez, 2011). In response, in 2012 CDI opened the Early Learning Center (ELC) in Canoga Park as a health promotion and prevention component to complement the early intervention that they already provided to the local community.

The ELC is a free, drop-in play and learning space, where caregivers are invited to open play and partake in structured activities and programming with their children. Emphasizing social emotional development, activities are centered on the theme of nature and emphasize nature’s role in children’s healthy development. To promote family engagement and learning, volunteers and interns run activities, such as “Storytime” and “Music and Movement” aligned with NAEYC’s developmentally appropriate practice and the California Department of Education Infants/Toddler and Preschool Learning and Development Foundations. Volunteers and interns are made up of dedicated community members and service-learning students who want to take part in building a healthy and happy Canoga Park through working with children and families. They receive ongoing training in family engagement, child development, and Strengthening Families. Interns specially trained in developmental screening support free screenings and linkage to community resources and referral agencies.
Developmental Screening

CDI has a dedicated history of commitment to developmental screening. As an example, the Outreach and Screening Project sought to “build systemic and programmatic cross-agency and parent partnerships to increase community capacity to sustain screening activities throughout the community” (Maltese, Aguayo, & Chavez, 2011, p.19). Before opening the ELC, CDI held community-based screening events at high-density locations like the local mall, farmer’s market and a CVS pharmacy (Maltese, Aguayo, & Chavez, 2011). Another component of the Outreach and Screening Project was training local ECE and human service agencies to screen and identify children with delays and disabilities.

After opening the ELC, community screening events became regular, bi-monthly Saturday Screening Days. On Saturday Screening Days, developmental screeners who are child development specialists trained in using developmental screening tools accommodate both walk-in and scheduled appointments. While their children play, parents talk with a developmental screener, fill out a questionnaire, and receive activity suggestions for aiding development. If there are concerns, the parent will be referred accordingly. Offering screenings where families naturally congregate to play with their children, proves to be a successful, non-threatening method. When families see other families getting screenings, they are intrigued, ask what is happening and tend to schedule an appointment for themselves.

Universal screening – meaning that all children regardless of concern get screenings at periodic, regularly-scheduled intervals – is the goal. At the ELC screening days, questionnaires recommended by the AAP are used. Although screening
occasionally leads to over referral for assessment, it is not necessarily a detriment to the family:

Developmental screening tools undergo extensive testing for validity, reliability, and accuracy and are standardized using children and families who represent the cultural, linguistic, and economic diversity of the intended population to be as accurate as possible….Because screening needs to be periodic, a child not detected by a single screening will be detected by a subsequent screening. Children who have been overreferred may benefit from other community programs as well as a close watch on their development. (AAP, 2001, p. 193)

**Workforce Development Model**

The ELC activities are run by a trained cadre of volunteers and interns. Community volunteers from diverse educational backgrounds and training team up with university students completing service-learning internships and use their knowledge and skills to develop innovative, quality programming, implemented on a consistent basis with ELC children and families. Volunteers and interns receive skill-based training in child development, family engagement and the Strengthening Families framework. This training and experience supports the development of relationships to create connections with the greater good of the community. It develops a well-educated and compassionate workforce that meets the needs of children and families across many disciplines.

**Strengthening Families Framework**

The ELC is grounded in the Strengthening Families framework, an evidence-based model to increase families’ Protective Factors, enhance child development, and reduce the likelihood of abuse and neglect. All ELC programming supports the five
Protective Factors which include: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social emotional competence of children. When families are strong in these characteristics there is an increase in the likelihood of positive outcomes for children and families (http://www.cssp.org/reform/strengtheningfamilies).

**Statement of Need**

A study on the entire population of the state of California found that 36% of children under three have a moderate to high risk of developmental delay, yet only 2.2% of these children receive Early Start services, which is California state’s early intervention program (Children Now, 2014). Early identification of developmental delays is key to supporting optimal developmental trajectories for each child (Radecki et al., 2011). Developmental delays that go undetected have a great risk of affecting other aspects of a child’s development (AAP, 2006). In order to reduce the number of undetected delays, there needs to be an increased dialogue about child development and developmentally appropriate activities, and provision of community resources and services to families with young children (Marshall, Coulter, & Gorski, 2016). As professionals with authority and somewhat regular contact with families, pediatricians are in an ideal situation to have these conversations (AAP, 2006). Following AAP recommendations, pediatricians should be implementing regular developmental screening but a study looking at the use of standardized tools by pediatricians found that only 47.7% of pediatricians report always or almost always using a developmental screening tool (Radecki et al., 2011, p. 16).
Developmental screening tools can be implemented in many different settings; they do not need to be confined to pediatric offices. With training, developmental screening tools can be implemented by ECE professionals (such as family child care providers and infant-toddler or preschool teachers) who have ongoing knowledge of the child’s development and a relationship with the family. Unfortunately, there are some barriers to teachers’ use of developmental screening tools. Teachers feel uncomfortable having these conversations with parents. An article encouraging and supporting teachers to share developmental concerns with families, confirms that preschool teachers may avoid bringing up concerns with a family for fear that the family could pull the child from the program (Croft, 2011). Sometimes, there is pressure in childcare centers and preschools to not mention developmental concerns to parents in fear that parents will pull their children from the programs affecting revenue. Teachers do not necessarily have the sensitivity training to discuss these topics with parents, and they may not have the knowledge of available resources and options for families with concerns.

Given that ECE professionals, who spend a significant amount of time with children, do not always have the education or experience to identify delays, or to know about available services and may also lack the training to deal with highly sensitive discussions with parents when sharing concerns about a child’s development, the ELC seeks to train early ECE professionals to feel confident in supporting families. With increased knowledge and understanding about how to implement screening tools into early care and education programs as well as access to developmental screenings, early identification and linkage to services will happen sooner (Guevera et al., 2012). When there are not concerns, implementation of scheduled universal developmental screenings
for every child will aid ECE professionals’ and parents’ knowledge of child development and promote a non-judgmental dialogue about helping children achieve their next milestones. With the combination of teachers needing training and the ELC needing more developmental screeners, the Developmental Screening Certificate Program arose.

**Purpose of Graduate Project**

The purpose of this project is to examine the DSCP training, which is a step toward a sustainable system for community-based developmental screening that fits into the workforce development model of CDI. Key components of the system include in-service training of ECE professionals that aims to support participants to implement screening into their professional environments. The project also includes a comprehensive universal screening practice with follow up for families.

Yearly, the demand for developmental screenings increases at the ELC. A well-trained workforce is imperative in maintaining and increasing community screenings, referrals, and follow-up. The DSCP trains participants to gain the knowledge and skills needed to become screeners and complete community-based screenings. Therefore, this project documents the creation of and evaluates the DSCP. This project builds on the foundation that the Child Development Institute has created to support children and families.
**Terminology**

For the purpose of this project, the following terms will be defined.

- **Assessment** – an intensive process that evaluates the child’s development to determine the degree of impairment and whether the child could benefit from intervention (Bergman, 2004, p. 5).

- **Developmental delay** - A developmental delay is when a child does not reach a milestone within an expected period of time in one or more domains (American Academy of Pediatrics, 2001).

- **Developmental screening** – “the use of standardized tools to identify and refine the risk of developmental delay” (Guevara et al., 2013, p. 31).

- **Developmental screener** – The person who implements the developmental screening questionnaire with a parent.

- **Developmental surveillance** – “a process of recognizing children at risk for developmental delay without the assistance of standardized tools” (Guevara et al., 2013, p. 31).

- **Participant** – the person participating in the Developmental Screening Certificate Program.

- **Standardized screening tool** – a measure that gathers evidence indicating the probability of or potential for a developmental problem, delay, or risk (Bergman, 2004).
Preview of the Project

The next three chapters describe the evolution and implementation of the Developmental Screening Certificate Program at CDI’s Early Learning Center. Chapter Two will discuss research and information highlighting the importance of developmental screening for early identification and intervention of developmental delays. It will also review the barriers to screening. Next, Chapter Three will outline the Developmental Screening Certificate Program and the evaluation process. Lastly, Chapter Four will review the evaluation of the Developmental Screening Certificate Program by seven early childhood professionals. Suggestions for future research, policy implications, and remaining questions will be addressed.
CHAPTER TWO
LITERATURE REVIEW

Introduction

This chapter reviews research and important information on several topics related to developmental screening and adult learning models. The specific topics include: (a) how the use of standardized tools decreases the time to identification of developmental delays, (b) the process of parents recognizing concerns and seeking support, (c) parents’ perceptions of the screening process, and (d) an evidence based training model for in-service professionals.

Early intervention is key as time is a major factor in ensuring the best outcomes for children. Developmental screening tools offer a relatively quick and cost effective way of identifying red flags and risk for atypical development. Child care and preschool programs have unique opportunities to collaborate with families to gather information on young children’s development. Caregivers and teachers spend a lot of time with children and have child development background. They can build partnerships with families to help parents understand what is developmentally appropriate for the child.

The goal of this literature review is to highlight the research that supports the content of the DSCP. First, the research will demonstrate the importance of using standardized developmental screening tools to identify developmental delays in urban communities. Next, the research will look at parents’ perceptions of screening. Then, the research will review access to referral completion and satisfaction.
The Importance of Standardized Developmental Screening Tools

It has been established that using standardized developmental screening tools improves rates of identification and referral for young children who have developmental delays. Before this research by Guevara et al. (2012), few studies had shown the effectiveness of screening tools among a high-risk urban population. The objective of this study was to “determine the effectiveness of developmental screening on the identification of developmental delays, early intervention (EI) referrals, and EI eligibility” (Guevara et al., 2012, p. 30).

Despite the recommendation by the American Academy of Pediatrics (2001) to implement standardized screening tools at well-child visits, pediatricians were still relying solely on their discretion and developmental surveillance based on parent questioning to make early intervention referrals for multidisciplinary evaluations (MDEs) that could lead to early intervention services. This leads to an under-identification of delays and/or later identification after children have entered school (Guevara et al., 2012). Ultimately, the study found that there is an increase in identification of developmental delays when standardized screening tools are used.

Methodology

Subjects. The subjects included 2,103 children enrolled in four urban pediatric practices affiliated with The Children’s Hospital of Philadelphia from December 2008 to June 2010. In order to be eligible for the study, children had to be less than 30 months old at time of enrollment, been born full term, be without congenital malformations or genetic syndromes, not in foster care, and not enrolled in early intervention. Most
children came from African-American families reporting a household income of less than $30,000 (Guevera et al., 2012).

**Procedures and instruments.** The study was a controlled, parallel-group trial in which participants received a randomized assignment to one of three treatment arms. The first arm included a developmental screening with office support (OS). The second arm included a developmental screening without office support (NS). The third arm encompassed developmental surveillance (DS) only (Guevera et al., 2012).

The families in the OS screening arm “completed the Ages and Stages questionnaire-II (ASQ-II) at their child’s 9-, 18-, and 30-month well-child visits and the Modified Checklist for Autism in Toddlers (M-CHAT) at their 18- and 24-month visits” (Guevera et al., 2012, p.31). This was done as part of their appointment with trained office staff and screening props to test the task-oriented questions; for example, blocks were provided to see if the child could stack three blocks high. In the NS screening arm, families completed the screening tools on the same schedule as the OS arm but either at home (mailed from the doctor’s office) or in the office before the appointment but without the help of staff or screening props. The DS arm completed did not use a standardized developmental screener but instead answered a series of eight to ten questions referred to as a milestones test. The milestones tests were tailored to each well-child visit and looked at four domains: gross motor, fine motor, communication, and personal/social. Clinicians could use a standardized screening tool for the DS arm at their discretion (Guevera et al., 2012).

There were three different categorizations based on findings. Children were categorized as having a delay if they failed a developmental screening in accordance with
the testing manuals or failed an age-appropriate milestone which was determined as a 25% delay in milestone attainment (Guevera et al., 2012). Children were categorized as having an early intervention (EI) referral if there was an EI health appraisal and prescription completed or there was documentation in the child’s medical record that there was an EI referral. Children were categorized as eligible for EI services if they had a multidisciplinary evaluation (MDE) completed and had at least a 25% delay in one or more developmental domain (Guevera et al., 2012). The study examined time to identification of delay, EI referral, and a completion of EI referral (MDE evaluation) as secondary outcomes.

**Results.** The study found that in both screening arms that used standardized developmental screening tools, there was earlier identification and referral compared to the DS arm. A larger number of children were both identified and referred with delays for EI or an MED in the two screening arms, and within those arms, there was no difference in identification of delays. This means that whether or not the parent is assisted by a trained clinician to fill out the screening questionnaire screening, there is no significant difference in referral (Guevera et al., 2012). Over time, there were only slight differences in the referral rates among the three arms and using developmental screening tools sped up the process:

Looking at time-to-event analysis, in both of the screening arms, children had a 59% to 68% shorter time to identification of delay, a 64% to 70% shorter time to EI referral, and a 24% to 32% shorter time to EI referral completion than children in the DS arm. Children in the screening arms were identified with delays and referred earlier. (Guevera et al., 2012, p. 34)
There was a concern cited within this study. First, only 38.8% of the children identified as having delays were referred and completed an MDE. This was due in combination to a low percentage of identified children that were actually referred for EI or MDE by the pediatrician, in addition to, a low percentage of completed referrals among those who were indeed referred (Guevera et al., 2012). Still, most children, 62.9%, who completed referrals were eligible for services. This is concerning because it shows that barriers to receiving services are 1) getting a doctor’s referral and 2) completing that referral. This indicates the need for addressing identified developmental problems and supporting the family in getting further interventions (Guevera et al., 2012). Ultimately, the study found that there is an increase in identification of developmental delays when standardized screening tools are used.

**Parent Recognition and Responses to Developmental Concerns**

Marshall, Coulter, and Gorski (2016) conducted a study to understand parents’ perspectives on “recognition and appraisal of developmental concerns” (Marshall et al., 2016, p. 102). Since parents are primarily responsible for the process of identifying and appraising developmental concerns, having accurate developmental knowledge is key to making sure that children receive screening and referral services before they enter school. The study sought to identify the processes parents undergo when they have concerns and identify socially and culturally relevant access points to get support (Marshall et al., 2016).
Methodology

**Subjects.** Twenty three English- and Spanish-speaking parents of children aged two weeks to four and a half years old who had expressed developmental or behavioral concerns took part in the study. They were recruited through community agencies such as preschools or libraries, in both high- and low-income areas throughout Hillsborough County, Florida. All of the parents had identified developmental or behavioral concerns in their children but had not yet sought support (Marshall et al., 2016).

**Procedures and instruments.** Four experienced research assistants conducted private interviews or focus groups based on parent preference, in either English or Spanish. Focus groups were audio-recorded and transcribed verbatim. If done in Spanish, they were translated to English. Then followed a code development system. It began with themes based on the initial theoretical framework of the study and was finalized with emergent themes after three rounds of coding (Marshall et al., 2016). Before attending the focus group or interview, participants filled out three separate items to collect data: a demographic questionnaire, the Parent Evaluation of Developmental Status (PEDS), and the Knowledge of Infant Development Inventory (KIDI). The PEDS was used to find out the parents’ concerns regarding their children. The KIDI is a 75-item questionnaire that measures parents’ knowledge of parenting practices, child development, and infant behavior norms (Marshall et al., 2016).

**Results.** In total, 18 interviews and two focus groups were completed. Results indicated that “Parents described, in detail, observations that first prompted developmental concerns, their decision-making processes in assessing whether and when to seek help, and interpersonal influences on this process” (Marshall et al., 2016, p.107).
All parents reported concern about their child’s development either using the PEDS or through the interview. Following PEDS scoring criteria, responses indicated that eight children should be referred for assessment, 11 monitored, and five counseled and referred for parent training or behavioral interventions. Based on the results of the KIDI, there was a wide and varied range of knowledge of child development and the average score was low, 61%. Interestingly, “The KIDI score was significantly correlated with family income and maternal race/ethnicity but not with parent age or parenting experience” (Marshall, 2016, p. 109).

Looking at the process of identifying a potential problem, Marshall et al. (2016) found that most parents became aware of a potential problem either by a specific trigger or a sudden change in their child. Only three of the parents had been alerted of a concern by a professional (Marshall, 2016). Next, the parents spent time deciding whether or not the concern was significant enough to get help. Examining the concern within the context of the child’s characteristics such as temperament and comparing the child to peers were both part of the process (Marshall et al., 2016).

Parents usually consulted with a spouse, friend or family member about the concerns. In addition, they reported seeking help from pediatricians and other professionals. A theme that came up within the Spanish-speaking parents was feeling like they had very little time or invitation to talk openly about concerns with the pediatrician and that they were told to wait until the next visit to see if the problem continued (Marshall et al., 2016). Pursuant with research done by Guerrero, Rodriguez, and Flores in 2011 (as cited in Marshall et al., 2016) the study found that parents who are
Black or Hispanic, particularly non-English-speaking and of lower income, are less likely to receive developmental screening or elicitation of concerns by pediatricians.

**Strengthening Families of Children with Developmental Concerns**

Developmental screening within at-risk populations has proven to be beneficial to families. Head Start is a federally funded preschool program for low-income families. Within the first 45 days of enrollment in a Head Start program, all children must receive developmental screening. If concerns are identified, the Head Start program facilitates access to early intervention services. An investigation by Bergen et al. (2011) sought to understand parent perception of the developmental screening process in a Head Start Agency in Los Angeles.

Routine developmental screening can play a major role in implementing a Strengthening Families approach connecting families with concrete needs, educating them on knowledge of child development, and building confidence and resilience. This study helps illustrate the ways in which parents perceive the Head Start developmental screening process, supported them and the Protective Factors emerged as themes within their focus groups (Bergen et al., 2011).

**Methodology**

**Subjects.** Thirty parents of Head Start children participated in one of five focus groups. Of the participants, 69% were Spanish speaking and 83% were born outside of the United States. The majority of the children (81%) in the families were covered by public health insurance. All participating parents had developmental or behavioral concerns regarding their children (Bergen et al., 2011).
Results. Their perception of developmental screening is very positive. Parents noted a transition in seeking support for developmental and behavioral concerns. Where they had originally sought help from the child’s pediatrician, after being in a Head Start program, they felt that they had another avenue to address concerns (Bergen et al., 2011). They agreed that it increased their awareness of child development. Parents reported that there were aspects of development that they did not realize were important, and after doing a developmental screening, they would pay more attention. They also mentioned that screening sparked them to follow-up on routine visits with health care providers, like dentists (Bergen et al., 2011).

Parents agreed that a great benefit of screening were the services they got as a result of concerns raised during the screening process. They also mentioned the strides that their children had made in social emotional development. A surprising finding was that parents perceived the developmental screening process as therapeutic in addition to finding the diagnostic aspect helpful (Bergen et al., 2011).

Following Up on Community-Based Developmental Screening

To investigate what happens with children and families after screenings, Marshall and Mendez (2014) did a study following up with people who had participated in a community-based screening program six to eighteen months prior. Questioning the importance of screening and identifying young children with delays if referral and linkage does not result, they sought to understand how parents get connected to services, barriers to connection, satisfaction with services, and what needs continued to be unmet (Marshall & Mendez, 2014).
Sices (2007) stated that in addition to lack of screening efforts, barriers in the communication of results and timely action are issues (as cited in Marshall & Mendez, 2014). Further, some studies have shown that there can be an average of one to three years’ lag time between parental concern and a diagnosis, and sometimes parents choose not to follow through with referrals for various reasons. Overall, Marshall and Mendez (2014) noted a plethora of research regarding screening practices especially among pediatricians and also a great amount of research in the benefit of early intervention services for young children with delays, however, the lack in research examining parents’ perceptions, processing and action on positive screening results was the driving force for this study.

**Methodology**

Interested in what happens to children who screen positive for risk of developmental delays, Marshall and Mendez (2014) partnered with a community-based developmental screening program that had been conducting screenings in Florida County since 1996. The program included a coordinated system of screening and referral and collaboration with partner agencies. Florida County provides free, comprehensive screening efforts for young children who may be at risk for a developmental delay involving: phone prescreening, home-based screening, and/or site-based screening (Marshall & Mendez, 2014).

**Subjects.** The participants in the study were 55 parents of 57 children who had agreed to be contacted for the study when they received their site-based screening between 2009 and 2011. The children of the participants ranged from two years, eight months old to five years, four months old. Demographic information of the participants
was not collected, but the general demographic of the program was diverse (Marshall & Mendez, 2014).

**Procedures and instruments.** The telephone survey used to gather data asked three questions for each of the referrals that the family had received when their child screened positive for risk of a delay. The survey addressed 1) whether the family connected with the program, 2) whether the program was able to help them, and 3) the parents’ rating of satisfaction on a Likert-type scale (Marshall & Mendez, 2014). If questions one or two were no, there was a series of follow up questions to understand why. On the third topic, if parents were not satisfied with services, again, there was a series of follow up questions to describe why. If families had unmet needs, they were given a hotline number developed to assist parents for a variety of issues (Marshall & Mendez, 2014).

**Results.** Sixty seven percent of families felt that the services did meet their child’s needs. Respondents were very satisfied with the screening experience, but although the majority of children referred qualified for services, 30% of families did not connect with at least one of the service providers referred to them. The reasons cited were difficulty establishing contact with the referred agency, waitlists and insufficient selection of providers. There was also a high report of misunderstandings during the screening regarding results, service recommendations, referral process and timeline (Marshall & Mendez, 2014). In line with previous studies, Marshall and Mendez (2014) found that many families do not follow through with referrals due to both family and referral agency barriers.
Thirty percent of parents of both children who were not connected with referrals and those who did get connected reported that they still had unmet needs. Sometimes this was due to ineligibility because of a child’s age or a family’s income. Other times, provider characteristics, such as services not being culturally sensitive or not addressing social emotional development, were challenging for the parents (Marshall & Mendez, 2014).

An interesting finding was that behavior concerns are less likely to be referred than developmental or medical concerns. Recommendations include supporting practitioners (implementing developmental screenings) to feel more comfortable with mental health and psychosocial issues (Marshall & Mendez, 2014). The most shocking finding was that the wait time to receive assessment through the state-funded program averaged six months. The conclusion of the study is that there is a lot of research and improvement that needs to be done to meet the families’ needs (Marshall & Mendez, 2014).
CHAPTER THREE
PROJECT AUDIENCE AND IMPLEMENTATION FACTORS

Introduction

The purpose of this project is to create an effective training program for the implementation of the workforce development model of CDI. The program is designed to: (1) support a high volume of screenings; (2) implement universal screening awareness; (3) raise the rate of parent rescreening; (4) improve professionals’ and para-professionals’ confidence with screening practices; (5) support screening referral and follow-up processes; and, (6) create and feed-back procedures which allow continual improvement and refinement of the DCSP. This chapter explains the development of the DSCP and analyzes its feedback procedures.

Development of Project

Purpose of the Certificate

The DSCP focuses not only on early screening and identifying delays, but also on increasing access to the early intervention systems and referral programs for children with identified delays. It seeks to train and empower early care and education professionals to implement effective screening procedures, and to advocate for children. Participants are provided tools to encourage thinking strategically about how to implement universal screenings whether at a childcare center, with therapy clients, or with a friend. The certificate training also educates participants about how to form partnerships with families through the Strengthening Family framework, and how to address any critical concerns. The DSCP addresses all the aspects of successful screening and intervention, including follow-up. One of the ways that DCSP is unique is
that it provides practical application training combined with the mentoring and reflection necessary to ensure that a certificate recipient has the tools necessary to effectively implement appropriate screening procedures in their practices. This is in line with an effective in-service training model as described by Dunst (2015).

**Certificate Creation**

The certificate program was created in 2013 in collaboration with Joan Maltese, CDI’s President and Chief Executive Officer and Laura Counts, CDI’s Community Training Program Specialist. Four developmental screening tools and one maternal depression screening tool were chosen as the content for the program. The Parents’ Evaluation of Developmental Status (PEDS) is a screening and surveillance tool for children birth through eight years old that takes about ten minutes and can be implemented easily at large scale events. The Ages and Stages Questionnaire – 3 and Ages and Stages Questionnaire – Social Emotional take about 15 to 20 minutes to complete and ask about a child’s achievement of specific tasks. The M-CHAT-R screens specifically for risk for Autism Spectrum Disorder (ASD) in children 16 months to 30 months old. There are 18 yes or no questions, and it is quick and simple. It includes a follow-up interview to clarify specific questions and improve accuracy and is great to use with families that are concerned about ASD (Ringwalt, 2008). The Edinburgh Postnatal Depression scale is a ten multiple-choice item survey that produces a possible depression score with one single question focusing on potential suicidal ideation.

In addition to learning to implement the screening tools, discussing results with families and navigating the resource and referral system are critical components of the program. As concluded by previous research, barriers to receiving early intervention
services are incompletion of referrals, lag time to assessment and services, and a lack of culturally sensitive services (Marshall & Mendez, 2014). For this reason, a module in Sharing Results and Navigating the Referral System helps the DSCP participants understand the challenges that families face. The importance of following up and supporting families in referral completion and in the event that children don’t qualify for services is emphasized.

An important component of the DSCP is that it requires 30 practicum hours in addition to the 10 hours of in-class training sessions. The practicum hours are completed at regularly scheduled Saturday Developmental Screening Days at CDI’s ELC where each participant is partnered with an experienced developmental screener. Through mentoring, the participants are able to observe, reflect and eventually implement the skills that they learned in the class sessions with supervision.

More specifically, the training consists of seven modules that cover the following topics: Strengthening Families; Parents’ Evaluation of Developmental Status; Ages and Stages-3; Ages and Stages-SE; Modified Checklist for Autism in Toddlers-Revised; Edinburgh Postnatal Depression Scale; and Navigating the Resource and Referral System.

Developmental screening days include a one-hour reflective practice lunch, which is provided by CDI. During the lunch, a facilitator leads a reflective practice session. The reflective practice is a dialogue space to identify feelings and biases, and to reflect on the experience of the day, while getting useful peer feedback. DSCP participants are required to attend two reflective lunches. The first lunch focuses on Taking and Closer Look and Sharing Results. With an emphasis on using parent reported language from the
screening to shape the conversation, this reflection deals with sharing screening results. The second reflective lunch focuses on Incorporating Screening Into Your Practice. Participants brainstorm about ways to bring screening to their current roles professionally, and what it will take to implement a complete screening program (from identification through referral).

**Intended Audience**

To promote professional development and the sustainable screening practices at the ELC, the DSCP is designed to be implemented by CDI staff and is tailored to the specific format of the ELC. That being said, with simple modifications, it would be easy to adapt the DSCP to accommodate the needs of another community-based center, child care center or preschool. Participants in the training could be teachers, students, and community members with at least 12 child development units. While the screening tools used do not require specific educational certifications, many conversations that arise with parents during screenings require an understanding of child development, typical and atypical behavior. Screeners should feel confident in their child development and parenting knowledge.

**DSCP Evaluation**

For the purpose of this project, evaluators were recruited to provide input on the DSCP training (see Appendix A, recruitment materials) by completing an evaluation form, which assists the evaluator in assessing the DSCP training (see Appendix B, evaluation form). The evaluation form was created to gather information on the strengths and areas for improvement of the seven modules of DSCP’s PowerPoint presentation, the format of the certificate program, the accomplishment of program objectives, and open-
ended comments or suggestions. The evaluation form is divided into five sections: evaluator’s background information, strengths and suggestions for improvement regarding the seven modules, strengths and suggestions for improvement about the format of the DCSP, a five level Likert-type scale measuring the achievement of the program objectives, and an additional comments/suggestions area.

**Personal Qualifications**

**Researcher’s Qualifications**

In 2009, the researcher received developmental screening training from CDI and began implementing developmental screenings in community settings through CDI. When the ELC opened, the researcher regularly volunteered at monthly screening days. Eventually, the researcher was hired as the Screening Program Coordinator and was promoted to Screening Program Specialist in 2014. The researcher has administered and overseen over 700 developmental screenings and developed the current system used for tracking screenings, referrals, and follow-up at the ELC.

**Evaluators’ Qualifications**

Seven evaluators were invited to assess the DSCP training. They are professional acquaintances of the researcher. Two of the evaluators are former early childhood educators retired from the Los Angeles Unified School District. Four of the evaluators work in schools at the time of the evaluation: one is a director of administration who is passionate about bringing developmental screening to all preschools and spearheaded the efforts at the preschool where she works; another is an assistant director of a preschool; one is an instructional assistant; and one is a behavior interventionist. The last evaluator is a volunteer developmental screener. All evaluators have a background in early
childhood education and extensive experience with developmental screenings. Some evaluators have training experience.

**Environment and Equipment**

The DSCP is held in three different spaces. First, for the in-class sessions, a room with table space for all participants and a Smart Board with internet connection are necessary. Training materials for the DSCP include the PowerPoint, developmental screening tool materials – some available for free online and some purchased, prepped vignettes for role play activities and relevant handouts. The Smart Board with sound and internet connection is useful for navigating resources online with the participants, for example, downloading the regional center application or using the Ages and Stages online age calculator. Walking through the use of these resources in real time is an effective way of relaying the information. One of the videos in the M-CHAT module requires Internet connection to play. A DVD player is needed for the ASQ-3 and ASQ-SE videos. It is also advantageous to have the interactive use of the Smart Board to “mark up” screening tools and score sheets in view of all of the participants.

The second environment needed for the program is a developmental screening program with mentors. Mentoring is a key facet, and there should be one mentor for every two DSCP participants. The third environment is a calm and quiet space for the lunch reflective practice.
Project Outline

The timeline for this project has been over the span of a few years:

- February – June 2013 – Strategy for increasing ELC capacity for screening discussed; information for program gathered; program created
- June 2013 – DSCP Piloted and Implemented with eight participants
- August 2013 – DSCP revised
- February 2016 – Evaluation form drafted, revised, and finalized
- March 2016 – Evaluation form and program materials sent to evaluators
- April 2016 – Evaluators returned completed evaluation forms
- May 2016 – Data compiled and analyzed
CHAPTER FOUR
CONCLUSION

Summary

The purpose of this thesis project was to create a certificate program to promote in-service training of ECE professionals. The model would support a workforce development in ECE as well as contribute to sustainable screening practices at CDI’s ELC. The training sessions and components are to designed to teach ECE professionals to: administer and score screening tools; share the results of developmental screening tools with families; identify and make referrals to the appropriate agency for children and families that need extra support; implement the practice of routine screening into their personal or professional role; and identify and explain to parents and professionals the importance that developmental screenings play in supporting resiliency in young children. The goal is that teachers and professionals have the confidence to support healthy development, advocate for universal screening, share developmental concerns with families, and know how to support the family through the referral process.

This chapter will review comments from the evaluations and determine the strengths and possible areas for improvements of the DSCP training. Conclusions of the evaluation and recommendations for future work will follow.
Evaluation

The seven evaluators were a convenience sample of early childhood professionals. All have experience implementing developmental screenings. The evaluators were emailed a recruitment letter (Appendix A), the evaluation (Appendix B) and DSCP outline and PowerPoint (Appendix C) and were asked to return it to the completed evaluation to the researcher within two weeks.

The evaluation consists of five parts. The first part is five questions eliciting background information and qualifications of the evaluator. The second part is a table of three columns. The first column is the module name. The second column is to describe program strengths for each module and the third column is to suggest improvements of each module. The third part asks for strengths and improvements on the format of the DSCP including the PowerPoint, Practicum Hours and Reflective Practice. The fourth part is a table with the five program objectives to be rated on a Likert scale. The last part is open space for additional comments/suggestions.

Demographic Information

To gain an understanding of the evaluators’ qualifications, the evaluation included five questions on their background information. Table 4.1 contains the information that the evaluators provided. This includes job title, years in ECE and education level, as shown below. Three evaluators have twenty or more years in early childhood education. Four evaluators have between two to ten years of experience. All evaluators have a BA, MA or Ph.D. with a background in either psychology or early childhood education.
Table 4.1

Demographic Information of Evaluators

<table>
<thead>
<tr>
<th>Evaluator #</th>
<th>Job Title</th>
<th>Years in ECE</th>
<th>Education Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluator 1</td>
<td>Developmental Screener</td>
<td>2 Years</td>
<td>BA in Psychology</td>
</tr>
<tr>
<td>Evaluator 2</td>
<td>Instructional Assistant</td>
<td>2 Years</td>
<td>BA in Psychology and Child and Adolescent Development</td>
</tr>
<tr>
<td>Evaluator 3</td>
<td>Behavioral Therapist</td>
<td>3 Years</td>
<td>MA Educational Psychology/Ed.S. in School Psychology</td>
</tr>
<tr>
<td>Evaluator 4</td>
<td>Director of Administration</td>
<td>21 Years</td>
<td>MA Educational Psychology- Early Childhood Education</td>
</tr>
<tr>
<td>Evaluator 5</td>
<td>Assistant Director</td>
<td>8 Years</td>
<td>BS Human Services Attending MA Educational Psychology- ECE</td>
</tr>
<tr>
<td>Evaluator 6</td>
<td>Retired Child Development Specialist, Early Childhood Special Education Teacher</td>
<td>20+ Years</td>
<td>Teaching Credential, MA and Early Childhood Special Education Credential</td>
</tr>
<tr>
<td>Evaluator 7</td>
<td>Retired Early Childhood Special Education Teacher, MFT License</td>
<td>35+ Years</td>
<td>PhD Psychology, Early Childhood Special Education Credential</td>
</tr>
</tbody>
</table>

Evaluation of DSCP Training and Format

The following summarizes the comments from the evaluators regarding Strengths and Suggestions for Improvement. It is broken down by module and format areas.

**Developmental Screening and Strengthening Families.** The first module introduces the Strengthening Families Protective Factors Framework and the importance of Developmental Screening. It provides the definition of screening, the goals and
implications of universal screening. It also covers the overview of the DSCP and logistics. Most evaluators appreciated putting developmental screening in the context of Strengthening Families to emphasize the benefit to the whole family. They also commented on the emphasis put on the importance of screening early and on a standardized schedule before children enter kindergarten. Two evaluators suggested giving more of an opportunity for reflection about screening and background about why people are joining the DSCP:

Evaluator 4: “Consider having a longer period of time for the reflective portion of the day. Many paraprofessionals have a hard time verbalizing the knowledge in their minds and may be intimidated when speaking to parents. Ensure participants understand goal of screening children”

Evaluator 5: “Provide a list of terms to avoid such as: ‘Normal’ when describing behavior”

Evaluator 7: “More opportunity to share expectations, concerns, fears and experiences in the beginning of the screening program”

Parents’ Evaluation of Developmental Status. All of the participants stated that this module was very clear and concise. The Parent Evaluation of Developmental Status (PEDS) module is 70 minutes long. Participants learn to calculate a child’s exact age, introduce the screening tool to the parent, implement, score and share result. After, participants break into pairs and role play using the tool alternating between being the developmental screener and the parent. Evaluator 4 liked that the training “encouraged parents to answer questions in a transparent manner and that there is no correct answer.”
Suggestions included ensuring a follow up conversation is held if/when no answers are given.

**Ages and Stages Questionnaire- 3.** The general sentiment of the Ages and Stages-3 module was that it was clear and easy to follow. The use of this screening tool is non-threatening. There is clear description of the different domains addressed and how to administer the screening tool with the family. They appreciate the opportunity for hands on experience with the tool.

**Ages and Stages Questionnaire- Social Emotional.** Most evaluators commented that there is “a comprehensive overview of what the ASQ-SE measures” (Evaluator 1). All evaluators agree that the vignettes are valuable practice and helpful in getting familiar with the content of the screening tools.

**Evaluator 1:** “Have a list of general concerns that often come up when using the ASQ-SE.”

**Evaluator 4:** “Suggest that both ASQ-3 and ASQ-SE be administered at the same time.”

**Modified Checklist for Autism in Toddlers- Revised.** Evaluators found that the combination of delivery of the material – lecture, video and discussion – was helpful for different types of learners. The video that explained typically developing children and children exhibiting non-typical behaviors was very helpful for participants that are not as familiar with children on the Autism Spectrum and helps explain the questions in the M-CHAT. Evaluator 2 suggested having a slide on how to introduce the M-CHAT screening to families instead of just having a discussing about it.

**Evaluator 5:** “Devote more time to scoring and interpreting the M-CHAT”
Edinburgh’s Depression Scale. Evaluators recognized the thorough explanation of the need for this screening tool and the explanation of research to back it up. There was a general sense from the evaluators that this tool requires a very experienced screener who is comfortable speaking about depression with mothers. Three evaluators suggested adding vignettes on how to interpret/share unfavorable results to parents.

Evaluator 3: “Make clear what the referral systems look like for this scale”

Evaluator 6: “Give definition of postnatal period”

Sharing Results and Navigating the Referral System. Evaluators noted that there is a lot of important information in this module and four evaluators commented that it prepared the participants with what referrals to give and how to help the family. They appreciated the multiple graphics that show the progression of screening to referral as well as graphics that explain the funding of intervention services. Evaluator 7 recommended a longer training in this area. Evaluators appreciated the emphasis on sharing results professionally and empathetically and being sure to give families referral options rather than tell them what they need to do next. They recognized that this puts the power in the hands of the families.

Evaluator 7: “Being able to communicate with the family to give them clear results and a valuable ‘road map’ to navigate through the referral system is a vital task.”

Evaluator 3: “Discuss reasons why there may be a disagreement between screener and parent”

Format. All of the evaluators said that the PowerPoint was clear and concise. They agreed that the visuals and graphics were helpful and a great reference for after
training is completed. Some said that they were interactive, interesting and important facts and statistics were presented in an engaging manner.

While the PowerPoint received praise, the Practicum Hours and Reflective Practice portions were clearly the favorites. All participants emphasized the importance of getting to practice with an experienced screener and also being able to reflect on both the logistical and emotional processes that arise during screenings. Evaluator 7 wrote, “In doing this work, it is imperative that the screeners reflects on their own experiences through this learning process because the ‘screener’ is an extension of the tool. The less distortion in ones’ self the better one can listen to the family at hand and give more accurate feedback to the family.”

**Program objectives.** To evaluate whether or not the five program objectives were addressed in the DSCP, evaluators rated each objective on a Likert-type scale. Results are presented to follow:

Table 4.2

*Response to Objective 1*

| After completing training participants will be able to administer and score screening tools |
|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| Strongly Disagree | Disagree | Neither agree or disagree | Agree | Strongly Agree |
| 0 | 0 | 0 | 0 | 7 |
Table 4.3

**Response to Objective 2**

After completing training participants will be able to share the results of developmental screening tools with families

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 4.4

**Response to Objective 3**

After completing training participants will be able to identify and make referrals to the appropriate agency for children and families that need extra support

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 4.5

**Response to Objective 4**

After completing training participants will be able to implement the practice of routine screening into their personal or professional role

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
Table 4.6

Response to Objective 5

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree or disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

**Additional Comments and Suggestions.** In this last section, evaluators shared positive sentiment for the content of the training. Some comments included:

**Evaluator 1:** “It serves as a catalyst for changing the lives of children who have developmental delays”

**Evaluator 6:** “This is a very important program that should be taught to all Child Development students as they are usually the first people to come into contact with parents and young children”

**Evaluator 7:** “The Developmental Screening Program is a great asset to the community at large…I also believe that this thesis project serves as a ‘beacon’ to pointing out much needed services in our community and should be the impetus for more research and investigation in this area”
Discussion

Overall, the evaluation of the DSCP was very positive. All evaluators agreed that the information is important and that the DSCP format is a good method of teaching the information. Some general themes emerged in the evaluators’ responses.

Evaluators suggested incorporating more “what-if” situations into the training. Thinking about the sensitive nature of the information being shared with families, many agreed that more specific and targeted practice of difficult situations that may arise during screening with scripted statements about what to say would be beneficial. While this is something that is discussed, there are not handouts for those areas. One evaluator suggested observing each screening tool being used the day they are taught.

Another piece that all evaluators agreed on is that the reflective practice is valuable so that participants can evaluate themselves, understand their biases, and explore responding to families. They acknowledged that personal and childhood experiences can be triggered when talking with families. Making sure that everybody has enough time to process and share their experiences is important. Incorporating more intentional time for reflection will be good. This could be addressed by adding a written reflective piece.

Future Work/Research

In line with conclusions from the study done by Marshall et al. (2015), parents are “accurate identifiers of developmental delays in their children regardless of education, income, or parenting experience” (p. 112) and they need to be heard. This sets the platform for more training in developmental screening and more family-centered services to normalize partnerships with families to the extent that preschool teachers who see
families almost every day, are equipped and confident in listening to a parent’s concerns, screening a child, and referring them appropriately.

Incorporating screening and referral systems trainings, such as the DSCP, as a requirement for college and university child development majors seems to be a very simple way to train ECE professionals. Screening training is cost-effective and efficient especially with reliable standardized screening tools that are available for free online like the PEDS and M-CHAT.

There is a limited amount of research regarding ECE professionals’ perspectives and feelings about screening and sharing developmental and behavioral concerns with families. In order to successfully implement screening universally in early care and education centers, it would be wise to research teachers’ experiences with screening and the potential barriers to implementation. Research would need to look at how many preschools implement routine screening, how developmental concerns are brought up to families, and examine qualitative information regarding teachers’ experiences. After information is gathered and there is an understanding of how teachers could be supported in the classroom with screening and referral, tailoring training programs, like the DSCP, to meet preschool needs will lead to optimal, sustainable screening practices.
REFERENCES


APPENDIX A

Recruitment Letter

Dear Evaluator,

I am so grateful that you have agreed to participate in my graduate thesis project for the Early Childhood Education (ECE) program at California State University Northridge.

The Developmental Screening Certificate Program (DSCP) was created by a team at the Child Development Institute (CDI) to train ECE professionals in developmental screening, and strengthening families through supportive screening and the subsequent referral processes. The program consists of 10-hours of training with practice vignettes and 30 practicum hours implementing screenings at CDI’s Early Learning Center with experienced developmental screeners and participating in reflective supervision. The DSCP consists of seven modules. Each module consists of an outline describing a series of PowerPoint slides, and the slides themselves. The outline provides the presenter with information regarding the activities associated with each set of slides including the nature and duration of activities, as well as the materials required for each activity. Each module is attached to this email as a separate file. I am also attaching a fillable evaluation form for you to use in connection with your review of the program. You can either print out the evaluation form and scan it back to me or you can type directly into the PDF file, save a version, and send it back to me.

Thank you again for participating, it means a great deal to me. Please complete and return the evaluation form by April 13, 2016. If you prefer a paper copy of the materials, let me know and I will gladly drop them off. I look forward to receiving your feedback. Do not hesitate to contact me if you have any questions.

Sincerely,

Allie Baldassari

abaldassari@cdikids.org
APPENDIX B

Background Questionnaire

Name ________________________________

1. Role in education: __________________

2. How many years have you been working in education? ______________

3. Please describe your educational background post-high school. Include the college/university, field of study, and year you completed each degree.

4. What is your professional experience in early childhood education?

5. Please describe your experience with developmental screening and referral.
Evaluator Feedback

After reviewing the Developmental Screening Certificate Program PowerPoint and Module Activities please comment on the strengths and areas for improvement.

<table>
<thead>
<tr>
<th>Module</th>
<th>Strengths</th>
<th>Suggestions for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Screening and Strengthening Families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Evaluation of Developmental Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages and Stages-3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages and Stages- Social Emotional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modified Checklist for Autism in Toddlers- Revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edinburgh’s Depression Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing Results &amp; Navigating the Referral System</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please comment on the format of the Developmental Screening Certificate Program:

<table>
<thead>
<tr>
<th>Format Area</th>
<th>Strengths</th>
<th>Suggestions for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>PowerPoint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practicum Hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflective Practice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. To what extent do you believe the training will prepare participants to:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer and score screening tools</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Share the results of developmental screening tools with families</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Identify and make referrals to the appropriate agency for children and families that need extra support</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Implement the practice of routine screening into their personal or professional role</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Identify and explain to parents and professionals the importance that developmental screenings play in supporting resiliency in young children</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Additional Comments/Suggestions:
## APPENDIX C

### Module 1

**Developmental Screening and Strengthening Families**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Content</th>
<th>Type of Activity</th>
<th>Time</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome and</td>
<td>1. Welcome everyone to the certificate program. The presenter introduces</td>
<td>Group Activity and Lecture</td>
<td>10 mins</td>
<td>Training folders, Agenda</td>
</tr>
<tr>
<td>Introductions</td>
<td>herself.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Ask each participant to introduce themselves, giving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Their name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The capacity in which they work with children and families</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Housekeeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Bathrooms – The bathrooms are located in kitchen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Breaks – There will be scheduled breaks, but if you</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>if you need to get food or go to the bathroom, please feel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>free to get up quietly at any time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Cellphones – please put your phones on vibrate or turn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>them off. If you need to take an emergency call,</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

please step out of the room.

C. Agenda

1. Go over the agenda of the training -
   • Ask for any questions

2. Introduce the parking lot –
   • Instruct the participants that there is a pen and post it notes on their tables and they can put their questions on the parking lot board. We will answer all of the questions in the parking lot – either where they belong in the agenda or at the end of the training.

3. Evaluation –
   • Your feedback is very important to us. We will ask you to fill out an evaluation form at the end of the training.
## II. Overview of DSCLP

<table>
<thead>
<tr>
<th>A. Overview of Developmental Screening Certificate Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Training Objectives</td>
</tr>
<tr>
<td>• Identify and explain to parents and professionals the</td>
</tr>
<tr>
<td>importance of developmental screenings play in</td>
</tr>
<tr>
<td>supporting resiliency in young children</td>
</tr>
<tr>
<td>• Administer and score screening tools</td>
</tr>
<tr>
<td>• Share the results of screenings with families</td>
</tr>
<tr>
<td>• Identify concerns and red flags and make appropriate</td>
</tr>
<tr>
<td>referrals</td>
</tr>
<tr>
<td>• Implement developmental screening into one’s own</td>
</tr>
<tr>
<td>practice</td>
</tr>
<tr>
<td>2. Program Logistics</td>
</tr>
<tr>
<td>• 10 hour training</td>
</tr>
<tr>
<td>• 30 practicum hours:</td>
</tr>
<tr>
<td>a) Two mandatory screening days</td>
</tr>
<tr>
<td>b) Third scheduled screening time with mentor</td>
</tr>
<tr>
<td>• Two hour long reflective practices with lunch on</td>
</tr>
<tr>
<td>screening days</td>
</tr>
<tr>
<td>• Screener Levels I, II, III</td>
</tr>
<tr>
<td>• Mentoring opportunity once Level III Screener</td>
</tr>
</tbody>
</table>

| Lecture | 10 minutes |

## III. Introduction to Developmental Screening

<table>
<thead>
<tr>
<th>A. What is Screening?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Why Screen?</td>
</tr>
<tr>
<td>2. Why use a standardized screening tool?</td>
</tr>
<tr>
<td>3. How screening and referrals can help?</td>
</tr>
<tr>
<td>4. When delays go undetected or untreated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Goals for participation in developmental screenings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All young children receive standardized</td>
</tr>
<tr>
<td>developmental screening according to authoritative</td>
</tr>
<tr>
<td>schedule of preventive care</td>
</tr>
<tr>
<td>2. Parents will receive appropriate information to</td>
</tr>
<tr>
<td>promote their children's development</td>
</tr>
<tr>
<td>3. Children suspected of having or being at risk for a</td>
</tr>
<tr>
<td>developmental delay are referred to appropriate</td>
</tr>
<tr>
<td>agency</td>
</tr>
<tr>
<td>4. No child enters kindergarten with an unrecognized</td>
</tr>
<tr>
<td>or untreated developmental concern</td>
</tr>
</tbody>
</table>

| Lecture | 15 minutes |

## IV. Strengthening Families

<table>
<thead>
<tr>
<th>A. Center for the Study of Social Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strengthening Families (SF) Research</td>
</tr>
<tr>
<td>2. Five Protective Factors</td>
</tr>
<tr>
<td>a. Parental Resilience</td>
</tr>
<tr>
<td>b. Social Connections</td>
</tr>
<tr>
<td>c. Concrete Support in Times of Need</td>
</tr>
<tr>
<td>d. Knowledge of Parenting and Child Development</td>
</tr>
<tr>
<td>e. Social Emotional Competence of the Child</td>
</tr>
<tr>
<td>3. Ask participants to think about what the protective</td>
</tr>
<tr>
<td>factors look like in their lives.</td>
</tr>
<tr>
<td>a. Share with the group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lecture/Discussion</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protective Factors Handout</td>
<td></td>
</tr>
</tbody>
</table>
### Agenda Item

<table>
<thead>
<tr>
<th>Parent Evaluation of Developmental Status: Basic Facts</th>
<th>Content</th>
<th>Type of Activity</th>
<th>Time</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Introducing the screening tool</td>
<td>Lecture</td>
<td>35 minutes</td>
<td></td>
<td>PEDS Response Form, PEDS Score and Interpretation Form</td>
</tr>
<tr>
<td>B. Calculating the child's age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Correcting for prematurity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Filling out the response form</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Scoring and Interpretation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Second Stage Screeners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Referral options</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Vignette</th>
<th>Activity</th>
<th>35 minutes</th>
<th></th>
<th>Age Calculator Worksheet, Sample Response Form, Sample Score and Interpretation Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Split into pairs and role play.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 minutes - one person is parent, one person is screener</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 minutes - switch roles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Module 3

**Ages and Stages-3**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Content</th>
<th>Type of Activity</th>
<th>Time</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Ages and Stages Questionnaire-3</strong>&lt;br&gt;Basic Facts</td>
<td>A. Introducing the screening tool&lt;br&gt;B. Show Ages and Stages Home Visit Video - 20 minutes&lt;br&gt;C. Ages and Stages Online Age Calculator&lt;br&gt;   b) Correcting for prematurity&lt;br&gt;D. Filling out the response form&lt;br&gt;E. Scoring and Interpretation&lt;br&gt;F. Second Stage Screeners&lt;br&gt;G. Referral options</td>
<td>Lecture/Video</td>
<td>30 minutes</td>
<td>• ASQ-3 Blank Response Form&lt;br&gt; • ASQ-3 Score Sheet</td>
</tr>
<tr>
<td><strong>II. Different types of Screening Tools</strong></td>
<td>Break into groups. Discuss the difference between ASQ-3 and PEDS. Brainstorm on flip chart</td>
<td>Discussion</td>
<td>20 minutes</td>
<td></td>
</tr>
</tbody>
</table>

### Module 4

**Ages and Stages-Social Emotional**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Content</th>
<th>Type of Activity</th>
<th>Time</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Ages and Stages Questionnaire- Social Emotional Basic Facts</strong></td>
<td>A. What are social emotional screenings?&lt;br&gt;B. ASQ-SE Basic Facts&lt;br&gt;  7 Key Areas:&lt;br&gt;    a) Self-Regulation&lt;br&gt;    b) Compliance&lt;br&gt;    c) Communication&lt;br&gt;    d) Adaptive Functioning&lt;br&gt;    e) Autonomy&lt;br&gt;    f) Affect&lt;br&gt;    g) Interactions with People&lt;br&gt;C. ASQ-SE in Practice Video&lt;br&gt;D. How do I know what screening tool to use?</td>
<td>Lecture/Video</td>
<td>30 minutes</td>
<td>• ASQ-SE Blank Response Form&lt;br&gt; • ASQ-SE Score Sheet</td>
</tr>
<tr>
<td><strong>II. Practice Vignettes</strong></td>
<td>A. Participants break into pairs&lt;br&gt;B. Pass out Vignettes&lt;br&gt;   i) Calculate ages—</td>
<td>Practice</td>
<td>80 minutes</td>
<td>• Vignette for Renee&lt;br&gt; • Vignette for Claire&lt;br&gt; • Vignette for Sam</td>
</tr>
</tbody>
</table>
### Module 5

**Modified Checklist for Autism- Revised**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Content</th>
<th>Type of Activity</th>
<th>Time</th>
<th>Materials</th>
</tr>
</thead>
</table>
| 1. Modified Checklist for Autism- Revised Basic Facts | A. M-CHAT Basic Facts  
   h) Autism Screening Tool- 20 questions  
   i) Identifies children 16-30 months old  
   j) Written at a 6th Grade Reading Level  
   k) Indicates who should be referred for a more thorough assessment because they are at-risk | Lecture | 30 minutes | • M-CHAT-R Blank Response Form  
   • M-CHAT R/R Packet |
|  | B. Developmental Areas Addressed | | | |
|  | a) Social Play  
   b) Social Interest  
   c) Pretend Play  
   d) Joint Attention  
   e) Pointing  
   f) Use of Expressive and Receptive Language  
   g) Functional Play  
   h) Motor Development  
   i) Rough and Tumble Play  
   j) Sensory Impairment | | | |

---

**Training Curriculum**
Page 19

---

52
## Module 6

### The Edinburgh Postnatal Depression Scale

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Content</th>
<th>Type of Activity</th>
<th>Time</th>
<th>Materials</th>
</tr>
</thead>
</table>
| I. Basic Facts | A. Postpartum Depression  
  a) Affects at least 10% of women  
  b) Many go untreated  
  c) Greatly impacts infant development  
  B. EPDS  
  a) Can be completed in less than 5 minutes  
  b) Designed to assist not replace clinical judgement  
  C. Filling out response form  
  D. Scoring  
  E. Referrals and Resources | Lecture | 20 minutes | • EPDS Info Sheet and Screener Version of Response Form  
• Blank Response Form |

II. Autism

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Signs of Autism</td>
<td><a href="https://www.youtube.com/watch?v=yyhP5AS0Hgu">https://www.youtube.com/watch?v=yyhP5AS0Hgu</a></td>
<td>35 minutes</td>
</tr>
</tbody>
</table>
### II. Supporting the referral process

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>How do we make sure parents get connected?</td>
<td>Discussion</td>
<td>30 minutes</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Difficult conversations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advocate vs. Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Mandated Reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>What to do if?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Observation and results

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>How to introduce a screening to support a child</td>
<td>Lecture/Discussion</td>
<td>30 minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i)</td>
<td>Depends on your setting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii)</td>
<td>Introduce it as a positive event</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>The Whole Picture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Key Areas to Observe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Supporting Parents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>Sharing Results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>Referral Systems</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Module 7**

**Navigating Referrals, Services, and Resources**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Content</th>
<th>Type of Activity</th>
<th>Time</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV. Laws and Regulations</td>
<td>A. IDEA, Part C</td>
<td>Lecture</td>
<td>30 minutes</td>
<td>Service provided for children handout</td>
</tr>
<tr>
<td></td>
<td>B. California Early Intervention Services Act</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Parent and Child Rights</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. Early Intervention Systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Early Intervention Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V. Regional Centers</td>
<td>A. Understanding Eligibility</td>
<td>Lecture</td>
<td>30 minutes</td>
<td>Early Start Application</td>
</tr>
<tr>
<td></td>
<td>- Early Start</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- lanternman Act</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Application Process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Filling out the application</td>
<td></td>
<td></td>
<td>lanternman Application</td>
</tr>
</tbody>
</table>
| VI. School Districts | A. Transitioning from RC to the School District  
B. Requesting an assessment  
a) Early Childhood Special Education Intake  
b) Kindergarten and Older Intake | Lecture/Discussion | 30 minutes | - Sample Assessment Request Letter |
|---------------------|---------------------------------|---------------|------------|----------------------------------|
| VII. Referring to Community Organizations | 1) Know your local resources  
2) Know how to contact  
3) Common challenges with referrals | Lecture/Discussion | 30 minutes | - CC Resource Guide  
- Developmental Info Sheets by Age |
Certificate in Developmental Screening

Developmental Screening and Strengthening Families

Training Objectives

After training you will be able to:

• Identify and explain to parents and professionals the importance and role that developmental screeners play in supporting resiliency in young children.

• Administer and score screeners.

• Share the results of developmental screeners with families using a developmental systems model.

• Identify and make referrals to the appropriate agency for children and families that need extra support or further evaluation.

• Implement the practice of routine screening into your professional role or organization.
Benefits of Screening

- 16% of all children have a delay, disability, or challenge
- Only 20-30% are identified before starting kindergarten

**Significantly Impacts Child**

*When undetected or untreated:*
- Motor, language, cognitive, and social-emotional delays get worse
- Delays in one area can have a negative impact on other domains

**Negative impact on family:**
- Parent’s feeling about their own abilities
- Child-parent relationships

**Significantly Impacts Family**
Risk Factors

Environmental
- Poverty, SES
- Teen Parenting
- Traumatic Event
- Non English Speaking
- Isolated from Network of Support
- Lead or Environmental Toxins

Biological
- Poor Prenatal Care and/or exposure to drugs, alcohol, drugs
- Low Birth-Weight
- Serious Illness
- Vision or Hearing Difficulties
- Feeding or Nutrition Concerns

How Screening and Referrals Can Help

Improve outcomes for children and families by

Decrease severity of delay or disability
Decrease Delinquency

Improve parent-child relationship

Increase H.S. Graduation
Increase Employment

Why Screen?

- Benefits of screening
  - Snapshot of child’s development
  - Promotes parent awareness of development
  - Collaboration
  - Promotion of healthy s/e development
  - Help identify earlier
    - Behavior issues
    - Eating concerns
    - Peer relationships
Definition of Screening

A brief evaluation designed to identify children who should receive a more intensive diagnostic assessment from local Regional Center (RC), early intervention center, or a mental health agency.

Screening is not a diagnosis, it is merely a snapshot of development. Therefore screening can be done by a paraprofessional.

Why Use a Developmental Screener:

- Developmental information useful for childcare programs
- Parent Report
- Identify those who are at risk or who have a delay
- Identify when delays are within normal range or not
Another Use of Screeners:

Monitor children at risk for developmental delay resulting from medical factors such as low birth weight, prematurity, seizures, serious illness or from environmental factors such as poverty, parents with developmental delays, history of abuse and/or neglect in the home, or teenage parents.

Children with Special Needs

- Will a child with special needs really enter your program?
- Facts
  - 16% of all children have a Delay, Disability or Disturbance
  - However, only 20 – 30% are identified before starting school
  - Family frustrations
When undetected or untreated:

- Significant impact on child’s motor, language, cognitive and social/emotional delay
- Delays in one area can have negative impact on other domains
- Negative impact on family
  - Parent’s feelings about own abilities
  - Child – parent relationships

How Screening and Referrals can help

- Help mitigate the severity of a delay or disability
- Greater satisfaction in parent/child relationships
- Improve outcomes for children and families
  - More likely to:
    - Graduate from HS
    - Hold a job independently
    - Avoid delinquency
How Will We Know When We’ve Succeeded?

- **Screening**  All young children receive standardized developmental screening according to an authoritative schedule of preventive care.

- **Education**  All parents of young children receive appropriate information to promote their children’s development.

- **Referral**  All children suspected of having or being at risk for a developmental problem are referred to appropriate service providers in their community.

- **Ready to Learn**  No child enters kindergarten with an unrecognized or untreated developmental problem.

STRENGTHENING FAMILIES

Small but significant changes in programming and staffing of early childhood programs support parents under stress and help to prevent harm to children.
5 Protective Factors

1. Parental Resilience
2. Social Connections
3. Knowledge of Parenting and Child Development
4. Concrete support in Times of Need
5. Social and Emotional Competence in Children

Parental Resilience

- Psychological health; parents feel supported and able to solve problems; can develop trusting relationships with others and reach out for help

- Parents who did not have positive childhood experiences or who are in troubling circumstances need extra support and trustworthy relationships

CENTER FOR THE STUDY OF SOCIAL POLICY
Social Connections

- Relationships with extended family, friends, co-workers, other parents with children of similar ages
- Positive community norms about parenting and families
- Mutual assistance networks: child care, emotional support, concrete help

Knowledge of parenting and child development

- Basic information about how children develop
- Basic techniques of helping children develop, dealing with challenging behaviors
- Alternatives to parenting behaviors experienced as a child
- Help with challenging children
Concrete Support in Times of Need

- Response to a crisis: food, shelter, clothing
- Assistance with daily needs: health care, education, job opportunities
- Services for parents: depression and other mental health issues, domestic violence, substance abuse;
- Specialized services for children

Social Emotional Development

- Connection between normal development and positive parent child interaction
- Appropriate adult response to challenging behaviors, traumatic experiences or when development is not on track
- What classroom learning sends home to families
resources available

- [www.strengtheningfamilies.net](http://www.strengtheningfamilies.net):
tools, presentations, handouts, message boards, training listings, and much, much more

- **Strengthening Families Guidebook (Downloadable):** includes information about the research behind Strengthening Families and exemplary programs, as well as the Self Assessment

- **Self Assessment:** will help you evaluate what you are already doing to build Protective Factors that enhance your program.

Certificate in Developmental Screening

Parents’ Evaluation of Developmental Status

PEDS
Parent Evaluation of Developmental Status (PEDS)

by Frances Page Glascoe
Professor of Pediatrics, Vanderbilt University

PEDS – Basic Facts

• For children 0 – 8 years
• Parent Completed
  – 5 minutes
  – 2 minutes for staff to score
• 10 questions eliciting parent’s concern
• Written at 4<sup>th</sup> – 5<sup>th</sup> grade reading level
• Determines when to refer for evaluation, provide parent support and education, and/or monitor development
How to Administer

PEDS Response Form

Child's Name: ___________________________  Father's Name: ___________________________
Child's Initial: _________________________  Today's Date: ______________________________

1. Please list any concerns about your child's learning, development, and behavior.

2. Do you have any concerns about how your child takes and makes speech sounds?
   Circle one: No  Yes  A little  COMMENT:

3. Do you have any concerns about how your child understands what you say?
   Circle one: No  Yes  A little  COMMENT:

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?
   Circle one: No  Yes  A little  COMMENT:

5. Do you have any concerns about how your child uses his or her arms and legs?
   Circle one: No  Yes  A little  COMMENT:

6. Do you have any concerns about your child's behavior?
   Circle one: No  Yes  A little  COMMENT:

7. Do you have any concerns about how your child gets along with others?
   Circle one: No  Yes  A little  COMMENT:

8. Do you have any concerns about how your child is learning to do things for himself/herself?
   Circle one: No  Yes  A little  COMMENT:

9. Do you have any concerns about how your child is learning preschool or school skills?
   Circle one: No  Yes  A little  COMMENT:

10. Please list any other concerns:

   ___________________________  ___________________________

© 1998 Susan Hage Gallas, Silvertownd Publishing Group, Inc., PO Box 161102, Nashville, TN 37216
Phone: 615-258-0000  Fax: 615-258-5800  Website: www.pedtest.com

Please do not attach materials to this form.
Ask parents whether they would like to:
  complete the **RESPONSE FORM** on their own
  or have someone go through it with them.

If parents only circle answers, such as *yes, no* or *a little*,
and don’t write anything on the form, you cannot be sure of literacy and should re-administer PEDS as an interview
Computing the Child’s Age

Once parents have completed the Response Form, begin the scoring process by computing the Child’s Age.

Correct for prematurity if less than 24 months old

Age Calculation Worksheet

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Month</th>
<th>Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today’s Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child’s Date of Birth</td>
<td>2005</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Child’s Age at Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SCORING: Find Age Column

Find the correct column for the child’s age on the PEDS Score Form

SCORING- Categorize Concerns

- Read through all comments on the Response Form
- Look at the PEDS Brief Guide for examples of how to categorize concerns in the various domains of development
SCORING: Mark the Score Form

- Mark the box to show the kind of concern
- Even if there are several different kinds of issues under the same category, only check the box once (e.g., tantrums, hyperactivity, biting—all just get a single check under behavior)
- When parents circle “a little” to indicate the degree of concern, view this as a “yes”

Scoring: Alert

Parents don’t always answer the question asked so be sure to focus on the categories of concern, not the type of question asked
Scoring: Add your concerns too

- If you have a concern about a child, you can add checks to the boxes
- However, don’t remove or ignore the parents concerns

Scoring: Summary

- Total the number of concerns in the shaded boxes into the large shaded box at the bottom
- Total the number of concerns in the un-shaded boxes into the large un-shaded box at the bottom
Scoring: Finding the Correct Path

- First, follow the directions below the large shaded box.
- If the number is 2 or more, follow Path A
- If the number is 1, follow Path B

**Specific Decisions**

0-3 mos. counseled re: safety

4-5 mos. happy baby, happy mom, gave info on promoting sleep

6-11 mos. no concerns, gave info babyproofing house

12-14 mos. concerns about delayed walking, gave info on wide age range

15-17 mos. no concerns, no poor response to "no". Focus issues of uneasy babyproofing house

18-23 mos. no concerns, no sufficient calories, intake. Growth rate normal

2 yrs. progressing well, no concerns. Same info on tantrums and positive discipline

3 yrs. Sent home with PDJ to return 4/28.

4/28: passed, counseled re: sleep, return

4-6/1 yrs.

4 1/2-6 yrs.

6-7 yrs.

7-8 yrs.
Interpretation Form: Path A

- High Risk path = possible developmental disabilities
  - Refer promptly for evaluations

- Suggests the type of evaluations needed based on the types of concerns

Path B

- Moderate Risk for developmental disabilities
  - PEDS:DM, referral for extended screening

- Provide “watchful waiting”/extra monitoring
Path C

- Low risk of developmental disability but elevated risk of mental health problems, especially in children 4 years and older
- For children under 4, give parents advice and written information, and monitor effectiveness
- If such counseling is not effective, refer for screening (both child and family-focused)
- For children 4 and older, refer for screening (child and family)

Path D

- Path D is rare but is used for parent-provider communication difficulties (e.g., no language in common, teen parent who doesn’t know her child, parents with serious mental health or language problems)
- Refer these children for hands-on screening (e.g., with the PEDS:DM)
Path E

- Path E: Low risk for problems either in development or social-emotional areas
- Offer reassurance unless your clinical judgment suggests a problem

PEDS – Interpretation Form Details

- The Interpretation Form has space on the right to record your decisions, referrals, advise, etc.
Certificate in Developmental Screening

Ages and Stages Questionnaires-3
ASQ-3

by Jane Squires, LaWanda Potter & Diane Bricker
ASQ-3 Basic Facts

- 19 questionnaires
  - Monthly intervals (4, 6, 8, 10, 12….)
- 30 developmental items
  - 10 – 15 minutes to complete
  - 5 minutes to score
- 5 domains
- Written at 4th – 5th grade reading level
- Overall section = parental concerns

ASQ– Basic Facts, continued

- Illustrations provided to assist understanding
- Parents check yes, sometimes, or not yet
- Available in Spanish and French
- Use of questionnaire is flexible
- Completed at home and brought in at designated time or can be done at center
- Summary sheet to keep on file so can give the questionnaire to parents to take home
Video

ASQ 3– Summary Sheet

- Child’s total score and individual item responses are transferred onto the summary sheet.
- The summary sheet also provides you with guidelines for interpretation and a follow up section related to recommendations and referrals.
- The questionnaires are designed so you can keep only the summary sheet and leave the individual items with the family.
Scoring

• Parent’s responses – yes, sometimes, not yet- are converted into points
  • 10, 5, 0
  • Totaled for each area

• 5 areas are then compared to cutoff points that are shown on the Summary Sheets
  • If score falls in shaded portion of the bar graph in any developmental area than refer

Certificate in Developmental Screening

Ages and Stages Questionnaires-
Social Emotional
ASQ-SE
Social Emotional Screening

- Focuses on regulating emotions and managing social interactions
- Early identification reduces risk factors
- Prevention begins with catching at-risk children during the early years
ASQ-SE Basic Facts, continued

- Series of 8 questionnaires that correspond to age intervals from birth to 6 years.
- Length varies depending on age of the child
- Can be used every 3 to 6 months
- 10-15 minutes to complete, 2-3 minutes to score
- Addresses 7 key areas:
  1. Self-Regulation
  2. Compliance
  3. Communication
  4. Adaptive Functioning
  5. Autonomy
  6. Affect
  7. Interactions with People

ASQ-SE Parent Comments

- Questionnaire contains open ended questions that provide space for parent comments.

- Questions are modified to address the developmental concerns associated with that age group indicated in the questionnaire.

- There is not a set scoring system for the parent comments, instead the screening administrator is to use their knowledge of child development to determine if the parent comments are cause for concern.
ASQ-SE Information Summary Sheet

- Each information summary sheet is unique to the child’s age and indicates how to interpret the scores.

- It also provides referral criteria and considerations

- Prior to scoring: Review the parent comments. If a comment is written, determine if the response indicates a behavior that may be of concern
ASQ-SE Scoring

Point System:
- Z next to the checked box = 0 points
- V next to the checked box = 5 points
- X next to the checked box = 10 points
- Checked concern = 5 points

Add Together:
- total points on page 3 = 40
- total points on page 4 = 30
- total points on page 5 = 0
- total points on page 6 = 0
- Child’s total score = 70

<table>
<thead>
<tr>
<th>Questionnaire Interval</th>
<th>Cutoff Score</th>
<th>Child’s ASQ-SE score</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 months</td>
<td>57</td>
<td>70</td>
</tr>
</tbody>
</table>

ASQ-SE Interpretation

If score is above the cutoff, indicating the child has a problem OR near the cutoff indicating the child may have a problem, possible referral decisions include:

1) referral for diagnostic social-emotional or mental health assessment OR
2) provide the parent with information and support and monitor the child using the ASQ:SE

If the score is below the cutoff, indicating the child does not have a problem.

- Recommend continuing to monitor the child over time using the ASQ:SE.
- provide the family with informational and support on any behaviors that are of concern.

- Follow up on any parent concerns indicated in the questions. Provide information or referrals to appropriate agencies.
Vignettes

- Break into pairs
- Calculate the age of the children in the provided vignettes
- Based on parent concerns, decide which screening tool to use
- Score the filled out screening tools
- Discussion

Certificate in Developmental Screening

**Modified Checklist for Autism-Revised**

*M-CHAT-R*
Background

• Autism screening tool (20 Questions)
• Identifies children 16 to 30 months of age
• 6th grade reading level
• Indicates who should be referred for a more thorough assessment for possible early signs of autism spectrum disorder (ASD) or developmental delay.
Developmental Areas Addressed

- Social Play
- Social Interest
- Pretend Play — using objects/toys as though they have other properties or identities
- Joint Attention— sharing of an activity with a partner
- Pointing — To obtain or name an object or to share social experience (joint attention)
- Use of Expressive and Receptive Language
- Functional Play — objects used as intended
- Motor Development
- Rough and Tumble Play
- Sensory Impairment

Scoring

For all items except 2, 5, and 12, the response “NO” indicates ASD risk.

For 2, 5, and 12, the response “YES” indicates risk for ASD.
Scoring

• 0-2

• Low Risk

• If child is younger than 24 months, screen again after second birthday

• No further action required

Scoring

• 3-7

• Administer the Follow-Up to get additional information about at-risk responses.

• If score remains at a 2 or higher, the child has screened positive. Refer for diagnostic evaluation.

• If score is 0-1, child has screened negative. No further action required. Rescreen at future visits.
Scoring

• 8-20

• Bypass the Follow-Up

• Refer for diagnostic evaluation

Understanding the Results

Not all children who fail the checklist will meet criteria for a diagnosis on the autism spectrum.

Children should receive a follow-up if:

They fail a specific number of items
Or
If you or the parent have additional concerns about their development
Follow-up

- Follows a structured questionnaire.
- If after the follow-up, an item is failed, it indicates risk for an ASD.
- Failing the interview does not diagnose ASD; it indicates increased risk.
Signs of Autism

Scoring Practice
Certificate in Developmental Screening

Edinburgh Depression Scale
EDS

The Edinburgh Depression Scale (EDS)
(L. Murray and J. L. Cox 1990)

Also known as The Edinburgh Postnatal Depression Scale (EPDS)
(J L Cox, J M. Holden, R Sagovsky – 1987)
EDS Basic Facts

• 10 item self report measure is designed to screen women for symptoms of emotional distress during pregnancy and the postnatal period.

• Used to screen mothers for postpartum depression

• Previous studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated.

• These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long-term effects on the family.

EDS Basic Facts, continued

• Can be completed in 5 minutes.
• Indicates how the mother has felt during the previous week.
• Will not detect mothers with anxiety, phobias or personality disorder.
• As all screeners a careful clinical assessment should be carried out to confirm the diagnosis.
• The EPDS score is designed to assist, not replace, clinical judgment. Women should be further assessed before deciding on treatment.
EDS Instructions

- The mother is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
- All 10 items must be completed.
- Care should be taken to avoid the possibility of the mother discussing her answers with others.
- The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
- The EPDS may be used at 6-8 weeks to screen postnatal women.

Sample Question

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

I have been able to laugh and see the funny side of things.

0  As much as I always could
1  Not quite so much now
2  Definitely not so much now
3  Not at all
EDS Scoring

- Responses are scored as a 0, 1, 2 or 3

- Certain items are reversed scored
  - Questions 3, 5, 6, 7, 8, 9, 10 (i.e., 3, 2, 1, 0)

- The total score is calculated by adding together scores for each of the 10 items.

- A score of 12+ indicates the likelihood of depression, but not its severity.

EDS Scoring, continued

- A score above 10 requires a repeat of the EDS within 2 weeks.

- Two scores above 12 require further assessment to establish if a clinical disorder is present.

See also range of scores on the EDS.
Range of EDS Scores:

Remember that the EDS scores apply to the *last seven days*. Use the guide below in relation to the most recent EDS.

**Scores**

**0-9**: May indicate the presence of some symptoms of distress that may be short-lived and are not likely to interfere with day to day ability to function at home or at work. If symptoms have persisted more than a week or two further enquiry is warranted as to the cause.

**10-12**: Indicate presence of symptoms of distress that may be discomforting. Repeat the EDS in 1-2 weeks time for women scoring in this range and if the scores increase to above 12 assess further and consider referral to a mental health specialist or general practitioner for review.

**13 +**: Scores above 12 require further evaluation and possible referral to a perinatal mental health specialist. Repeat the EDS at intervals to monitor progress.

Referral/Resources

[Los Angeles Perinatal Mental Health logo]

[www.maternalmentalhealthla.org](http://www.maternalmentalhealthla.org)
Observation and Sharing Results

How to Introduce a Screener
Supporting the Child

• Parent are better prepared for screening results when they understand the purpose for screening upfront
• Introduce screening as a positive event
  – Opportunity to view how children are progressing developmentally and behaviorally
  – Used to support child’s ongoing development
• Skills building now help them later on in life!
The Whole Picture

- Accurate screening takes more than simply looking at numbers.
- Your conversation with the parent and your observations of the child are key to making appropriate recommendations and referrals.

Key Areas to Observe

What is the child doing?

Transitions

Interaction with adults or peer

Regulation

Engagement

Communication

Play
Supporting Parents

At one point or another all parents experience feelings of frustration and powerlessness. These feelings are sometimes intensified by a child's personality and behavior.

Screening supports parent by directly addressing any difficulties child may be experiencing.

Sharing Results

- When children pass (screening indicates no delays)
  - Offer praise and reassurance that learning and development appear to be coming along well
  - Offer support for anything that seems challenging to parent – teachable moments!

- When parent voices concerns up front
  - Reaffirm value of their concerns and how important their careful observation of their child is
Sharing Results

- When a child is **red-flagged** (Screening indicates evidence of delay)
  - Express the observed concern and explain within the context and setting in which it occurs
  - Allow parent to share if they see something different
  - Acknowledge any fears
  - Explain that a further evaluation will not hurt their child, but will identify if child needs extra support in order to be successful in school and beyond.

Referral Systems 0-3 years
Referral Systems - Over 3 years old

Certificate in Developmental Screening

Navigating Referrals, Services, and Resources

CDI Early Learning Center
Laws & Regulations

- IDEA, Part C- Federal
- California Early Intervention Services Act
- Parent and Child’s Rights

Individuals with Disabilities Education Act (IDEA)

(1993)

The purpose of IDEA is to govern early intervention programs for infants and toddlers, aged birth through 3 years.
The California Early Intervention Services Act (CEISA)

(1993)
The purpose of CEISA is to provide a statewide system of coordinated, comprehensive, family-centered, multidisciplinary, interagency programs, responsible for providing appropriate early intervention services and support to eligible infants and birth through 3 years.

Early Intervention Services are mandated by Federal and State Law

- Evaluation of Eligibility
- Service Coordination
- Service Planning
- Family Centered Services
- Services located in inclusive, natural environments
- Collaboration
- No Cost
Navigating the Systems

- Regional Center
- School Districts
- Insurance Companies
- Other Government Agencies

Programs and Services
Early Intervention System of Services

Federal Funding

State Funding

Statewide System

Services to Child & Family

Federal & State Funding

State Funding

Regional Center Funding

Regional Centers

Non-profit corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities.
Understanding Eligibility

• Children Under age 3 (Early Start):
  0-36 months of age
  • 33% delay in 1 developmental area.

Children Over age 3 (Lanterman Act):
  *Must have a qualifying diagnosis*

• Autism, Cerebral Palsy, Intellectual Disability, Epilepsy, Disabling conditions found to be closely related to intellectually disabled or requiring treatment similar
Eligibility Criteria for Early Intervention Services

3 Categories of Eligibility Criteria:
1. Established Risk
2. High-Risk
3. Developmental Delay

Established Risk

Conditions with a known etiology with a high probability of resulting in delayed development

- Down Syndrome
- Metabolic Disorder
- Seizure Disorder
- Other Causes
High Risk

- Combination of 2 or more of following factors:
  - Prematurity <32 weeks
  - Low birthweight < 1500 grams
  - Assisted ventilation for 48 hours or more during first 28 days
  - Small for gestational age below 3rd percentile
  - Asphyxia with APGAR score of 0-5
  - Metabolic, genetic, congenital disorders
  - Prenatal exposure to drugs or teratogens
  - Failure to thrive
  - Hypertonia or hypotonia

Developmental Delay

- Significant difference between current level of functioning and expected level of development for age in one or more developmental areas:
  - Cognitive
  - Physical (motor, vision, hearing)
  - Communication
  - Social-Emotional
  - Adaptive Skills
No Eligibility?

If a child is not found eligible by a program or agency parents can explore service options through their insurance.

Examples of Early Intervention Services
IFSP- Individualized Family Service Plan

- Legal document that specifies:
  - Infant or toddler’s present level of development
  - Family’s concerns, priorities, resources
  - Major outcomes to be expected and criteria, procedures and time lines used to evaluate outcomes
  - Specific Services Awarded- how often, how much, method of delivery, location.
  - Dates for initiation of services
  - Name of agency responsible for providing services

Changes to Funding at 3 Years
Transitioning to Preschool

Regional Center
- Behavior Services
- Adaptive Skills
- Respite Care

School District
- Special Education
- Speech Therapy
- Occupational Therapy
- Adaptive P.E.
Parents have the right to:

- Request a mediation conference and/or due process at any time a regional center proposes or refuses to initiate or change:
  - Identification, evaluation, assessment, placement, provision of services
- Be informed of right to file a complaint
- File a complaint if there has been a violation of any law governing early intervention services
- File a complaint if a due process decision fails to be implemented
Making Referrals

**Regional Center**
- Parent calls, or fills out application online
- Offer to fill out and fax application with a parent same day as screening.

**School District**
- Before kindergarten- Parent calls Early Childhood Special Education Intake
- Kindergarten and after- Parent submits assessment request letter to home school

**Pediatrician**
- Give parent sample pediatrician letter
- Discuss what concerns parent should share with Dr.

**Other Referrals**
- View handout of other referral options

Screening to Referral Flow Chart

1. **Screening Initiated**

2. **REFERRAL**
   - **(0-3 years old)** Regional Center for Early Start Services
   - **(over 3 years old)** Refer to School District and Regional Center
   - (If Autism, mental retardation, cerebral palsy, seizure disorder is suspected)

3. **EVALUATION**

4. **DIAGNOSIS & SERVICES**
   - Preschool
   - Child Care
   - Head Start
   - Physicians
   - Health Clinic

**Concerns**

**No Concerns Offer Developmental Support**

**NO ELIGIBILITY OR DIAGNOSIS**
Communicating with Service Providers

Common Challenges with Referrals

Barriers to coordinating an effective support system

- Lack of awareness
- Lag time
- Lack of access to services and programs
- Lack of cultural competence
- Insufficient communication
- Movement of children between placements
- Accessing transportation to services
- Being waitlisted for various services
Tips for Developing an Effective System of Care

- Actively increasing knowledge of the different sectors and building relationships within those sectors including the providers working with your child.
- Learn how to observe and assess/screen and communicate concerns to other professionals.
- Make recommendations and referrals based on your knowledge, experience, and coordination with other service providers.
- Facilitate consistent communication between the parent/caregivers and the professionals providing services to the children.