Child Outreach
Screening Guidelines

Best Practice Guidelines | 2009

for the implementation of culturally competent, high quality screening programs for children age three to five years

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Foreword

Approximately 10% of all children born each year have developmental disabilities or live in environments that place them at-risk for disabilities. The percentage of children between the ages of three and five receiving intervention services is, however, significantly less than 10%. It has been clearly demonstrated that children with developmental delays who receive early identification and intervention services require less intensive services when they are older. Early identification not only effectively promotes positive outcomes for young children and their families, but has substantial cost benefits to our educational systems and to society.

History

Major strides in the provision of special education services to preschool age children with disabilities were first made with the passage of the Education for All Handicapped Children Act of 1975 (P.L. 94-142) and its amendments. **The Individuals with Disabilities Education Act (IDEA)** was subsequently passed in 1991 and represents the most comprehensive public legislation ever passed affecting very young children with disabilities. This law mandates that states "develop and implement a statewide, comprehensive, coordinated, multi-disciplinary, interagency program of early intervention services for all infants, toddlers and preschoolers with disabilities" (Individuals with Disabilities Act Amendments of 1991, Part B and 619).

In 1997, Section 619 of Part B of IDEA authorized grants to all states for special education services for children ages 3 through 5 with disabilities and for the continuity of services for children moving out of Part C, Early Intervention (birth to age 3). This provided incentives for states to locate and serve young children with disabilities, thereby renewing the focus and strengthening the responsibility of existing Child Find preschool screening programs, first mandated in 1975. States were required to not only identify children with conditions such as cerebral palsy and Down syndrome which are known to be associated with developmental delays, but also to provide screening of children aged 3 through 5 who may be at-risk for developmental delays in one or more of the five domains addressed by the law (Communication, Cognition, Social-Emotional, Motor and Adaptive Functioning).

In June 2002, in compliance with the federal monitoring process through the US Department of Education's Office of Special Education Programs (OSEP), **The Rhode Island State Improvement Plan – Continuous Improvement Monitoring Process (CIMP)** was developed. This unified Part C/Part B birth to age 21 systems change plan was developed as a vehicle to measure compliance with the Individuals with Disabilities Act (IDEA). CIMP was organized around seven key areas, one of which was Comprehensive Public Awareness and the Child Find System. This key area was developed to address the requirements of IDEA and statewide needs pertaining to early identification and intervention of young children.

Establishing Best Practices Guidelines

As part of the Rhode Island State Improvement Plan – Continuous Improvement Monitoring Process (CIMP), the Department of Education designated qualified staff and resources to lead, support, and oversee a revision of the Child Outreach (formerly Child Find) System. The Child Outreach Network, comprised of Child Outreach and Early Childhood Coordinators in Rhode Island, was subsequently organized in March 2004. The Network, facilitated by state level leadership, has met on a monthly basis since that time. The initial goal was to clarify requirements and establish a system of guidelines, procedures, and accountability for the implementation of culturally competent, high quality screening programs for children aged three through five. The following objectives were established:

Develop guidelines regarding the implementation of Child Outreach Programs, including: purpose and content areas of screening, screening availability, personnel, procedures and protocols for screening, rescreening and referral, and recommendations for psychometrically sound and culturally sensitive screening instruments.

Disseminate approved guidelines to all Child Outreach and Early Childhood Coordinators in Rhode Island. Disseminate an executive summary to all district Special Education Directors and Superintendents.

Establish a system of accountability in which the numbers of children screened and referred for Special Education evaluations for each age group are reported annually and compared to live birth data for the district. Develop benchmarks for increased numbers of children and families participating in the program each year.

Enhance prevention and intervention strategies prior to referral for special education services, particularly in the area of social/emotional development, through professional development focusing on partnerships with families, interagency collaboration and best practice guidance.

Build district capacity for outreach and marketing to health care providers, teen-age parents, culturally and linguistically diverse populations, licensed family child care homes and other "difficult to access" populations, including families of 3-year old children.

Design and implement a seamless Birth-Five Tracking System as part of a revised interagency agreement with the Early Intervention Program.

Provide training and technical assistance as necessary to support local school districts in implementing Child Outreach standards in accordance with best practice guidelines, improving outreach and collaboration efforts, and accountability systems.

The following document addresses these objectives and establishes best practice guidelines for the implementation of culturally competent, high quality screening programs for children aged three to five in Rhode Island. It is intended for use by all Child Outreach Coordinators to ensure consistency across districts. The Rhode Island State Special Education Regulations (2008) require that districts follow the Best Practice Guidelines set forward in this document.

Part I.
General Screening Guidelines

Purpose of the Screening Program

"A primary rationale for screening is prevention — to help children who need services gain access to them at a very early age in order to prevent the occurrence of more severe problems later" (Meisels and Burnett, 2005).

"Screening is a brief, relatively inexpensive, standardized procedure designed to quickly appraise a large number of children to find out which ones should be referred for further assessment" (McAfee, Leong, Bodrova, 2004).

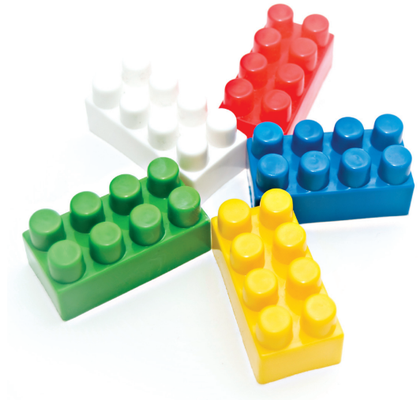
The purpose of the Child Outreach Screening Program is **twofold**:

1 Child Outreach is a universal developmental screening system designed to screen **all** children, aged three to five years old. Screening serves as a **first step** in the identification of children who might have special needs or be at risk for a learning problem and who could benefit from intervention. A system for identifying children with disabilities is a required component under IDEA and the Rhode Island Special Education Regulations.

2 Child Outreach serves as a resource to families. Information about general child development, and specifically, the development of their child, is provided. Child Outreach provides families with information regarding referrals to agencies and programs within their community as well as opportunities for family involvement in their child's development and education.

Screening should always take place within the context of a program of authentic assessment, evaluation and intervention. When a school system establishes a screening program, it commits itself to a process that can lead to the early identification of children with special needs. Public schools are legally responsible for providing follow-up evaluation and intervention services for those children who are identified in this process.

Screening test results can help to organize information about a child and serve as a means for assisting families in assessing community resources. Screening results are often the **first** step in identifying children who may be in need of further evaluation. Results of screening should not be used to label a child, even as "at risk." They must not be used to place or deny a child's entrance into a school or program or infer a child's "readiness" for a program. In addition, results alone should not be used in isolation to group children for educational purposes.



Content Areas of Screening

Screening must be conducted in each of the following areas:

- Vision
- Hearing
- Speech/Language Skills
- Social/Emotional Development
- General Development including, but not limited to, gross and fine motor skills, language and cognition

Family involvement provides a critical component of the screening process. The Family Questionnaire provides information regarding the child's medical/health status and history, language dominance, developmental milestones, current skill development as well as any areas of concern. Information regarding the child's racial background or ethnicity does not need to be obtained. Procedural safeguards regarding Due Process do not need to be provided to families during the Child Outreach process.

Developmental screening, as conducted through Child Outreach, must not be confused with Early Literacy Screening or Readiness testing. These are different assessments used for different purposes. Developmental screening samples developmental tasks in a wide range of areas. It is designed to determine whether a child **may** experience a challenge that will interfere with the acquisition of knowledge or skills. Developmental screening tests focus on a child's **ability to acquire skills**. In general, Early Literacy Screening and Readiness testing seek to find out what early literacy skills and specific academic readiness skills the child **has already acquired**.

Personnel

Each Child Outreach Program requires a designated Child Outreach Coordinator and a team of Child Outreach Screeners, which may or may not include a Head Screener.

Child Outreach Coordinator

The Child Outreach Coordinator should be a licensed/certified special education professional such as a special education teacher, speech/language therapist, psychologist, or social worker with a background in early childhood education.

The Child Outreach Coordinator or Head Screener (as designated by the Child Outreach Coordinator) must be present during screening sessions. The Child Outreach Coordinator or Head Screener is a person who is able to administer screening in all content areas and handle difficult screening situations. In addition, this person must be readily available to families during the screening process and possess the knowledge and skills necessary to discuss the following topics with them:

- The special education referral and evaluation process
- Resources and programs in the community
- Child development in general
- Their child's development, in particular
- Opportunities for family involvement

Screeners

Child Outreach Screeners should have knowledge, acquired through in-service preparation, of general child development and skills in working with young children. Training in the specific screening tests they are to administer must be formal and comprehensive. Periodic observations of the screeners are to be made by the Child Outreach Coordinator to ensure that screening test protocols and guidelines for appropriate interaction with young children and families are followed.

Child Outreach Programs should have screeners available who represent the cultural make-up of the community (primary culture groups) and are able to communicate in the primary language of the child and family.

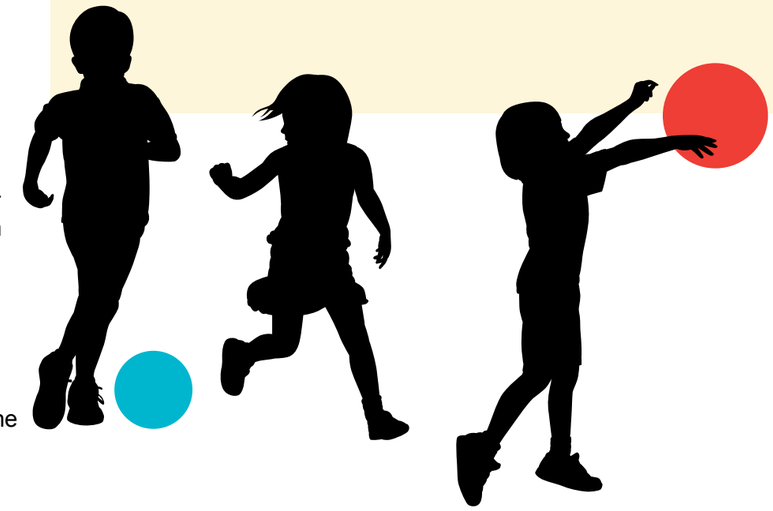
Screening Availability

Screening will be provided on an ongoing basis from, at least, September through June. Children are to be screened in their dominant language. Screening instruments used in multicultural, multilingual communities must be sensitive to cultural and linguistic differences. Resources are available to Child Outreach Coordinators so that the services of bilingual screeners or trained interpreters can be procured.

Screenings may be accessed in the following ways:

Direct Requests: Questions or concerns expressed by a family, physician or staff in an Early Care and Education Program will be addressed promptly by the Child Outreach Coordinator or Evaluation Team liaison; a screening or referral will be made within **ten** (10) school days of the communication with the family, physician or child care provider. If screening is requested and there are no concerns expressed, screening will take place within **thirty** (30) calendar days.

On-site Screening: Screening will be made available in all Early Care and Education Centers, private pre-schools, center-based child care centers, Head Start Programs, public pre-school classrooms, ELL classrooms, Early Childhood COZs, licensed family child care homes, and neighborhood sites which are convenient and familiar to diverse (culturally, linguistically, low-resourced, hard-to-access) populations within the community. When the on-site facility is inadequate for screening, appointments should be scheduled for families to participate at another site or screening should be conducted on a smaller scale (ex. one or two screeners). For sites that decline on-site screening, it is the responsibility of the Child Outreach Coordinator to work with that site to ensure that those children have every opportunity to participate in screening at another site.

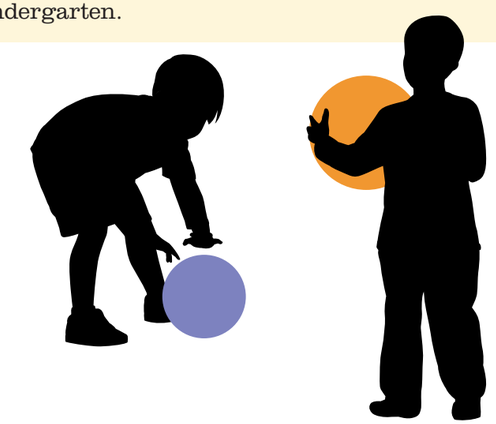


Community-wide Screenings: Large scale screenings occurring in the community (ex. libraries, churches, recreation centers, Public Health Centers, etc.), should be conducted in fall and spring.

Community Support: Child Outreach Programs should make every effort to collaborate with Head Start Programs and any Early Care and Education Programs where children are placed by a state social service agency to assist them in meeting their screening requirements. Children enrolled in these programs will be screened within **45 days of entry**.

District Cooperation: For children who are residents in one district, but attend an Early Care and Education Program in another district, the child's district of residence is responsible for providing screening services. This does not preclude districts working cooperatively to provide screening services for children who reside and attend school in different communities. However, communication between Child Outreach Coordinators is critical, both prior to, and following screening.

Kindergarten: All children enrolled in Kindergarten for the first time will participate in developmental screening for disabilities. Child Outreach Programs may be utilized to provide this developmental screening. Screening results obtained within one calendar year prior to kindergarten entry or within 45 days after a child's entrance into the school department will be made available to appropriate school personnel. Since the Rules and Regulations for School Health Programs require that Kindergarteners participate in vision, hearing, and speech/language screenings administered by medical or appropriate school department personnel (e.g. Doctor, School Nurse-Teacher, Speech/language Pathologist, etc.), it is not necessary for Child Outreach Programs to screen vision, hearing and speech/language skills of children after they have entered Kindergarten. It is also not necessary to obtain parental permission for screening after children have entered Kindergarten.



Criteria for Rescreening and Referrals to the Evaluation Team

Rescreening involves taking a second look at the child in order to clarify questions raised during the initial screening process. Early childhood screening is designed to categorize children into two groups: those who are considered to be functioning within an age-appropriate range of development and those who require referral for diagnostic assessment. There are children, however, who cannot be categorized into either of these two groups on the basis of the initial screening process. Therefore, Child Outreach Programs should have systematic follow-up procedures in place for all children. These procedures are an important component of a well-structured system that provides for the learning needs of all children.

When to Rescreen: Cut-off Scores and Sub-tests

Although the large majority of children will obtain results within an age-appropriate range in all areas, approximately one-third of children screened will require additional consideration in one or more areas. Once cut-off scores have been determined, decisions should be made regarding the use of sub-test scores versus total scores. In the event that, only total scores are considered as the criteria for rescreening, a large number of children who may have significant needs in just one developmental domain may potentially be overlooked. When a child performs poorly in any one skill area of development (for example, in the gross motor area, or on most items that involve verbal presentation, etc.), but the total score is still within an age-appropriate range, rescreening should be conducted in that specific area. In cases where concerns still emerge after the child has been rescreened, results should be discussed with the family. If agreement is reached, a referral for evaluation should be made to the Evaluation Team. Families should always be informed participants and joint decision makers in each step of the process.

When to Rescreen: Above Cut-off Scores

Another reason for rescreening is that a child "just passes" or scores just above the cut-off score designated to be within

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an age-appropriate range. A child who performs in this way might be displaying nonspecific, mild delays across one or more areas and should be rescreened. In situations where the second set of screening results corresponds to the initial screening results, and the child attends an Early Care and Education Program, an individualized, modified classroom program to address the area(s) of concern may be initiated. Parents, the classroom teacher and the Child Outreach Coordinator should be directly involved in this decision. For example, a child who does not do well on the fine motor tasks might be given more experience both at home and at school with fine motor and visual motor activities. Monitoring the child's progress is critical. When after 3 to 4 months of individualized programming, close observation, careful monitoring of progress, rescreening and/or classroom assessment, it is suspected that the child is not developing in a typical manner, an immediate referral for diagnostic assessment should be made.

When to Rescreen: Other Factors
In addition to specific questions raised regarding a child's status in specific areas of development, there are several other factors that may contribute to the need for a child to be rescreened. The location where screening occurred may have been noisy or disruptive. The child may have been ill, feeling sleepy, "shy" around unfamiliar adults, or simply having an "off-day."

A child should also be rescreened if the Family Questionnaire indicates a problem that was not identified during screening. The use of clinical judgment must not be excluded. There may be children who obtain age-appropriate results on the screening, but for whom there are lingering concerns related to the quality of their performance, observations regarding their social/emotional skills and/or input from the family or teacher. For example, input from the family or teacher might indicate that a child has difficulty answering questions, frequently talks off-topic and "mixes up" words (ie. "snowmower" for snow blower). These are characteristics of a language disorder that might not be detected during a screening. These children should not be overlooked for a referral for a diagnostic evaluation.

Rescreening Protocol

Due to the variability in behavior of young children, it is always in the child's best interest to have the rescreening administered by a different screener. In most cases, rescreening should take place within three weeks of the initial screening. While there may be some concern regarding a child's "remembering" the tasks presented during the initial screening, a far greater problem exists when a child who is eligible for services does not receive them in a timely manner because of a lengthy screening/rescreening process prior to the submission of a referral.

Referral

Children who present with obvious or significant delays or conditions need not be screened at all and should instead, with parental consent, be referred for diagnostic evaluation. Similarly, there are some children who will bypass rescreening and be referred directly to the Evaluation Team when screening results indicate that their level of functioning is clearly not within an age-appropriate range. Frequently, these are the children whose score is two standard deviations below the norm for their age and whose family confirms that the child's performance during screening represents their typical or usual patterns. In accordance with Rhode Island Special Education Regulations, a direct referral for a Special Education Evaluation may be made at any time by a parent, teacher, or other individual, such as a pediatrician or mental health professional. Participation in a developmental screening program does not preclude children from being referred directly for an evaluation, nor is it to be used as prerequisite for diagnostic evaluation.

Child Outreach Records

Information collected through the Child Outreach process must be held in strictest confidence. Screening packets, which generally include a signed parent consent form, a completed parent questionnaire, an Outreach Screening Summary Form (See Child Outreach Screening Manual), and scored test protocols in the following areas: vision, hearing, speech/language, general development and social/emotional skills, are stored in locked files at a central site.

Child Outreach results can be shared with public school professional personnel directly involved with the child's educational program. The Outreach Screening Summary Form can be part of the child's cumulative folder and can travel from teacher to teacher. The entire screening packet containing protocols, however, should remain in the central site under the responsibility of the Child Outreach Coordinator. Child Outreach records should be kept until the child is in third grade or until such a time where there are other evaluations which supersede the screening results (e.g. if the child is evaluated for special education services). In the event that a child lives in a district other than the district where screening was conducted, screening results, including test protocols, should be shared with the Child Outreach Coordinator from the district of residence.

Families are encouraged to provide written permission on the consent form to share Child Outreach results with their child's pediatrician and/or Early Care and Education Program. If written permission has been obtained, Child Outreach Coordinators are required to forward a copy of the Child Outreach Screening Summary Form to their child's pediatrician and Early Care and Education Program, if applicable.

Data Collection and Tracking System

An established accountability system must be implemented by each school district. Such a system of data collection is best accomplished with an electronic tracking system, whereby the following information is entered on a continuous basis:

- child's name
- date of birth
- resident or non-resident
- age at the time of screening
- screening results in each area
- rescreening results (if applicable)
- follow-up provided

Child Outreach Coordinators are responsible for ensuring that a system for collecting data and tracking is implemented so that accurate numbers can be reported in the annual Consolidated Resource Plan. The number of children screened is to be reported and compared to live birth data for the district. Annual statewide reports will include the percentage of resident children screened at ages 3, 4, and 5. The following Child Outreach data is required:

- Number of 3, 4,and 5 year old resident children screened in the district
- Number of 3, 4,and 5 year old resident children screened elsewhere
- Number of 3, 4,and 5 year old resident children whose parent(s) refused screening
- Number of 3, 4,and 5 year old resident children referred for special education evaluations based on Child Outreach screening results
- Number of 3, 4,and 5 year old non-resident children screened
- Number of 3, 4,and 5 year old non-resident children referred to their district of residence for evaluation based on Child Outreach screening results

In addition, Child Outreach Coordinators must provide a description of their district's Child Outreach system. Components of this description include screening targets and goals for the current and upcoming year, screening schedules, availability, sites, personnel, training procedures, screening instruments utilized, and referral procedures. The Preschool Section of the annual Consolidated Resource Plan submission is reviewed by the Rhode Island Department of Education to verify the status of the district's Child Outreach Program, as reported above.

Communicating with Families

For many families, Child Outreach Screening is their introduction to the public school system. The climate created during screening is critical, not only to the immediate success of the Child Outreach experience, but also to the establishment of a cooperative relationship where families and schools are genuine partners in a child's development and education. Child Outreach Programs should be characterized by enjoyment of children, respect for families, professionalism, and a calm, organized approach to implementing all aspects of the screening process.

Child Outreach Programs communicate with families throughout the process, even if they are not present during the screening itself. Both families and Child Outreach staff provide sources of information needed in the screening process. The effectiveness of this exchange of information depends on the type of information shared, the manner in which it is exchanged, and how it is used to support the expressed needs of families and children. The ease, accuracy, sensitivity, and courtesy with which Child Outreach staff communicates with families leave a lasting impression. Typically, **five types** of information are exchanged with families:

1. Information about the Screening Process Itself

Prior to screening, parents should be informed about:

- the purpose of screening
- what areas will be screened (including an explanation of the meaning of each of the named areas and the kinds of activities involved in each area)
- who will conduct the screening
- where and how it will take place
- how confidentiality will be respected
- how results will be communicated
- what will happen after screening

From the beginning, families should have the name and contact information of one person they can call if they have additional questions or comments about the screening process or their child, in particular. A sample of a pamphlet which meets all of these criteria is included in the Child Outreach Manual.

2. Information from Families

Families are a primary source of information about their child's development in all areas. By completing the Family Questionnaire and the Social/Emotional Screening instrument, they provide Child Outreach Programs with an invaluable resource. Information obtained from families often:

- provides a perspective of the child from a natural context, over time, in a variety of settings
- helps to qualify the brief sampling of their child's performance collected during screening
- contributes contextual information about family culture, child-rearing practices, and their child's habits and experiential background
- highlights concerns about their child's development

Child Outreach Programs should respond to any concerns that are expressed about a child on either of these questionnaires, regardless of whether or not these concerns are confirmed during screening. By discussing areas of concern, programs can provide the guidance, support and/or reassurance families may need. For example, the family may be concerned that their child writes his/her name backwards or has temper tantrums at bedtime. Child Outreach staff can provide verbal information about general child development, materials or suggestions regarding strategies to address the specific issues expressed. Child Outreach staff can also provide information or referrals to other community resources and/or programs.

3. Information about Child Development

Child Outreach staff provides families with objective information about the wide range of age-appropriate expectations for their child's age and educational experience. Screening results should be communicated promptly (within two weeks). In general, providing verbal results immediately following screening is not recommended. Results need to be collected, reviewed in greater detail, and integrated prior to communicating with families. Only after information about all developmental domains from multiple sources is reviewed and interpreted, can valid hypotheses be made about possible areas of concern. The only exception to this recommendation is in the case of vision or hearing screening where a family indicates concern about this area and mentions that they already have an appointment with a medical professional to address their concerns. In this case, it is appropriate for the Child Outreach Coordinator or Head Screener to share the results verbally, and make a copy of the results for the parent to bring to the appointment.

When a child appears to be developing typically in all areas, results are reported by mail with an invitation to contact the Child Outreach Coordinator should the family wish to have the results explained in greater detail. In the event that a child needs to be rescreened, it is also appropriate to communicate this option via mail, however, the communication should emphasize that screening yields only tentative results following a brief encounter with their child and could be affected by a variety of factors, including illness, fatigue, or just "an off day." It is extremely important that parents do not view this communication as a report card and that their child has "passed" or "failed." Letters explaining the results of screening should indicate if the results in each area are "within age-appropriate expectations", or whether "rescreen/follow-up" is warranted. Forms for reporting screening results are included in the Child Outreach Manual. When communicating with families either verbally or in writing the following should be **avoided**:

- Any emotionally-charged words such as Fail, Weakness, Very low scores, Poor results, Normal/Not Normal, Problem, etc. (some professionals object to the terms, average/below average as well)
- Any reference to percentile scores or explanation of what numerical scores mean (ex. scores of 17 or higher are considered to be within "acceptable limits.")
- Any reference to possible diagnosis or reason for needed rescreen or follow-up (ex. fluid in the middle ear, child not feeling good about himself, etc.).
- Any reference to Child Outreach results being used to refer the child to a specific program (ex. ELL Kindergarten) or to a team to determine if preschool programs will be offered (no mention of family involvement)

4. Information about Available Resources

Child Outreach staff offer resource information about general child development and ways in which families can enhance their child's growth and development in the years before school. High quality Child Outreach Programs have a multitude of resources on hand to share with families. While some families may identify specific concerns or needs, other families are identified as possibly needing additional resources based on the screening results. In both cases, conversations should take place prior to sending any information to the family. Information about a variety of resources ranging from names of area Early Care and Education Centers and community recreation programs, to hand-outs regarding otitis media, strategies to foster development in specific domains such as fine motor skills or early literacy development, etc. should be readily available to families. In the event that a recommendation is made for a formal program (e.g. Parents as Teachers Program, Head Start, etc.), Child Outreach Coordinators frequently assist families in accessing those services. Resource information should be useful and respectful of the varying structures, culture, resources and needs of individual families.

5. Information about Special Education Services

For children who may be eligible for special education services, the Child Outreach Coordinator should facilitate the families' access to evaluation services based on discussions with the family about their child's development. In situations where screening or rescreening results trigger the need for a referral for special education evaluation, the family should be contacted personally to arrange a face-to-face meeting, or by telephone if a meeting cannot be scheduled. During this conversation, it is important to indicate what the child is doing well in addition to communicating the aspects of screening that remain of question or concern. Families should be reminded that a screening test is not diagnostic. The purpose of screening is to indicate if further evaluation may be needed. It is important to listen carefully to what the family has to say and to work with them as a team to determine what is best for their child. When the Child Outreach Coordinator is going to make a referral for further resources or evaluation, written material regarding next steps should be provided to families. A sample is provided in the Child Outreach Manual.

In some districts, the Child Outreach Coordinator presents the referral at the Evaluation Team Meeting. This practice, whereby the Child Outreach Coordinator is a member of the Evaluation Team, serves two primary purposes: to provide support to the family as they enter into the evaluation process and to provide clarification regarding any aspects of the screening questioned by the Evaluation Team. In addition, families frequently have questions after the meeting with which the Child Outreach Coordinator can assist. In other districts, the Child Outreach Coordinator's role and responsibilities end with the submission of the referral for evaluation. In the latter case, the Child Outreach Coordinator can continue to be supportive to the family by being available to them, not only after the Evaluation Team Meeting, but when needed throughout the evaluation process. It is always good practice for Coordinators to obtain feedback regarding the results of the evaluation to assist in evaluating the efficacy of the Child Outreach Program.

Community Outreach

Rhode Island has the goal of screening 100% of its 3, 4 and 5 year old children though Child Outreach. Districts report annually the percentage of children screened in each age group. As part of the Child Outreach System, districts are required to set screening targets or goals that address the percentage of the population screened for the year and to establish target percentages at each age level for the following year. Districts are also required to describe the plan that will be implemented to achieve these goals. Districts failing to demonstrate growth in achieving screening targets are assisted in developing viable improvement plans.

The responsibility of building capacity for marketing, outreach and collaboration must be addressed at both the state and school district levels. In an effort to locate and make all families aware of the purpose and availability of screening services, we must broaden our efforts to include teenage parents, culturally and linguistically diverse populations, licensed family child care homes and other populations presenting access challenges, especially families with need-related indicators such as poverty, illiteracy, high degrees of stress, etc. In addition to traditional Child Outreach activities which include sibling searches, newspaper and media publicity, posters and leaflets, districts should make every effort to enlist the cooperation and systemize collaborations with community programs/ agencies and health care professionals serving families of young children. The development of specific strategies and resources designed to build opportunities for collaboration and outreach to the community will require sustained state and district level commitment.

Part II.
Recommended Screening Procedures and Instruments

Vision

Young children learn a great deal about their world through their eyes. In normal circumstances, 80% of what is learned is through our visual sense. Vision disorders are one of the most prevalent health problems children have, and in preschoolers, the majority go undetected. One in twenty preschoolers is affected by vision problems. Without good vision, children lose a critical pathway for learning about their world.

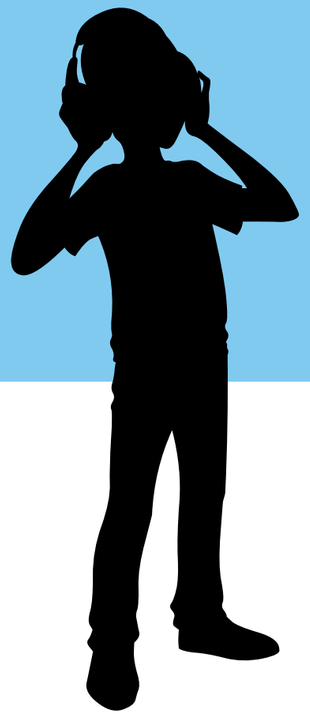
It is often difficult for a parent to know if their child has difficulty seeing. Most young children don't complain about their eyesight. Children typically believe that the way they see is the way everyone sees, even if their vision is doubled, blurred or normal in just one eye. Most eye problems can be corrected if they are detected and treated early. Some eye problems, however, if left untreated for even a short period of time, can lead to permanent blindness. For example, 4 out of 100 children have a lazy eye (amblyopia). If left undetected and untreated, permanent, preventable vision loss could result.

For these reasons, the American Academies of Pediatrics, Family Practice, Opthamology and Optometry all advocate preschool vision screening; especially a key check of children aged three to four. By helping families meet this recommendation for early, appropriate vision screening at no cost, Child Outreach Programs can help to prevent learning, personality and school adjustment problems that could result from untreated eye disorders. Early detection reduces treatment needs and improves outcomes.

At the present time, Child Outreach Programs in the state of Rhode Island have two options for vision screening:

1. to access the services of Saving Sight Rhode Island, an organization which provides free vision screening for children using the **Suresight Vision Screener**
2. to conduct vision screening through the traditional method, using a **visual acuity chart** and two trained screeners employed by the district's Child Outreach Program.

Additionally, input from the Family Questionnaire provides essential information regarding vision history and symptomology. The Child Outreach Screening Manual includes a detailed description of vision screening instruments, administration procedures, suggested follow up as well as samples of vision checklists and forms for reporting vision results to families.



Hearing

During the early years, when foundational language learning is occurring, it is critical to identify any kind of hearing loss in children. A small hearing loss, even in one ear, is significant due to the adverse impact that hearing loss has on communication skills, learning abilities, psychosocial development and academic achievement. Children who are hard of hearing have much more difficulty learning vocabulary, grammar, word order, idiomatic expressions, and other aspects of verbal communication, than their hearing peers.

The rationale for providing a high quality hearing screening program, which includes continuous, periodic monitoring of hearing status for some children, is also supported by the following information:

- It is estimated that 1 to 6 children per 1000 are born with congenital hearing loss. While most of these children have hearing impairment at birth which can potentially be identified during infant hearing screening, some congenital hearing loss may not be evident until later in childhood (Task Force on Newborn and Infant Hearing, 1999).

- Approximately 14.9% of U.S. children have low-frequency or high-frequency hearing loss of at least 16-dB hearing level in one or both ears (Niskar, A.S., et al, 1998).

- Otitis media, an inflammation of the middle ear behind the eardrum, is one of the most common illnesses of early childhood. Acute otitis media involves an infection of the middle ear. The fluid, however, may remain even after the infection is gone. Otitis media with effusion, also called middle ear fluid, is fluid that is not infected. Because fluid in the middle ear prevents the ear from conducting sound properly, it can interfere with normal hearing. The degree of hearing loss caused by otitis media is usually mild to moderate. Children with even a mild loss will not hear 25-50% of what is said in a classroom, depending on the type and configuration of the loss (American Academy of Audiology, 2003). For some children, it is as if they plugged their ears with their fingers. Because chronic middle ear disease in early childhood is a potentially significant condition that can have both medical and developmental consequences, it should be identified, treated and periodically monitored.

It is imperative that Child Outreach Programs screen children in the area of hearing with either an **audiometer/ tympanometer combination** or with **Otoacoustical Emission Testing (OAE)**. These two methods are sensitive to both sensorineural and conductive hearing loss. Many children with middle ear dysfunction will be “missed” if screening is conducted by pure tone audiometry alone. **Input from the family** should also be collected regarding history and symptomology. A hearing checklist can be included in a developmental or health questionnaire to be completed by the family prior to screening. The Child Outreach Screening Manual includes a detailed description of hearing screening instruments, administration procedures, suggested follow, up as well as a sample hearing checklist and forms for reporting hearing results to families.

Speech/Language

The acquisition of speech and language skills is central to a child’s learning and development. Language has a critical role in fostering optimal brain development. Speech and language skills are the single most powerful and sensitive indicator of a child’s development.

We know that babies begin learning about language long before they are able to verbalize. Similarly, speech and receptive/expressive language skills develop primarily in the early years and lay the foundations essential for learning. Delayed speech and language development impacts learning ability and specifically reading and writing skills. Children with speech language difficulties, who are not given help, are more likely to have difficulty in school and social emotional areas.

Learning to read requires the ability to produce different sounds and to discriminate between and among sounds. Vocabulary is another important ingredient in learning to read fluently, which in turn, facilitates comprehension. Language competence is a crucial precursor to reading comprehension, making reading to learn new ideas and concepts possible and academic success achievable. Research indicates that 38% of all 4th graders cannot read at a “ basic” level, for example, read a paragraph at the 4th grade level and answer questions (Naomi Karp: Language, Literacy, Reading, NAEYC, June 2002).

While the prevalence rates for speech and language disorders for the general population range from 7% to 19% (American Speech-Language-Hearing Association, 2004), the prevalence rate may be as high as 30% among children from poor urban areas (Tineo et al., 2004). Child Outreach Programs, therefore, have an extremely important role in terms of prevention. Early screening, evaluation and timely intervention for young children who have disordered or delayed speech/language skills can have far-reaching effects on the child’s success in school.

The two screening instruments recommended for use in Rhode Island’s Child Outreach Programs are the **Preschool Language Scale Screening Test — Fourth Edition** and the **Fluharty Preschool Speech and Language Screening Test — Second Edition**. While neither of these instruments has been normed specifically on Spanish speaking children, they both demonstrate cultural sensitivity. The Child Outreach Screening Manual provides a detailed description of these screening instruments, administration procedures and suggested follow up.

General Development

Although the developmental screening instrument is frequently considered to be the core test, it should be viewed as an integrated aspect of a comprehensive screening program. Results can only be interpreted in the context of information obtained from other screening activities, such as screening in the vision, hearing, speech/language and social/emotional areas, as well as input obtained from families and possibly Early Care and Education Providers. Developmental screening instruments focus on a wide range of areas of child development including language, cognition, gross and fine motor and social/emotional skills. The screening is conducted one-to-one in a game-like format using manipulatives, questions directed by the screener, and activities whereby the child moves around and responds to prompts. While individual screening instruments differ from one another, they generally include items in the following areas:

- **Fine Motor and Visual Perceptual Motor:** items that examine fine motor planning and control, eye-hand coordination, visual memory, sequencing, perception, scanning, copying forms, drawing two-dimensional forms and reproducing three-dimensional visual structures.
- **Language and Cognition:** items that focus on language comprehension, verbal expression, vocabulary, logical reasoning, quantitative concepts, categorization, completion of analogies and repetition of auditory sequences.
- **Gross Motor/Body Awareness:** items that focus on balance, large motor coordination, locomotion, patterning, body awareness and initiating body positions or movements from visual or auditory cues.

These skills, together, form the foundation for the acquisition of literacy and math skills and future success in school. Our primary purpose is to help children who need services gain access to them at a very early age to prevent the occurrence of more severe problems. We can also serve as a resource to families by helping them understand the relationship between everyday experiences and future school success, for example, how playing on the playground's monkey bars relates to writing skills, or putting away toys in designated areas connects with classification and self-organization skills. Our work is based on the premise that a young child's skills and even intelligence can be positively influenced. Providing children with appropriate everyday experiences, and when necessary, intervention, can significantly impact a child's abilities, potential and life.

The two instruments which have been approved for screening in the area of General Development and listed below in order of preference are:

1. **Early Screening Inventory, Revised**
2. **First Screening Test for Evaluating Preschoolers (First Step)**

The Child Outreach Screening Manual includes a detailed description of general development screening instruments, administration procedures and suggested follow up.

Social/Emotional

In recent years, we have seen a significant increase in the numbers of young children who exhibit challenging behaviors within their homes and/or Early Care and Education Programs. Nearly five percent of parents with children 4 to 7 years old report that their children have "definite or severe difficulties with emotions, concentration, behavior, or the ability to get along with other people" (Federal Interagency Forum on Child and Family Statistics, 2005). The results of a study conducted by Walter S. Gillam, a psychologist and associate research scientist at the Yale University Child Study Center (May, 2005), revealed that children in preschool are being expelled from Pre-K programs at a rate 3.2 times higher than that for students in grades K–12. Research data from 3,898 classrooms, representing all of the nation's 52 state-financed pre-K programs in 40 states, indicated that 6.67 out of every 1,000 preschoolers are being expelled from school in comparison to 2.09 per 1,000 Kindergarten–12th grade students. Expulsion rates are even higher for young children attending community-based programs. Because children who are expelled from their educational programs lose access to the benefits that high quality preschool education provides, it is likely that these students will enter elementary school behind their peers, not only in regard to social/emotional development, but in the cognitive and academic areas as well.

The need for prevention and early intervention of social/emotional problems in young children is a serious concern for Early Childhood professionals. Social-emotional competence, or the lack thereof, can significantly alter the course of a child's life. Child Outreach Programs can make an important contribution to this national dilemma by offering high quality screening in the social/emotional area for all children as a first step to early identification and/or appropriate intervention services.

The two screening instruments selected for use in Rhode Island's Child Outreach Programs are the **Ages and Stages Questionnaire: Social Emotional** and the **Devereux Early Childhood Assessment (DECA)**.The ASQ: SE is better suited for one-time screening. While the DECA does provide one-time screening for children who exhibit insipient behavior problems, the strength of the DECA is that, based on the results, a classroom profile can be generated and a comprehensive program of prevention/intervention strategies can be implemented. Both instruments have systems for monitoring children's progress in the social/emotional area. Please refer to the Child Outreach Screening Manual for a detailed description of these instruments, administration procedures and suggested follow up.

Summary Statement

The Rhode Island Child Outreach Screening Guidelines underscore the importance of the implementation of best practice in providing high quality screening programs for children ages three through five years. Child Outreach Screening not only meets Federal and State mandates, but also provides significant benefits to children, their families and to the communities in which they live. Screening provides the first step in identifying children who may benefit from early interventions services. It is well documented that early identification and intervention result in improved child outcomes as well as reductions in the amount of time special education services are required and the need for more costly remedial services. The goal of the Rhode Island Department of Education is the realization of comprehensive screening programs which reach **all** young children. Toward this goal RIDE has developed these guidelines and will monitor and support their implementation though annual reporting and technical assistance.

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