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ABSTRACT

Developmental screening is a brief survey of a child's level of functioning in the areas of fine and gross motor skills, cognitive abilities, speech and language (communication), social and emotional development, and sensory functioning. Screening differs from assessment, which is conducted after screening and may mean either a diagnostic evaluation conducted by a specialist, or an ongoing process to determine children's developmental progress. Assessment may also be used to plan appropriate curriculum for children. The paper provides information on the results of screening tests, discusses the Head Start mandate concerning screening, and lists what should be included in the screening process. The attributes of a good standardized screening measure are listed as validity, reliability, developmental content, norms, brevity, efficiency, cost effectiveness, special needs, space needs, administration, clarity of instruction, target, and scoring. The benefits and pitfalls of using a standardized tool are examined, as well as how, when, and by whom screening should be conducted. Developmental screening needs to be a part of preschool programs. (MDM)

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TAKE A GOOD LOOK

Developmer ıl Screening

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EDC

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INTRODUCTION

The meanings of developmental and health screening can be confusing for early childhood teachers. Sometimes professionals mistakenly use the term *assessment* when they mean *screening*. (*Assessment* may mean either a diagnostic evaluation conducted by a specialist, or an ongoing process to determine children's developmental progress and to plan appropriate curriculum for them.) This confusion can easily lead to an inappropriate use of screening results that compromises the quality of services. New England RAP has developed this resource paper to eliminate the common misunderstandings about screening.

This *Resource File* is arranged in a question and answer format. We hope that disabilities coordinators will share this information with all staff in their Head Start programs so that everyone has an accurate and common understanding of:

- what screening can and cannot do
- how screening should be conducted
- what Head Start performance standards and other regulations require.

WHAT IS SCREENING?

Screening is a brief survey of a child's developmental level of functioning in the areas of fine and gross motor skills, cognitive abilities, speech and language

(communication), social/emotional development, and the functioning of the senses (such as seeing, hearing, and touch). It also looks at a child's health status.

It is a first, quick look at a child to determine whether or not a diagnostic evaluation is required.

Screening is easy to confuse with other procedures such as assessment and readiness testing. It may be helpful to clarify screening by stating what it is not.

- It is *not* an IQ test.
- It is *not* a diagnostic test—no diagnosis can be made on the basis of screening.
- It is *not* able to label a disability.
- It is *not* a tool used to plan a curriculum or plan special services.
- It is *not* a comprehensive examination.
- It is *not* a predictor of a child's future abilities and successes.

WHAT DOES SCREENING TELL US?

There are three possible outcomes of the screening process.

Outcome # 1: The results show the child has acceptable developmental levels. The screening results raise no particular questions about the child. No further action is required at that time.

Outcome # 2. The screening results raise concerns about one or more areas of a child's development. If standardized screening tools are used, the score is below the cut off point. These results indicate the need for a referral.

Outcome # 3. The screening results are questionable. There are some concerns but the screener is unclear if the results are valid or whether the results were affected by the child being tired, sick, frightened, or disturbed by the environment. Sometimes a child is unable to understand because the language of the screen is not the child's primary language, or there are other cultural barriers. This outcome requires a rescreening.

Screening results either:

- eliminate a child from concern
- lead to a referral to an interdisciplinary team for a diagnostic evaluation
- require a rescreening

WHAT IS THE HEAD START MANDATE CONCERNING SCREENING?

The Head Start performance standards require that programs conduct developmental screenings of all children. The instructions about screening are found in different places. The Health Component requires vision, auditory, health, medical and dental screening. Developmental screening is mentioned in the Mental Health Performance Standards and also in the draft transmittal notice. The Head Start regulations do not say how screenings must be done and do not state that standardized tools must be used.

Written consent from parents must be obtained before the screening process is initiated. Screening procedures must be adapted to a child's culture, language, and disabling conditions. Even children with diagnosed disabilities should be screened

to be sure that other problems are not overlooked. It is easy to concentrate so heavily on what is identified as a need, that we do not notice other areas that need attention. For example, a child with cerebral palsy may also have a hearing loss. This might not be noted because of an assumption that the cerebral palsy is the cause of the child's lack of responsiveness to speech.

WHAT SHOULD BE INCLUDED IN THE SCREENING PROCESS?

Best practice suggests that a screening process should gather the following information:

- a developmental history (from the parents)
- parents' observations and any concerns about their child's development
- information about the family's native language and culture
- input from teachers based on systematic observation and often the use of a screening instrument. (A standardized tool must be used with common sense. For example, if a child has only been in the country for two months, the results might not be accurate. If the child refuses to do something you have seen that child do in the classroom such as make a three block tower, make note of that.)

Parents usually provide the developmental history of their child. Sometimes, however, this information comes from other family members, doctors, or social workers. Parents often offer keen observation about their child's preferences, temperament and skills.

Teacher input is a vital part of screening. Teachers' observations provide information about a child's abilities in all developmental areas and help to fully describe each child.

Standardized screening tools are often administered on a one to one basis and therefore, important information about a child's behavior in a group situation is not obtained. If any developmental area is ignored, the screening will not generate a true picture of the child.

No matter how a screening is conducted, the screener must decide on a point below which a child will be referred for a diagnostic evaluation. If a standardized test that has appropriate norms is used, it will provide this cut off point.

WHAT ATTRIBUTES SHOULD A STANDARDIZED SCREENING TOOL HAVE?

Validity. Does the tool measure what it claims to measure? To determine validity, results are compared to the follow up diagnostic evaluations. There should be none or few false positives (children identified as needing referral but further evaluation or the child's classroom actions negate this), or misses (children not targeted for referral although problems are later apparent that should have been caught).

Reliability. How consistent are the results? A tool that is reliable gives results that are not measurement errors, but truly reflect the child's performance. Two people using the same tool within the same week with the same child should get the same score. One person using the tool and one or more observers of a screening should get the same score.

Developmental Content. Does the tool require children to do developmentally appropriate tasks? For example, asking a three year old to tie shoes would not be appropriate even though some three year olds can complete the task.

Norms. On what population was the tool tested? Is this population similar to the population in your classroom? The experiences of children living in rural settings and children living in urban settings can be vastly different. Economic issues can also affect the experiences of children.

Brevity. 10 to 20 minutes is the most that a screening should take with a standardized tool. Beyond that time children become restless and results may be inaccurate.

Efficiency. Does the tool do what you want it to do? Does it cover all the areas that you want looked at?

Cost Effectiveness. How much does it cost for each child screened? What does the tool itself cost? Are specially trained professionals needed for the screening?

Space Needs. Where is the tool to be used? Do you need a private area? Do you need a large area where stations can be set up? Can it be done in the classroom? Are distractions a problem?

Administration. Can you be sure that the tool will be administered the same way to all children? Who will administer the tool and how will they be trained?

Clarity of Instructions. Do the instructions tell exactly what is to be done and how it is to be done?

Correct Target. Is the tool prepared for your group's age?

Objective Scoring. Is the tool designed in such a way as to be sure that the administering person's biases will not interfere?

WHAT ARE THE BENEFITS AND PITFALLS OF USING A STANDARDIZED TOOL?

The question of whether or not to use standardized tools is a controversial one, with many experts divided on the issue.

BENEFITS

- You can communicate more effectively with other professionals in clinics and public schools if you use the same screening tool that they use. Everyone knows what the same score means and you can point to specific responses to explain concerns.

- It is a comfortable way to screen. When volunteers or paraprofessionals help with screening, standardized tools minimize the subjective decisions they must make.

PITFALLS

- Results often tell if a child does something, but may not tell how the child does it. A child may draw a straight line thus completing the task, but may hold the crayon in an extremely awkward manner.

- There are many issues concerning language and culture that may affect the validity of the tool. It may have been normed on a very different population. Some children may not make eye contact with screeners because eye contact with adults it is not considered appropriate in their culture. Words have different

meanings in different areas of the country such as hot dog, frank, or wiener. A child might be familiar with one term but not the term used in a specific tool.

- There are often different meanings attached to words. Words may be spelled differently but may be pronounced the same (where, wear, we're, ware). In different parts of the country, words may be pronounced in different ways (*aunt* pronounced *ant* in New York and *ahnt* in Massachusetts).

- Sometimes a specific tool is universally used in a program and is translated to accommodate the many languages represented in that program. Not only is this subject to cultural bias as stated above, translations are not usually accurate. For example, in the case of screening tools that examine a child's articulation, we know that some languages do not use particular sounds found in the English language, and vice versa.

- The tool is often administered in an isolated place. The classroom is not an isolated place. A tool administered in isolation may not accurately screen a child for troubles he or she might have in the noisy, more distracting environment of the classroom.

- There is sometimes no place to amend a response or add a comment which may give a false picture of a child. (Many people who administer screening tools use a separate piece of paper to record impressions and comments of interest concerning how the child responds. For example, a child may respond to something after the time limit or later during the screening time. As a standardized tool, technically we can not change the results or the tool is no

longer standardized. However we can note that the child did respond on the side paper.)

- Standardized tools should be used as is and should not be changed in any way. All instructions for administration should be followed exactly or the tool is no longer reliable or valid and the norms no longer apply. Some people decide to leave out parts or add things they feel are missing without realizing that they have changed the character of the tool and are then no longer using a standardized procedure.

The session should always end with something the child can be successful at even if it is not part of the actual screening. An item can be used that will not be part of the scoring, but that allows a child to leave feeling good about what has been done.

Although there are many pitfalls, when a standardized tool is used in conjunction with a developmental history, parent observations, teacher input, and cultural and language information, a more complete picture of the child may be obtained.

HOW SHOULD SCREENING BE CONDUCTED?

A screening program should contain the following features in order to get the most accurate snapshot possible of a child's development at that point in time.
A screening program should:

- gather background information from parents (birth and medical history), and health status information from pediatricians and other medical personnel.

- include a screen of all developmental areas, hearing, vision, and basic health (hematocrit, lead levels, specific areas as for sickle cell, immunizations, etc.)

- interpret the results of developmental and health screenings together. For example, a child whose hearing is impaired may appear unable to respond to the language components of the screening.

- be conducted by knowledgeable, trained people including teachers, coordinators and paraprofessionals who can calm a child's concerns and insure that the child is not frightened. People who will use the tool must be trained on it and given a time to practice so that they know exactly what to do and are confident in their ability to do it. They must be helped not to "telegraph" right answers or outwardly react to right or wrong responses. The tool instructions usually tell how responses should be reacted to and it is very important to follow these patterns as children can often pick up the reactions of the administering person and feel upset about them. The fewer people involved in the administering of the screening tool, the better since there will be fewer chances for differing styles and personalities to affect the results.

- include opportunities for observation in the classroom and playground, at free play, in groups, and during other play situations.

- solicit information from anyone who works with the child. Differences between how a parent and a teacher, or how different teachers see a child, give needed insight into that child's levels of functioning in various settings.

- be conducted in a familiar or comfortable setting so that the child is relaxed. Some people prefer to screen in the classroom, some on a one to one basis, and some use a relay system where there are a number of stations and children move from station to station. Under this system, several children may be in the same room at one time, doing different activities. (For some children this is distracting and may affect the results of the screen.)

WHO SHOULD SCREEN CHILDREN?

Everyone who comes in contact with a child performs a simple screen. Teachers note quickly in the morning how a child looks and "screen" for illness. During an art activity, an aide notes how a crayon is held. This person is also screening. Parents constantly screen their children. All staff (and this included cooks and bus drivers who often observe different reactions in their unique settings) should be alert to children's needs and to changes in their responses to everyday activities. The more people who actively observe children, the more likely the children are to have their special needs noticed and responded to.

WHEN SHOULD SCREENING BE DONE?

The regulations say that screening must be completed within 45 days of the start of the program. This allows appropriate referrals to be made and enough time for help to be given. It allows time to rescreen and respond to the needs of the children who require a rescreening process.

WHY SHOULD SCREENING BE PART OF OUR RESPONSIBILITIES?

Some services are most valuable only during the early years when children are still changeable (certain areas of physical therapy are most successful with children under age eight). When we screen children early and refer them for diagnostic evaluation, they have a better chance to get their needs met. Then we truly are giving them a Head Start.

Hopefully, the difficulties that some children experience can be eliminated before they ever get to public school. Then they can experience their school years as times filled with discovery, learning, and success.

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