Section 3: Group Activities to Assess and Build Inter-rater Reliability

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Group Activities to Assess and Build Inter-rater Reliability

This section contains group activities to assess and build inter-rater reliability. These can be incorporated into staff meetings, trainings and professional development activities.

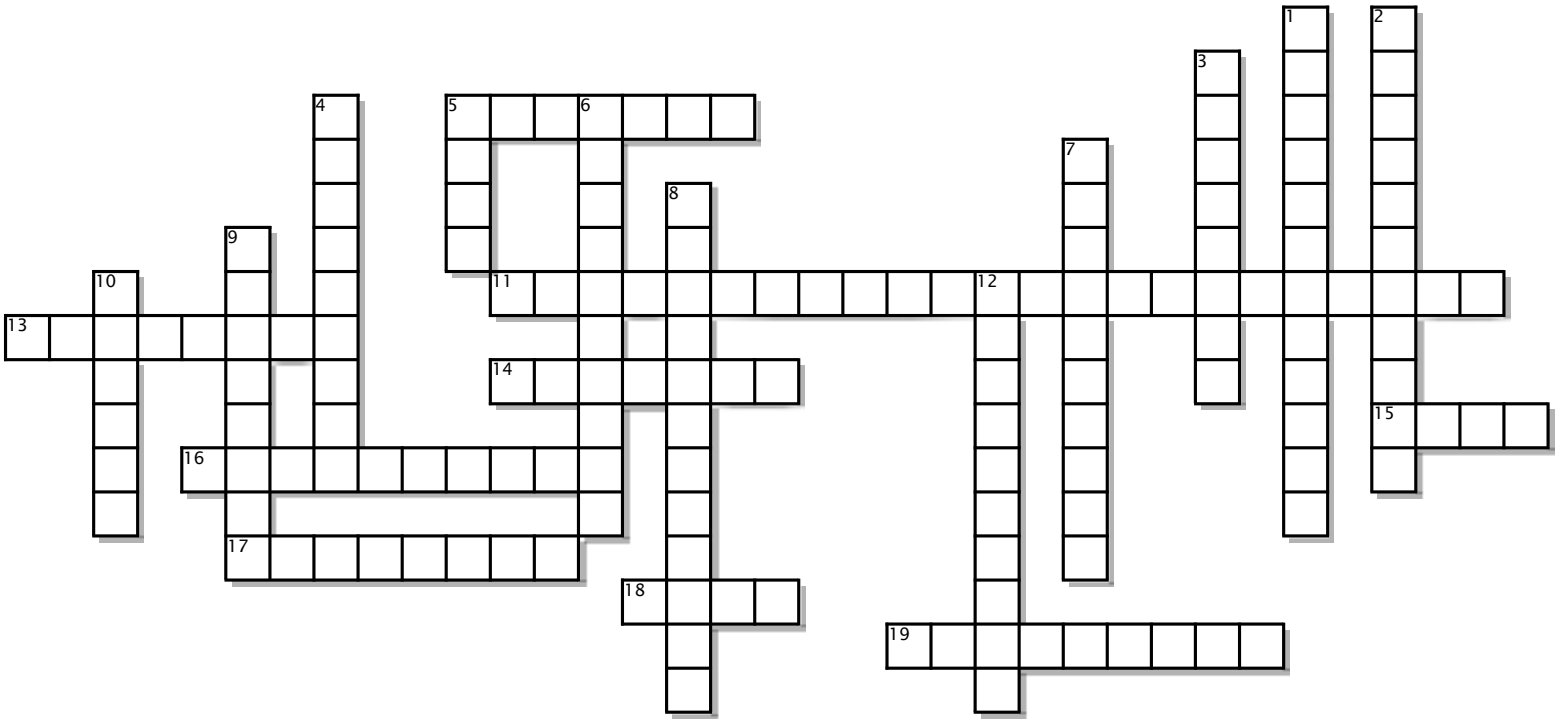
When using Decision Tree Narratives, ask participants to individually review the narrative and consider the following questions:

1. Was there enough information provided to determine a rating? What additional information do you need?
2. Was there input into the narrative from all members of the assessment team including the family?
3. Was the child's functioning across setting in each outcome clear?
4. Were functional skills listed under the correct outcome?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family, or way off? Did you agree with the ratings given by the team? Why or Why not?

After individual review, discuss responses as a team. After participants gain familiarity with the process, consider using narratives written by staff members.

Increasing Interrater Reliability

Essential Knowledge Needed



ACROSS

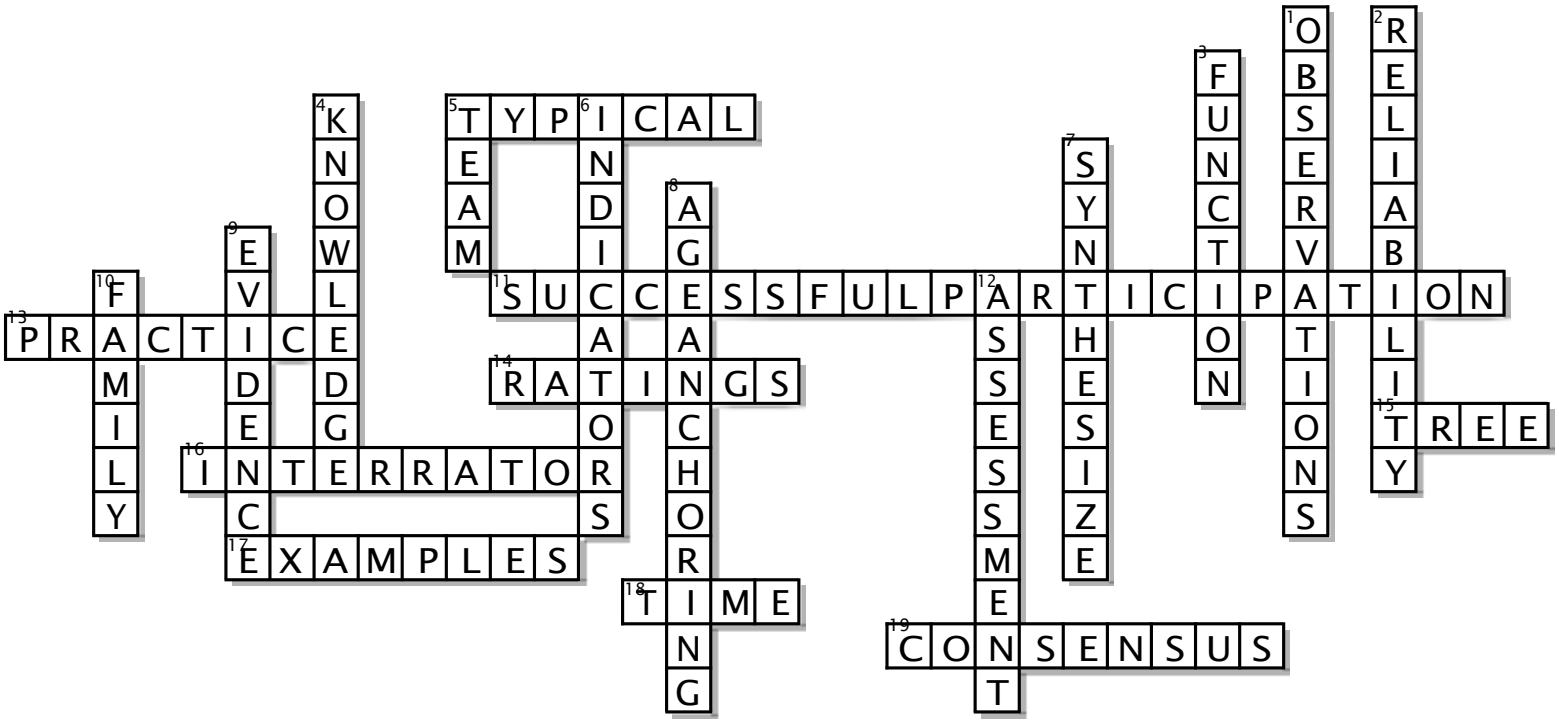
5 compare these peers
11 what we want for all children
13 teams do this to become comfortable with the process
14 a way to measure
15 helps us decide a rating
17 what team members share when discussing choice of rating
18 take this when making decisions that aren't rushed
19 team members reach this

DOWN

1 what we see
2 accuracy
3 integration of isolated skills
4 teams must have a solid one for the ratings and indicators
5 who determines the ratings
6 there are three
7 gathering information from multiple sources and across settings
8 knowing what skills are expected
9 the supporting facts
10 critical team members
12 one source of information

Increasing Interrater Reliability

Essential Knowledge Needed



Quality Indicators for Completed Narratives
To ensure quality data for child indicators measurement and reporting, IFSP narratives should provide all the required information, including evidence that supports the ratings given. A review of completed narratives should look for and provide feedback on missing information and evaluate the quality of the evidence provided for each rating. Common errors in documenting the rating include providing assessment information that does not correspond with the appropriate indicator area and providing information that does not correspond with the rating.

Questions to guide the review process
Use the following questions to guide a review of completed narratives.

1. **Is the narrative complete?**
   - Is information provided on all three indicator areas?
   - Is information provided to support ratings given to each indicator area?
   - If it is an exit narrative or rating, is the progress question addressed?

2. **How well does evidence address each indicator? Does evidence correspond to the appropriate indicator area? Does it cover the breadth if the indicator? Is it functional?**
   - Is the summary of relevant results completed for each indicator area?
   - Does the information provided in the narrative relate to the appropriate indicator per area? In other words, does the evidence for Indicator 1 relate to social relationships, Indicator 2 to acquisition and use of knowledge and skills, Indicator 3 to taking action to meet needs?
   - Does the information cover all appropriate aspects of the indicator? In Indicator 1, for example, does the evidence touch on relationships with peers as well as adults?
   - Are examples of functioning provided? In other words, does the summary of relevant assessment results include examples of the child's every-day functioning in each indicator area? Rather than just a list of skills or items from an assessment tool?
   - Is discipline-specific evidence provided to support the targeted indicator? For example, if speech or motor skills are described, do those related to socialization appear under Indicator 1, those related to learning appear under Indicator 2, and those related to getting needs met appear under Indicator 3?
3. **Does evidence support ratings?**
   - Is enough information provided to support the rating given?
   - Does the evidence relate to the targeted indicator area?
   - Does the evidence support the rating? In other words, if the rating is:
     - 7 -- does the summary of relevant results illustrate age-appropriate skills and behaviors?
     - 6 -- do relevant results include skills and behaviors that are age appropriate with an identified area of concern?
     - 5 – is there a mix of skills and behaviors that are age-appropriate and not?
     - 4 – are there a few examples of skills and behaviors that are age appropriate, but mostly not?
     - 3 – do relevant results reflect immediate foundational skills, and none that are age-appropriate?
     - 2 – are there a few examples of immediate foundational skills, but mostly skills and behaviors that are much lower than age expectations?
     - 1 – do relevant results reflect skills and behaviors that are much lower than age expectations, with none that are immediate foundational?
   - Is the evidence anchored to the child's age? In other words, if a child is two years old, do examples of age-appropriate skills and behavior reflect those of a two-year old?
   - Do immediate foundational skills reflect those of a child younger than two? Do the skills and behaviors provided for ratings of 1 and 2 reflect those of a much younger child?
   - Assuming that a reviewer knows age-expected child development, could the reviewer estimate, within one point in either direction, the rating based on the information provided? Without looking at the rating given?

The Decision Tree

Child Indicator Seeds for Success

Inclusion Matters: Access and Empowerment for People of all Abilities

Since we have spent the last year recognizing monthly celebrations that are relevant to our practice, it seems only fitting we end 2015 honoring **International Day of Persons with Disabilities.** This annual celebration held each December 3 has been commemorated since 1992 to promote awareness and mobilize support for critical issues relating to the inclusion of persons with disabilities in society. The day works to promote action to raise awareness about disability issues and draw attention to the benefits of an inclusive and accessible society for all. **The theme for 2015 is Inclusion Matters: Access and Empowerment for People of all Abilities.**

When we think about the importance of inclusion for our families, one of the first activities families often mention as a priority is taking their child to the playground. In Virginia, we have seen in recent years the opening of many ADA compliant playgrounds across the state. When discussing playground options with families, it is important to understand what would make it a meaningful experience for that child and family.

There is a difference between ADA, Accessible and Inclusive
There is a difference between a playground that *is ADA compliant*, truly accessible and truly inclusive. ADA, when it comes to playgrounds, is primarily concerned with people using mobility devises. When a playground is built to ADA standards it lets a person who is using a wheelchair get in and around the playground. It enables that person to get on a module structure. It doesn't necessarily enable that child to actually use any of the playground equipment.

An accessible playground goes beyond ADA compliance. A truly accessible playground will enable a person using a wheelchair to use the equipment. An accessible playground will have better surfacing enabling a person using a wheelchair to maneuver through the playground more easily. It may have playground pieces that children with autism enjoy—things that move and/or make music. There may be quiet places for children to go and calm down. There may be pieces like an accessible swing seat and see-saws with supportive backs to enable a child with limited body support to enjoy this type of movement.

An *inclusive playground* goes beyond an accessible one in that it is designed to encourage children of all abilities to play with one another. This playground is one where every child who goes to the playground is challenged at their level. It is a playground that may have pieces like an accessible glider which enables a person using a wheelchair to experience movement, along with all of their typically developing peers.

With the goal of socialization and full participation in mind, Special Education Degree: Your Guide to a Career in Special Education set out to identify 30 of the most impressive accessible and inclusive playgrounds from around the world. I'm thrilled to share with you that Virginia had 3 in the top 30!

Here they are with their worldwide rating:
30. A Dream Come True – Harrisonburg, Virginia

Located in Harrisonburg, Virginia, the project was the brainchild of a group of Girl Scouts whose dream it was for there to be a space where all kids could play alongside one another, regardless of their abilities. The Girl Scouts embarked on a mission to acquire the necessary funding, approaching local religious groups and companies for donations while also applying for grants and selling cakes and cookies. It took almost a decade, but eventually enough money was raised for the $1.4 million facility to be built. The brightly colored equipment caters to different age groups, and there are special Made-for-Me swings designed for kids who need extra body support.

15. Clemyjontri Park – Fairfax County, Virginia

The playground at Clemyjontri Park in Virginia's Fairfax County is tough to miss. It stretches across two acres and is decked out with an eye-catching rainbow color scheme. The playground opened in 2006 and is split into four areas, with each section featuring different apparatus, helping kids to learn about colors, read, find out about the world, and exercise their imaginations. There are also plenty of opportunities to get active on accessible equipment, which includes ramps, various special swings, and more. The play park's centerpiece is a carousel, which children can even use while still seated in wheelchairs. This unique park was the dream of Adele Lebowitz, who donated land to the local authorities on the condition that it be used to create a playground for disabled children. Landscape architect Grace Fielder, who helped develop the park, said, "Its imaginative design really gets all kids into the outdoors expending energy. There is even a wheelchair drag strip."

13. JT's Grommet Island Beach Park and Playground for Every"BODY" – Virginia Beach, Virginia

JT's Grommet Island Beach Park and Playground for Every"BODY" opened in May 2010 and was the brainchild of Josh Thompson and his family. Thompson loved the beach and surfing from childhood, but in 2006, while still young, he was diagnosed with Lou Gehrig's Disease – which causes weakness and wasting away of the muscle. After Thompson hung back from a family trip to the beach because of the challenge of negotiating the sand in a wheelchair, his father approached the City of Virginia Beach with the idea of an accessible beach park. City authorities agreed that it was a great idea, and the nation's first such beachfront park was built for about $1 million – with funding for its upkeep and maintenance coming from sponsors' donations and events. Unsurprisingly, the park is decked out with a beach theme; it also features elevated tables for making sandcastles, a "sway board," and a sensory panel that provides entertainment for visually challenged children.

Looking for an inclusive playground in your community?
http://www.accessibleplayground.net/united-states/virginia/

Looking for supports for when parents ask the tough questions about accessibility and full participation?
Check out Mason's Story featured on Virginia's Early Intervention Strategies for Success Blog:
http://veipd.org/earlyintervention/will-mason-ever-walk/

Here's an excerpt: *About 30 min into your first visit with Mason's family, his father asks "Will he ever walk?" Mason had a stroke shortly after he was born which affected the left side of his body. He is just under two years old and is beginning to sit with very little support. His father is an athlete and dreamed of having a son who would love to play sports as much as he does. How do you answer this hard question?*
Explore what "walking" really means for the father – This is important. Walking might mean walking on two feet. Or, it might really mean Mason being able to move about independently, however that happens. Mason's father might be wondering how long he will have to carry Mason around, if Mason will be able to play on a playground, or if he'll ever play baseball. Exploring his question a little more will help you understand what underlies this tough question. It'll also help make sure he knows you are addressing what is so important to him, even though it might not look like walking yet.

The IFSP narrative that follows represents an annual review capturing one family's hopes and experiences for their child. This family has many of the same desires as Mason's family. How would you capture Logan's functional participation in the activities that are important to his family in the context of the three outcomes and address the parent's desire for him to walk and participate in activities with other children his age including going to the playground with his cousins?

Test Your Inter-rater Reliability

Our state's focus on child indicator ratings has led many to wonder, "Are we all rating children similarly?"

As part of our efforts to improve results for children, we are focusing each month on increasing our statewide inter-rater reliability. We are using examples of narratives from around the state that ideally will include observations of functional behaviors, parent/caregiver input, results from assessment tools and informed clinical opinion. Below is an example of a narrative from a recent Assessment for Service Planning. Using the limited information provided in the narrative and the process outlined in the child Indicator Booklet talk thru the scenario with your colleagues to determine a rating. The ratings given by the assessment team can be found at the end.

Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Logan's Age: 27 months Adjusted Age: NA

Referral Information, Medical History, Health Status: Logan was referred to Early Intervention by the NICU. He has been receiving services for two years. Logan was born at 28 weeks gestation and weighed 2lbs 12oz at birth and spent 84 days in the NICU. Logan continues to have seizures and has had intractable epilepsy that has included infantile spasms. His seizures are currently being managed with Tegritol. Logan has a diagnosis of cortical visual impairment. He does well with oral feedings and does not have a feeding tube. There are no concerns with his hearing.

Daily Activities and Routines: Logan lives at home with his parents and older sister. He spends his days at home with mom or his nurse. He loves attention including when someone talks to him, sings or plays. He also enjoys being held and cuddled. He likes to spend time in his room and enjoys being rough housed by dad. Logan also loves to play in the bath tub where he can kick and splash in the water. He uses a bath seat that was specially fitted for him. Logan prefers consistency and gets frustrated when he becomes tired making family outings difficult. He cries nonstop when in the car so the family chooses their outings carefully and don't get to participate in visiting relatives or going to the playground as often as they'd like.

Family Concerns: Mother is most concerned with Logan's neck and his ability to keep his head up. She states that she would like for his neck muscles to get stronger so that he can hold his head up without any assistance. She reports that his legs seem to be much stronger and she would like to see the same with his neck muscles. Mother states that she has seen some improvements in the strength of his neck because he is able to lift it up by himself at times. She reports if Logan's head falls forward and he is unable to lift it up he will yell until someone lifts it up for him. Logan spends time in his Rifton Activity Chair, car seat and specialized stroller.

Family Priorities: Logan's family would like to see him become more mobile and verbal. Mother explains that Logan has shown progress in both areas but she would like to see these increase. She explains that Logan is

getting harder to carry around as he gets bigger and that it would be helpful if he could stand independently and walk. She would like him to say "hey I want this" now that he is making purposeful sounds. She is open to exploring a communication device.

Developmental Levels: Cognitive- 5 months Gross Motor- 2 months Fine Motor- 2 months
Receptive Language- 9 months Expressive Language- 9 months Social/Emotional- 6 months
Adaptive/Self Help- 3-5 months

Social/Emotional Skills including Positive Social Relationships: Logan has a wonderful personality and is a pleasure to be around. He loves to be held and cuddled particularly by his mother. He has a very strong attachment to his father and loves interacting with his sister. He tends to "light up" when his sister comes in the room and gets very excited when his dad comes home. He will vocalize to let others know if he is happy or mad and is quick to give a smile when he is picked up. Logan enjoys being talked to and having books read to him. He enjoys being tickled and will laugh in hopes that the tickling will continue. He will cry to get someone's attention.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Logan is beginning to be much more vocal with many sounds, although there are no recognizable words at this time. He is able to vocalize his emotions using vowel sounds. He is beginning to vocalize in response to other communication he hears. He will vocalize when he hears his mother's voice to get her attention and will smile when people are interacting with him. Logan is very vocal and particularly loves to "talk" during church when people are singing or preaching. According to Logan's mother, he will kick his legs when they say "kick your legs". He is beginning to demonstrate the ability to track light as well as faces significantly better than before.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Logan is able to assist with rolling though he does not roll on his own. He seems to enjoy being rolled repeatedly and playing rough with his dad. Logan smiles while being rolled from tummy to back. He is able to sit while being supported by a caregiver. He is able to lift his head at times when in a sitting position and Mother calls his name. He will also kick his legs at times. When on his tummy, while assisted with a ball or a cushion, Logan will hold himself up with his forearms. When family members hold him up, he will support his own weight and will often take some steps. Father reported he is looking forward to when Logan can go to the playground with his cousins. Logan enjoys eating and this is a definite area of strength for him. He mother reports he not only enjoys eating but he particularly enjoys good tasting food. He was observed to eat some ham lunch meat and chocolate pudding during the assessment and definitely preferred the pudding. Mother reports Logan will verbalize to let you know if he is ready to eat and will continue to get louder if the food isn't given quickly enough.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 1: Logan has the very early skills in this area. This means Logan has the skills we would expect of a much younger child.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 1: Logan has the very early skills in this area. This means Logan has the skills we would expect of a much younger child.
Use of Appropriate Behaviors to Meet Needs: Rating 1: Logan has the very early skills in this area. This means Logan has the skills we would expect of a much younger child.

Determining the outcome ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three outcome areas.

- When a child has a more severe disability it is more difficult to share functional assessment results with a family. How did the team do with incorporating the family's input into the ASP?
- Logan has several pieces of equipment. Were you able to tell how he used the equipment to participate functionally in activities with his family?
- What does going to the playground with his cousins mean to Logan's family?
- How should you consider the use of assistive technology when determining a child's ratings compared to same age peers?

A tip to consider when rating children with severe disabilities:

Child Related to Disability

- Ratings should be related to child's disability
- Groups of children with more severe disabilities should (may) have lower entry, annual or exit numbers than groups of children with less severe disabilities.
- Some children will widen the gap when compared to same age peers as they get older.

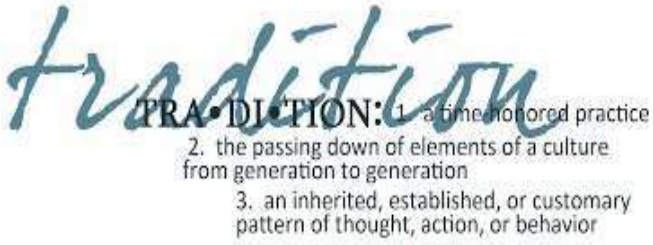
One more question to consider about Logan. If this was his exit assessment, how would you answer the progress question?

The answer would definitely be yes! Remember the progress question compares the child to himself and asks if he has gained any new skills since he entered early intervention. While Logan's progress has been slow, he has definitely gained new skills in each outcome area.

A word from Anne:
I have enjoyed this year long journey with you exploring and paying tribute to each month's commemorations. Next year looks to be equality exciting as we embark on improving functional assessment in the context of a child's culture including what's considered typical child development for that specific culture. My plans for next year's Decision Tree: Child Indicators Seeds for Success is to explore a new culture each month and share an assessment reflective of that culture.

I need your help! What cultures would you like to explore? Do you have IFSP's that represent different cultures that can be used for the inter-rater reliability section? If so, please fax them to my attention at the Part C office. The fax number is 804-371-7959. You can also mail them to me at 217 Plank Shore Drive, Boydton, Virginia 23917. Remember, the narratives don't need to be perfect! This is all about peer learning! Also, there is no need to worry about confidentiality. I modify the narratives enough to protect the identity of all involved.

I wish you all a happy holiday season filled with love, family and time to enjoy those customs and traditions that are important to you!



The Decision Tree

Child Indicator Seeds for Success

May is Better Hearing & Speech Month

Each May, the American Speech-Language-Hearing Association (ASHA) celebrates Better Hearing & Speech Month and provides an opportunity to raise awareness about communication disorders and the role of the Speech-Language Pathologist. For 2015, the theme is "Early Detection Counts." ASHA will be posting many resources to help you celebrate all month long. www.asha.org/bhsm

Hopefully you've been following the State Systemic Improvement Plan (SSIP) updates provided each month and know that we will be continuing our efforts to increase the accuracy of our Child Indicator entry and exit ratings. Here's a great resource from ASHA to check out: Roles and Responsibilities of Speech-Language Pathologists in Early Intervention: Guidelines. Scroll down to the guidelines for screening, evaluation and assessment. The guidelines are relevant to all of us and if implemented will help to increase our inter-rater reliability. Here are some of the guidelines discussed:

- Screening, evaluation, and assessment will be accomplished through a range of measures and activities, including standardized tests and questionnaire formats, interviews, criterion-referenced probes, dynamic procedures such as diagnostic teaching, and observational methods. Information will be drawn from direct interactions with the child, from indirect means such as parent interviews and report forms, and from observation of the child in natural activities with familiar caregivers.
- SLPs, through collaborative practice with other professionals and the family, interpret screening, evaluation, and assessment findings within the context of a child's overall development. Contextualized interpretation is of particular importance because communication is just one aspect of the dynamic, multifaceted interactions between children and their worlds that constitute their environment.
- Validating assessment findings and corresponding interpretations of results can facilitate consensus building. An important element when sharing assessment findings is for family and professionals to achieve mutual understanding and agreement about the child's strengths, needs, and desired outcomes. A strategy that may build consensus and contribute to mutual understanding is to share assessment information in an ongoing manner throughout the assessment/evaluation process (Crais, 1996). In this way, as each task, tool, or series of tasks is completed, families and professionals can discuss findings and begin generating a list of ideas for further assessment and/or later intervention planning. Ongoing feedback of evaluation/assessment results also may reduce the amount of information to be shared at the conclusion of the evaluation/assessment process, as well as help families have a more accurate understanding of the information shared with them.

Some assessment findings may be unexpected or difficult for parents to hear. At these times, it may be helpful to ask families to share their ideas about why their child is having difficulties. Discussion of children's performance during assessment/evaluation tasks can be linked to families' anecdotes and observations, thus helping families understand evaluation/assessment results.

Test Your Inter-rater Reliability

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Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Bob's Age: 23 months **Adjusted Age:** NA
Developmental Levels: Cognitive- 18 months
Receptive Language- 9 months **Expressive Language**- 12 months
Gross Motor- 24 months **Fine Motor**- 18 month
Adaptive/Self Help- 15 scattered skills up to 24 months
Social/Emotional- 6 months with scattered skills up to 24 months

Social/Emotional Skills including Positive Social Relationships: Parents report Bob doesn't care, stays to himself and does not interact with them. During his exam with the Developmental Pediatrician he made no eye contact, did not gesture, or engage with his sister or parents. He showed a lack of knowledge of personal space and kept sitting behind the dr. and would go back to playing. He showed an interest in spinning wheels on a car. Bob will play and interact with his sister sometimes but will not repeat anything or interact with his parents. He likes to jump, run and pull things down. He does not like men except for dad but does ok with women. He does not interact with other children. When taken somewhere he tries to run around. Parents report he does not make eye contact with others. He has no fear and will go down the stairs on his stomach and pull things off the stove. He communicates his feelings by crying and making faces. Parents report Bob does not interact with anyone. The Developmental Pediatrician report states Bob shows social impairments such as lack of engagement, eye contact, joint attention and social gesturing. Bob attended to a block activity for greater than 5 minutes until he was able to stack 4 blocks. He briefly participated in back and forth ball play. He displayed limited eye contact. He laughs when mom plays peek-a-boo with his feet.

Child's Development in Relation to Other Children the Same Age:
Acquiring and Using Knowledge and Skills, including early language/communication: Parents report Bob learns by exploring and purposeful play. His favorite toys are cars. He rolls cars and pushes buttons on the phone. The Developmental Pediatrician's report states he was interested in spinning the wheels of the car. It also states

Bob engages in repetitive play and is interested in parts of objects rather than the whole. Parents say his attention span has not increased and he began to show regression a year ago. Bob does not respond to directions and does not use language/actions to communicate what he knows and understands. He does not point to any body parts. He does not try to overcome obstacles or remember familiar routines. He will not sit to look at a book. Parents report he does not babble throughout the day. Bob does not know let them know what he wants and only cries. He does not imitate sounds or words. He demonstrated limited babbling during play. He vocalized when excited or trying to get parents attention. Bob interacts with the television show by counting and singing along. He will sometimes hide when playing hide and seek. Most activities are self directed as he does not consistently follow directions. Mom usually feeds him as he does not typically feed himself independently.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Parents report Bob has difficulty feeding and just stopped breast feeding. He is gaining weight. Bob will drink from a sippy cup but not thru a straw. He eats table foods and finger feeds himself. Parents say he chews food appropriately. He will only eat foods with no chunks in it. His favorite foods vary. He sleeps in bed with his parents and is able to go to sleep by himself. He goes to bed between 10 and 11 and wakes up around 11am. He enjoys bath time and tooth brushing and does not mind messy play or getting his hands dirty. He is not bothered by loud noises or busy places. He walks and is able to jump. He rides on a ride on toy. He climbs on and off of furniture. Parents report Bob walks up and down the stairs holding the railing or their hand but the Developmental Pediatrician report say he was unable to step up or down from a mat unassisted. He does not help with dressing or undressing. He is not yet toilet trained but is showing interest and will sit on the potty for a while. Bob is a very active little boy. He shows strong gross motor skills such as running jumping and climbing. Mom and dad report he will scribble with a crayon and sometimes turn pages of a book. He was able to play with small cubes and stacked four while stabilizing the tower with his left hand. Parents report he will try to self feed yogurt with a spoon but that he does not like mixed textures. Parents also report he is beginning to help with taking his socks off and putting his arms thru sleeves when dressing. Parents reports he often seeks sensory stimuli by climbing, hiding in small places and hanging on mom's back and rocking with her. He also appears to seek deep pressure sensations thru climbing.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 2- Bob is beginning to show some of the early skills that are necessary for development of more advanced skills in this area.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 2- Bob is beginning to show some of the early skills that are necessary for development of more advanced skills in this area.
Use of Appropriate Behaviors to Meet Needs: Rating 2- Bob is beginning to show some of the early skills that are necessary for development of more advanced skills in this area.

Determining the indicator ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three indicator areas.

- ✓ **Family members are always a critical part of the team**.

The Decision Tree

Child Indicator Seeds for Success

July is Social Wellness Month

As early interventionists, we are often too busy to take care of our own well being. There are so many different aspects to health. We hear daily about eating right and exercising, but health also involves our social connections and interactions. This is the month to nurture your relationships!

Research shows that:

- People who have a strong social network tend to live longer.
- The heart and blood pressure of people with healthy relationships respond better to stress.
- Strong social networks are associated with a healthier endocrine system and healthier cardiovascular functioning.
- Healthy social networks enhance the immune system's ability to fight off infectious diseases.

So build your social networks, both personally and professionally, not only this month, but every month, and stay healthy!

Need strategies for building successful teams?
Try the DEC Recommended Practices for Teaming and Collaboration!

DEC defines teaming and collaboration practices as those that promote and sustain collaborative adult partnerships, relationships, and ongoing interactions to ensure that programs and services achieve desired child and family outcomes and goals.

TC1. Practitioners representing multiple disciplines and families work together as a team to plan and implement supports and services to meet the unique needs of each child and family.

TC2. Practitioners and families work together as a team to systematically and regularly exchange expertise, knowledge, and information to build team capacity and jointly solve problems, plan, and implement interventions.

TC3. Practitioners use communication and group facilitation strategies to enhance team functioning and interpersonal relationships with and among team members.

TC4. Team members assist each other to discover and access community-based services and other informal and formal resources to meet family-identified child or family needs.

TC5. Practitioners and families may collaborate with each other to identify one practitioner from the team who serves as the primary liaison between the family and other team members based on child and family priorities and needs.

Looking to expand your professional network?

Join the Early Intervention Strategies for Success Blog for exciting discussions about implementing early intervention supports and strategies! Learn tips and strategies you can use when working with families of infants and toddlers with special needs within the context of their everyday routines. This blog offers you a place to share your insights and learn from others. Articles feature tips and strategies for using best practices, follow-up from professional development activities, and other topics relevant to early interventionists in Virginia.

Check out this recent blog: You are Not an Island…though It can Feel that Way

Test Your Inter-rater Reliability

Our state's focus on child indicator ratings has led many to wonder, "Are we all rating children similarly?"

As part of our efforts to improve results for children, we will be focusing each month on increasing our statewide inter-rater reliability. We will be using examples of narratives from around the state that ideally will include observations of functional behaviors, parent/caregiver input, results from assessment tools and informed clinical opinion. Below is an example of a narrative from a recent Assessment for Service Planning. Using the limited information provided in the narrative and the process outlined in the child Indicator Booklet talk thru the scenario with your colleagues to determine a rating. The ratings given by the assessment team can be found at the end.

Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Jacob's Age: 29 months **Adjusted Age:** NA

Background: Jacob has been receiving services for the last two years from the Infant & Toddler Connection of Virginia. Jacob was diagnosed with Spinal Muscular Atrophy Type 1 when he was 7 months old. He currently has a tracheostomy, ventilator and g-tube. The team is meeting with Jacob's family for his annual review. His team of service providers include a Service Coordinator, an Occupational Therapist, a Speech Therapist and a Developmental Services provider.

Daily Activities and Routines: Jacob lives with his mother, father and Joshua, his 4 year old brother. Jacob enjoys spending time with his family, so much so, mother reports having difficulty getting Jacob to go to sleep. She reports he does not like to go to bed because he is too interested in what his family members are doing. Jacob typically falls asleep around 11:00pm. He sleeps until 11:00 or 11:30 each morning. His brother, Joshua attends preschool each morning. Jacob gets very excited when he sees Joshua's bus pull up around lunch time. Joshua and Jacob have lunch together. Mother puts Jacob his chair and pulls it up to the small child sized table so he can have his g-tube feeding with Joshua. After lunch, Jacob spends time in his stander or in his chair. He enjoys watching Joshua act silly, looking at books, playing with his adaptive toys, looking at flashcards, colors, listening to songs, videos or watching cartoons. In the afternoon, mother takes Joshua and Jacob for a walk. Mother reports it is getting more difficult to fit Jacob and his equipment in their stroller. Jacob enjoys when his father comes home from work and they play rough house. Jacob's family eats dinner together every evening at the kitchen table. Jacob joins them by sitting in his chair on the floor and gets his g-tube. Mother reports she would like Jacob to be at the table with them instead of on the floor. Jacob enjoys bath time with his brother. Mother positions Jacob in a laundry basket in the tub so he and Joshua can play in the tub.

Developmental Levels: Cognitive- scattered to 18 months **Gross Motor**- newborn – 2 months
Receptive Language- 4 months scattered to 9 **Expressive Language**- solid 9 months scattered to 15
Adaptive/Self Help- newborn **Fine Motor**- scattered to 16 months with assistance at elbow
Social/Emotional- solid 6 months scattered to 16

Social/Emotional Skills including Positive Social Relationships:
Jacob is very alert and watches his family as they move around the room. He engages the people around him by using his facial expressions. When he tries to scrunch up his face, his brother laughs which makes Jacob laugh in return. He smiles, frowns and uses his eyebrows to interact with his family and therapists. Mother stated when Jacob is excited his eyes get big and he opens his mouth. Mother reports Jacob sometimes makes the sounds "mm" and "ahh" to get a family members attention. Jacob will respond to a familiar voice by looking towards the person. Mother states Jacob gets really excited when his brother or father come home or when he sees other children. He watches them and tries to interact with them. Jacob will wave "hi" and "bye" when given assistance at his elbow. Mother reports Jacob cries sometimes when he meets strangers.

Children at this age participate in symbolic play, offer other children or adults toys and initiate play activities with others.

Child's Development in Relation to Other Children the Same Age:
Acquiring and Using Knowledge and Skills, including early language/communication:

Jacob attempts to imitate actions that are physically demonstrated to him such as flipping pages of a book and lining up a shape for a shape sorter when given assistance at his lower arm and elbow. Jacob enjoys when his brother helps him push cars. Jacob tries to imitate the car sounds Joshua makes. Mother reports Jacob imitates faces others make like surprise, angry and happy. Therapists states Jacob will imitate lip sounds like blowing raspberries and coughing. Mother reports Jacob laughs when his father rough houses with him and blows raspberries on his belly. Jacob communicates his wants and needs by eye gaze, facial expressions and some gestures. Jacob responds to yes or no by shaking his head when he is sitting supported or using his eyebrows when lying down. He also frowns or smiles to let others know what he does or does not want. Jacob enjoys music and watching his brother dance. He joins in by shaking his head back and forth. When his brother says "do it again" Jacob repeats his dance. Mother reports Jacob responds to other simple directions like "look towards something" "point to something" or "close your eyes". Mother reported when asked how old he is Jacob will hold up two fingers

Children at this age have a vocabulary of 100+ words and are starting to use simple sentences to request wants and needs. The will begin to have conversations with peers using short phrases and can look at pictures or objects and tell what they are used for.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs:
Jacob recieves all food and liquids by G-tube. He has a trach and vent which requires suctioning. Jacob has limited movement of his hands and relies on his family members to meet his wants and needs. He lets others know what he wants or needs by using eye gaze, facial expressions and some gestures. He will move his legs and toes some on command. Mother reports this is how he let's her know he wants to go outside for a walk. In the evening, at bath time, mother asks Jacob if he wants to go swimming in the bath tub with Joshua. He responds by moving his legs and arms in sequence as if he was swimming. With assistance at his elbow, Jacob can participate in some play activities like turning pages of a book, putting objects in and out of a container and push/pull activites. After dinner, Jacob sits between his father's legs on the floor and with assistance at the elbow he rolls a ball or truck back and forth to his brother. Jacob will make a choice between playing with the ball or truck by using eye gaze.
Children Jacob's age can build tall towers and are using a mature grasp to hold crayons. They are beginning to use a fork, brush their hair, brush their teeth and put on some clothing independently. They can ask for what they want using two to three word sentences.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 1- Jacob has the very early skills in this area. This means Jacob has the skills we would expect of a much younger child.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 1- Jacob has the very early skills in this area. This means Jacob has the skills we would expect of a much younger child.
Use of Appropriate Behaviors to Meet Needs Rating 1- Jacob has the very early skills in this area. This means Jacob has the skills we would expect of a much younger child.

Determining the indicator ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three indicator areas.

Jacob and his family have a team of providers listed on the IFSP each making 1 time weekly visits for 45 minutes. All providers are committed to helping Jacob and his family and are present at the annual review. Each individual team member including the family must consider and share their ongoing assessment information and observations of Jacob across different settings and activities. This information is used to complete the ASP, Child Indicator Ratings, develop outcomes and determine the most appropriate service(s) to meet the outcomes.

Jacob's ASP and Child Indicator Ratings were difficult to develop and share with the family. Having honest conversations like this are hard**. Reflecting on the DEC Recommended Practices for Teaming and Collaboration, how would you recommend Jacob's team approach the annual review knowing that the information will be difficult for the team to share and for the family to hear.**

The following is a resource from the EIPD's Early Intervention Strategies for Success Blog to consider when preparing for honest and meaningful Assessments for Service Planning:
Writing an Honest, Balanced and Meaningful IFSP Narrative

Jacob's family has identified specific times of the day or activities that are either difficult or could be more meaningful to Jacob and his family. Each of his providers has worked hard to develop a relationship with the family and feels their unique knowledge and skills are necessary.

Consider the following DEC Recommended Practices for Teaming and Collaboration:
Practitioners and families may collaborate with each other to identify one practitioner from the team who serves as the primary liaison between the family and other team members based on child and family priorities and needs.

How does your team determine who is the most appropriate service provider to meet the outcomes identified by the family?

Role release can be a struggle for even the most confident of early interventionists. Here is a resource from the EIPD's Early Intervention Strategies for Success Blog to consider when determining the most appropriate provider:
Letting It Go: Role Release and Why It Can Be Hard

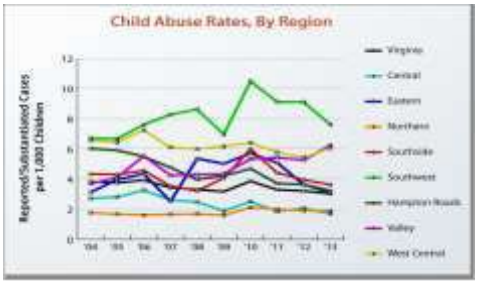
The Decision Tree

Child Indicator Seeds for Success

Serving Virginia's Most Fragile Children

I was reviewing an IFSP today that took me straight to my computer to investigate the occurren[illegible]nd neglect in Virginia. The IFSP follows in the test your inter-rater reliability section (identifying information altered) but here is what I found in my heavy-hearted investigation.

- **In Virginia, a child is abused or neglected every 75 minutes, and every 14 days a child dies from such mistreatment.** The immediate impact of abuse or neglect on a child is tragic, but so, too, are the long-term consequences -- affecting children, their communities, and the Commonwealth as a whole. Child abuse is often hidden, may occur over time, and is usually preventable. (VaPerforms)
- Data from the Virginia Department of Social Services (DSS) shows that in 2013 51,346 Virginia children were reported as possible victims of abuse and neglect. 6,205 of these were founded reports, meaning that a review of the facts gathered during an investigation met the standard of evidence required in Virginia. **Thirty percent of the children experiencing maltreatment were under the age of 4,** and 73 percent were under the age of 12. The most common type of abuse was neglect -- a failure to provide adequate food, shelter, clothing, or supervision. Sixty-seven percent of Virginia's child abuse victims in 2013 were white; the remainder were black (34%) or Asian (1%). (VaPerforms)
- The Central region had the lowest rate of child maltreatment in 2013 at 1.7 substantiated cases per 1,000 children. The Southwest and Valley regions had the highest rates, with 7.6 and 6.3 cases, respectively. (VaPerforms)



- Child abuse and neglect are not confined to any particular socioeconomic class, race or ethnicity, or religion. **Children younger than 4 are at the greatest risk of severe injury or death.**
- There are a number of situations that place children at particular risk for being abused or neglected, including:
  - Parents who were themselves abused as children
  - Parental depression, stress, or other mental health problems
  - Parents who lack knowledge of child development and children's needs
  - Lack of caregiver support for dealing with children with disabilities or developmental delays
  - Teenage parents
  - Parental or family substance abuse
  - Unemployment and poverty
  - Community violence
  - Family isolation
  - Family violence, such as intimate partner violence
- While physical injuries may or may not be immediately visible, abuse and neglect can have consequences for children, families, and society that last lifetimes, if not generations. The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioral, and societal consequences. In reality, however, it is impossible to separate them completely. Physical consequences (such as damage to a child's growing brain) can have psychological implications (cognitive delays or emotional difficulties, for example).
- Nationally child abuse and neglect affects over 1 million children every year. Child abuse and neglect costs our nation $220 million every day: for investigations, foster care, medical and mental health treatment, special education, juvenile and adult crime, chronic health problems, and other costs across the life span. In 2012, the estimated cost to address child abuse was a staggering $80 BILLION.
- While child abuse and neglect affects us all fiscally, the emotional impact it has on those directly impacted in the care of a child including social services, foster families and early interventionist must also be acknowledged.

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Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family? **Did the narrative contain jargon?**
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Mark's Age: 4 months Adjusted Age: NA

Referral Information, Medical History, Health Status: Mark is a 4-month old boy who was referred to E.I. by Cloudy County DSS after he suffered a broken femur and six broken ribs from alleged abuse by his uncle. Prior to his injuries, he spent 2 months in Sunnyside Medical Center NICU due to prenatal drug exposure and complications from withdrawal. Since being in foster care, the femur and ribs have healed and Mark appears healthy.

Daily Activities and Routines: Mark presently lives in a foster home with foster parents, his biological sister and another foster baby. His foster mother stays home with him and the other children most days. They have bi-weekly visits with Mark's biological family and the other foster child's family members. The family attends church on Sunday afternoons and Wednesday evenings. They also spend time with extended family members. Foster mother reports that Mark fights sleep very badly. She states that he has to be swaddled up tightly and patted on the bottom quite harshly to fall asleep. She states he sleeps all night normally and really only cat naps during the day. She reports he sleeps very lightly and they have to be very quiet in order not to wake him.

Family Concerns: Foster mom is most concerned with the way Mark holds his head constantly to the right. She also has concerns that he is not reaching for toys or grabbing them.

Family Priorities: Foster mother wants Mark to get the assistance he needs in order to be age appropriate in his development.

Developmental Levels: Cognitive- 4 months Gross Motor- 3 months Fine Motor- 2 months Receptive Language- 4 months Expressive Language- 4 months Social/Emotional- 3 months Adaptive/Self Help- 3 months

Social/Emotional Skills including Positive Social Relationships: Mark's foster mother reports that he seems to be more alert in new surroundings like church or the store, and he will look around a lot more there than he does

at home. Mark has been observed during assessment as a very social baby. He smiles and coos when spoken to. He will also chuckle when tickled.
Foster mother indicates, however, that Mark seems to have a difficult time self regulating and needs a lot of external support to calm himself and get himself to sleep. She reports when he wakes up in his bed, he will lay quietly for awhile. However, if he sees a caregiver, he then begins to cry.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Mark is beginning to pay more attention to objects and people. He will watch his own hands and will follow a moving toy. However, the PT noted during the assessment that he will not turn his head as far to the left or hold the position as long as he does to the right. She also noted he will not reach toward toys as much and is still using more of a reflexive grip instead of using a purposeful grasp.
Foster mother reports he definitely shows recognition for caregivers and will turn his head toward a voice. She also states he gets excited when he sees the bottle and begins to kick his legs.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Although Mark performs many age-appropriate skills, it has been noted that it is the quality of his skills that are a concern. For example, while on his tummy, he holds his head well above the floor. However, the PT noted that he is arching his neck back in an extension position that is characteristic of NAS babies. Also, if he holds a toy, it is reflexive and with a clenched fist. He holds his hands fisted often as well. Foster mother reports he does not attempt to place his hands on the bottle during feeding. She also states he has the same weak cry for everything making it hard to know what he needs.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:

Social/Emotional Skills including Positive Social Relationships: Rating 5- Mark shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

Acquiring and Using Knowledge and Skills, including early language/communication: Rating 5- Mark shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

Use of Appropriate Behaviors to Meet Needs: Rating 5- Mark shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

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Be sure to check out the new updates in the Practice Manual regarding Eligibility Determination for children with:
Toxic exposure, in utero to include fetal alcohol syndrome, drug withdrawal, and others (anticonvulsants, anticoagulants): In these cases there must be medical documentation that the baby was affected by prenatal toxic exposure. This category includes, but is not limited to, Fetal Alcohol Spectrum Disorders; Neonatal Abstinence Syndrome; symptoms of withdrawal; and evidence of "effects" of toxic exposure such as irritability, difficulties with self-soothing, and/or rigid or flaccid muscle tone.

Additional information about effects of toxic exposure can be found at
http://aia.berkeley.edu/media/roundup/Effects%20of%20Prenatal%20Substance%20Exposure%20on%20Children.pdf

The Decision Tree

Child Indicator Seeds for Success

Serving Virginia's Military Families

Each year the President signs a proclamation declaring November **Military Family Appreciation Month**. This annual proclamation marks the beginning of a month-long celebration of the Military Family in which the Department of Defense and the nation honor the commitment and sacrifices made by the families of the nation's service members.

MILITARY OATH OF ENLISTMENT

I, (name), DO SOLEMNLY SWEAR THAT I WILL SUPPORT AND DEFEND THE CONSTITUTION OF THE UNITED STATES AGAINST ALL ENEMIES, FOREIGN AND DOMESTIC; THAT I WILL BEAR TRUE FAITH AND ALLEGIANCE TO THE SAME; AND THAT I WILL OBEY THE ORDERS OF THE PRESIDENT OF THE UNITED STATES AND THE ORDERS OF THE OFFICERS APPOINTED OVER ME, ACCORDING TO REGULATIONS AND THE UNIFORM CODE OF MILITARY JUSTICE. SO HELP ME GOD.

This is the MILITARY OATH OF ENLISTMENT. It is recited by all Service Members at their swearing in ceremony. Speaking these words has far more emotional power than these words on paper could ever convey. Anyone who has done this for real knows, in that moment, that they are agreeing to defend a principle with their very lives. It is a moment they never forget, one that starts the bonding process with their fellow soldiers and one that will have a lasting impact on their families.

If you are working with military families of young children with developmental delays and disabilities, it's important to understand the military culture, commitment and experience in order to provide family centered services. The following short movie clip provides insight into why so many chose to take the oath and the emotional sacrifices they and their families make each day. As you watch the clip, jot down some of the stressors young military families may be experiencing that may shape the way you complete functional assessment and provide family centered coaching.

Here are 10 things that struck me as having a potential impact for the family portrayed in the clip but could very well be felt by many who face combat deployments. Discuss these with your team. Do you agree? Why? I added my rationale for the first two. Did you find others? How can you use this information in your work with military families?

1. The adrenaline high, or adrenaline addiction – "It's like the best!" Soldiers in combat zones live in heightened states of adrenaline that often leave them feeling empty when returning home.
2. Personality changes: No one returns the same from combat or lengthy deployments. Family members often report feeling like they have been reunited with a stranger.
3. Generalized and undifferentiated anger: short fuse, loss of patience, (increase in domestic violence and child abuse). "Now when he gets mad, he just screams."
4. Grief over absence during important life transitions (also, resentment by spouse at soldier's absence). "When I come home I just want to hug her, but she may not let me because she won't know who I am."
5. Intense bonding during deployment competes with and sometimes trumps marital and family bonds. "My friends here are closer than any I've had." "These guys take you on as a brother."
6. Survivor guilt and loss: "It hurts a lot to lose fellow soldiers."
7. Family of origin issues: "I want to make my Dad proud."
8. Fantasy verses reality: (living on dreams and through TV series).
9. Emotional numbing: "He used to be sensitive. Now, he shows no emotion and wants me to be the same way."
10. The ramifications of "sacrificing for family" and the sacrifices made by families.

In honor of Military Family Appreciation Month share your experiences, strategies and ah-ha's by visiting one of Virginia's Strategies for Success blogs devoted to supporting military families.

http://veipd.org/earlyintervention/military-deployment-is-hard-but-you-can-help/

http://veipd.org/earlyintervention/whats-the-deployment-cycle-for-military-families/

http://veipd.org/earlyintervention/dont-forget-fathers/

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2. **Was there input into the narrative from all members of the assessment team including the family? Did the narrative contain jargon?**
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Jimmy's Age: 26 months Adjusted Age: NA

Referral Information, Medical History, Health Status: Jimmy was referred to the Infant Program by his mother due to feeding concerns. At the time of this evaluation, medical records have been requested but have not been received. Per parent report, Jimmy passed his newborn hearing screening. He and his mother were discharged home two days after his birth. Jimmy currently receives medical care from the clinic on the Army Base. Jimmy's mother reported that he had his last check-up in August and everything was fine. His mother has no concerns with his hearing or vision. She said no concerns were mentioned at his well child visit and he passed his Part C Vision and Hearing Screening. He receives private therapy thru the County Speech Clinic. His mother reported that his feeding issues are significant and it was recommended that he receive additional therapy to address the feeding issues. His mother would prefer to have the additional therapy in her home if he qualifies for services.

Daily Activities and Routines: Jimmy lives with his mother and sister in an apartment off base. His father is currently on a six month deployment. Maternal grandmother is staying with the father to help out while father is overseas. Jimmy's mother works part-time but is home with him during the week when she is not working. Jimmy enjoys playing with his sister. He likes to watch the Wiggles. He loves zoo animals and can name many of them in a picture book. He also has a toy with zoo animals that he can put the animals in different parts of the toy. That is one of his favorite toys. His mother has a friend with two children and Jimmy enjoys playing with them. When the family goes to the park Jimmy observes from a distance and is very cautious staying close to his mother.

Understanding what Jimmy wants is very challenging to his family. He has a vocabulary of about 30 words but doesn't use them often. He has feeding difficulties and is very limited with the foods he will eat. His mother gives him homemade Smoothies and Enfamil for Toddlers to make sure he gets enough nutrients daily. She tries to get him to eat a larger variety of foods but he refuses, gags at just the sight of food and will choke and do whatever he has to, to get food out of his mouth.

Jimmy's mother also reported that bath time is challenging for him. She has to stay right next to him. He gets panicked with showers and does not want a bath. When the water is drained he starts grabbing all of his toys in a panic that they are going to go down the drain.

Family Concerns: Jimmy's mother is most concerned that he will not eat hardly any foods. The ones he will eat have very little nutritional value. He will eat popcorn, chips, crackers, apples, bananas and sometimes noodles. He will eat cereal without milk. He is still using a bottle. Mother reports Jimmy gags at the sight of food and will even gag when his sister eats.

Family Priorities: The most important thing for Jimmy's mother is that he eats a variety of foods without gagging or choking. She would also like for him to be less panicky about taking a bath and shower. Ideally she would like for this to happen before Jimmy's father returns home as it is very stressful to their marriage. Jimmy's father doesn't understand and blames mother for babying him.

Developmental Levels: Cognitive- 24 months Gross Motor- 24 months Fine Motor- 24 months
Receptive Language- 16 months Expressive Language- 22 months Social/Emotional- 18 months
Adaptive/Self Help- 15 months

Social/Emotional Skills including Positive Social Relationships: Jimmy has had some exposure playing with other children. He is interested in what other children are doing and will play with the children of a family friend. He doesn't really interact with the children but will play alongside them. He is starting to engage in pretend play and did a nice job with holding the baby doll and trying to feed her. He is using some social words and will say family names and will say bye when others leave. He has temper tantrums and will defend himself when others take things from him which is normal for his age. He is very particular with his likes and dislikes. He is not yet helping to clean up. He is not yet imitating household chores that he sees others do.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Jimmy's mother reported he has about 30 words that he uses somewhat regularly. He loves zoo animals and can say the names of many of them. He will try to say the names of family members by saying "ma-ma", "da-da", "baby" for his sister. He tries to say her name although it doesn't sound like her name. He is beginning to say words to label things but is not using conversational speech. Next he will be able to say what he wants more often and will use short phrases by putting two words together. His mother reported he does not follow directions when she asks him to go get something. He knows many body parts and will point to them when asked except when taking a bath or shower when he is too upset to listen. He can say his ABC's. He likes to do things on his terms but has difficulty following adult directed activities.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Jimmy walks, runs, and can climb up and down stairs but requires the assistance of his mother to hold his hand. Safety is still a concern for him when climbing the stairs and his mother reported he is not always aware and will try to walk up two steps at a time. His mother reported he will jump but not from a bottom step. He can kick a ball forward and enjoys doing this activity with his father when he is home. He enjoys climbing and can easily get on and off the furniture. He is not able to carry large objects when walking.

Jimmy is a picky eater and his mother is concerned that he is not getting enough nutrition from the foods he eats. He refuses to drink from a sippy cup. Mother reported she would like to have him off of the bottle before Jimmy's father returns. He feels like mother babies Jimmy. Jimmy likes homemade Smoothies and will sometimes eat chicken nuggets. When mother tries to introduce new foods he refuses. She tries to sneak a new food with something but as soon as Jimmy becomes aware of it he gags and tries to get it out of his mouth. He does not chew foods well. He nibbles food and at times chokes. He does eat a variety of textures but does not like anything that is slimy. He is not yet able to use a spoon by himself but does try to scoop with the spoon but then uses his fingers to take the food off of the spoon to put into his mouth. Jimmy is very fearful of bath time and it becomes an issue each night. He will take a shower but

someone has to be right next to him. He is also fearful of being in any room of the apartment alone. She has been letting him sleep with her since father is gone but knows he must go back to sleeping in his own bed before he husband returns. Jimmy does not help with dressing at all. He tolerates it but does not assist. He is just starting to show awareness of knowing when he is wet or has had a bowel movement and will make comments. However, he is not interested in sitting on the potty.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:

Social/Emotional Skills including Positive Social Relationships: Rating 5- Jimmy shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

Acquiring and Using Knowledge and Skills, including early language/communication: Rating 5- Jimmy shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

Use of Appropriate Behaviors to Meet Needs: Rating 2- Jimmy shows some of the early skills that are necessary for development of more advanced skills in this area.

Determining the indicator ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three indicator areas.

The Three Global Child Outcomes Are Related to One Another

Most children gain skills over their time. Development tends to progress in predictable stages across outcomes. As abilities in one outcome increase, abilities in the other outcomes tend to increase. Progress in functioning in the three outcomes proceeds together. Since each of the outcomes includes overlapping of skill across the outcomes, it would be unlikely (possible but rare) for a child to have a ratings that differed by 3 points or more across outcomes.
A good reminder when determining ratings is:

- Functioning in one outcome area will be related to functioning in other outcomes
- Functioning at entry (or exit) in one outcome will be related to functioning in the other outcomes

Test Your Inter-rater Reliability

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Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Maria's Age: 24.5 months Adjusted Age: NA
Developmental Levels: Cognitive- 22 months scattered to 24 months
Receptive Language- 18 months Expressive Language- 12 months
Gross Motor- 21 months scattered to 24 months
Fine Motor- 21 months scattered to 24 months
Adaptive/Self Help- 24 months Social/Emotional- 24 months

Social/Emotional Skills including Positive Social Relationships:
Maria communicates her feelings by smiling and interactive play. When she is frustrated or angry Maria grunts/growls and will also point for assistance. Maria engages her mother and other family members in play by handing them objects or toys. Maria is loving with her mother, giving her hugs and sitting next to her. Maria often waits on her mother to imitate what she does. Maria follows her brothers around when they arrive home from school, smiling and chasing after them. She engages others in interaction by walking over to them, leading them to toys and handing them toys. She will also say "aqui" (here) and "esse" (that/that one) during this time. She is slow to warm up to strangers and some adults that she already knows. Maria will stand close to her mother during entry and typically takes up to ten minutes to begin playing and interacting with those in the room. She will often stare for several minutes, standing close to her mother prior to her developmental services. Maria can wave and say "adios" upon leaving.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication:
Maria will play for long periods of time (10-20 minutes), she will play with her dishes by putting lids on, imitating pretend stirring and flipping with spatulas. She will look at picture books for up to 5 minutes at a time and will say pictures that she recognizes such as dog and shoes, sometimes needing prompting. Maria will imitate all types of play and include them in her role playing like dressing and undressing a doll, pretend to cook, make car sounds, and rock and wrap a baby in a blanket. During one of Maria's developmental services she watched the interpreter draw on a note pad. Now she can scribble on her own without imitation. Mother reports Maria repeats Spanish words more than English words, but she will repeat words especially for her mother. Maria responds to directions

English and Spanish and will do what is asked of her. If her mother says no, she will either grunt or stop what she is doing. If she is asked to bring something over such as a doll or book she will get it and bring it to that person. Maria communicates with gestures and some Spanish words (mother states she has 6-8 words in her vocabulary). Maria will sit for a few minutes at a time figuring out how to get lids onto her pots that fit. She does ask for assistance by trying to hand the object to others, but is often encouraged to do it herself and she will typically try it again. Maria always smiles when she has accomplished a task and looks for approval such as clapping or good job.

Some children Maria's age can say more than 50 words and put these words together in 2 word phrases to communicate with others. About 50%of what they say should be easily understood by strangers. They understand prepositions, such as under, over, in and out. They can refer to themselves by name or as "I". They can point to many body parts, even beyond the simplest ones.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs:

Maria walks, runs, climbs and reaches to get what she wants like toys and family members. Maria does stop when asked and she will hold hands if prompted to do so. Maria can feed herself by finger feeding and with a spoon. She can also drink from an open cup. Mother stated she asks Maria at meal times to grab a pillow to put in the chair so that she can sit at the table and eat with her family. Mother reports when she tells Maria to get the pillow she knows they are about to eat and when she is done eating she will take the pillow back to the couch. Maria can undress herself and can pet her shoes on and put her pants on part way. Mother reports Maria sleeps throughout the night but sometimes after they put her to sleep at night they find she has gotten back up and is playing with her toys. Some children Maria's age ask for snacks or drinks when hungry/thirsty. They have mastered the use of specific words such as juice, cookie and milk to request food/drink items. They also can ask for some specific toys, activities and people. Some children Maria's age let their parents know when they have a wet or dirty diaper.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:

Social/Emotional Skills including Positive Social Relationships: Rating 7: Maria has all of the skills we would expect in this area.

Acquiring and Using Knowledge and Skills, including early language/communication: Rating 5- Maria shows many age expected skills. She continues to show some skills that might describe a slightly younger child in this area.

Use of Appropriate Behaviors to Meet Needs: Rating 5- Maria shows many age expected skills. She continues to show some skills that might describe a slightly younger child in this area.

Determining the indicator ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three indicator areas.

- ./ Know what behaviors and skills are appropriate for the child's age; how do children who are developing typical function on this indicator?
- ./ Don't forget culture! What is the typical age for toileting readiness in a child from the Hispanic culture?

Here is a resource on expectations for appropriate behaviors to meet needs amongst different cultures:
Dimensions of Culture

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Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
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Yamir's Age: 6 months **Adjusted Age:** 3 months

Referral Information, Medical History, Health status: Yamir was referred to Sunnyside Infant and Toddler Connection by Dr. Meadow at Sunnyside Pediatrics due to concerns with Yamir's prematurity. Mother's water broke when she was 26 weeks along and Yamir was born then. He was born at Sunnyside Medical Center. When Yamir was born, he weighed 1 pound and 15 ounces. He passed his newborn hearing screening. The MRI completed showed that he had a grade 1 intraventricular hemorrhage. He was transferred to Cloudyside Children's Hospital shortly after birth. He finally came home from the hospital late summer. Yamir is diagnosed with left vocal cord paresis and subglottic stenosis with laryngomalacia. He had a Nissen procedure completed. He also had his G-Tube placed.
Dr. Gastric is the doctor following up on this. Yamir has dysphagia. He had a swallow study completed which showed aspiration to all liquids. He is scheduled to have a pharyngeal function study at Cloudyside Children's hospital. Yamir has left ventricular hypertrophy and an Echo completed showed a mild left ventricular hypertrophy. Yamir has right nephrocalcinosis. Yamir sees Dr. Meadow at Sunnyside Pediatrics for routine health care.

Daily Activities and Routines: Yamir Jives with his parents. His dad works at a nail salon and his mom is currently looking for a job. Yamir's grandparents help watch Yamir occasionally. Yamir loves bath time and he will cry when he is taken out of the bath. He also loves his mom talking to him. Sleep is currently a difficult time because Yamir will sometimes wake up mad, and his family is concerned that he might be having nightmares. Yamir's family would like for him to learn both Hindi and English. They would like for Yamir to attend child care when he is around one year old. Currently, Yamir has many doctor appointments and Mother has to bring him to Sunnyside Medical Center or Cloudyside Children's hospital often. It can be difficult for Yamir's family to communicate with doctors because Mother does not speak English.

Family Concerns: Yamir's family is concerned about his prematurity and his overall development. They are concerned that he keeps his head turned to the right and that he does not like to be on his tummy. They are concerned that he is using a G-Tube.

Family Priorities: Yamir's family would like for him to learn how to eat. They would like for him to tolerate being on his tummy and turning his head to both sides. They would also like for him to continue to gain skills and meet developmental milestones.

Developmental Levels: Cognitive- 4 months Gross Motor- 1months Fine Motor- 2 months
Receptive Language- 4 months Expressive Language- 4 months
Social/Emotional- 3 months Adaptive/Self Help- 2 months

Social/Emotional Skills including Positive Social Relationships: Yamir loves when his mom talks to him. He will smile when she holds him and talks. When he hears his giraffe sing the ABCs, he will smile, kick his legs, and wave his arms. Yamir is not yet recognizing the differences between people. When someone walks into the room, he does not react differently depending on the person. Mother calms Yamir by carrying him, and patting his bottom. He will follow people with his eyes when they walk around the room. Yamir enjoys looking at his mobile and bright lights.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Yamir loves to listen to his giraffe stuffed animal that sings the ABCs. He will turn his head when he hears his mom's voice. Yamir's airway is too narrow so he is constantly making heavy breathing sounds His family hopes that his airway will correct on its own. He is very vocal, but is not yet making babbling noises or vowel sounds. Yamir loves to see himself in the mirror. When he is in his swing, he will look at his mobile. His mobile also has a mirror and he will watch himself. He will watch his hands and also put them in his mouth. Yamir is not yet reaching for toys or his parents. He keeps his hands closed and will grab his mom's finger if she places it near his hand. He is not yet holding briefly onto a rattle or other objects.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Yamir is not yet rolling over. He does not like being on his tummy because of his G-Tube. His family does not put him on his tummy because they are afraid that it will hurt him. He will kick his feet while on his back. Yamir moves a lot and wiggles his body. He wiggled so much one time that his feeding tube was dislodged and they had to bring him to the hospital to get it fixed. Yamir keeps his head turned to the right side. His grandfather reported that he was kept on that side during most of his time in the NICU. He will bring his head to the middle when following an object, but not all the way to the left side. Yamir's cries sound the same for when he is hungry, wet, or tired. Sometimes he will wake u p from a nap mad, and his family is concerned that he might have nightmares. Yamir is fed via a G-Tube. His family will put a little bit of cereal on a pacifier for him to try to learn how to eat with his mouth. They would like for him to learn how to eat.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:

Social/Emotional Skills including Positive Social Relationships: Rating 2: Yamir is beginning to show some of the early skills that are necessary for development of more advanced skills in this area. Acquiring and Using Knowledge and Skills, including early language/communication: Rating 1-Yamir has the very early skills in this area. This means that Yamir has the skills we would expect of much younger child. Use of appropriate Behaviors to Meet Needs: Rating 1- Yamir has the very early skills in this area. This means that Yamir has the skills we would expect of a much younger child.

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Indicator statements (ratings) are based upon child's
chronological age- there is no adjustment for prematurity.

Yamir's family will face many challenges due to his prematurity and medical concerns. Check out the following resource from Virginia's EIPD Early Intervention Strategies for Success Blog to test your knowledge. Take a pop quiz to see what you know and keep reading for answers and tips you can use when supporting preemies and their families!
Preemie Pop Quiz and Tips

The Decision Tree

Child Outcome Seeds for Success

Why Culture Matters: Grandparents Raising Grandchildren

(courtesy of SCANVA)

When parents are unable to raise their own children, it is the grandparent who often steps in to assume the responsibility. Today in the United States, more than 2 million grandparents are living with and serving as the primary caregiver for their grandchildren. This trend poses incredible challenges both to the grandparent and the children involved, affecting everything from financial stress to child developmental to general family cohesion.

Why do grandparents become parents all over again? Grandparents often assume the role of parent in an effort to keep their family together and keep their grandchildren out of the foster care system. It might happen when a parent is incarcerated, or struggling with substance abuse, domestic violence, mental illness or other long-term health problem. A parent could be stationed overseas in the military. In some unfortunate cases, a parent may also be deceased. Whatever the reason, when a grandparent steps in to care for a child, they take on an incredibly demanding role at a time in their lives when they might have otherwise been relaxing and relishing time alone.

The challenges for the grandparent: Although a grandparent most often chooses to raise a grandchild for the right reasons, they are usually not prepared for the high demands of raising a child today. Unlike a foster parent, grandparent caregivers are usually offered no training to raise children, let alone a child who might be traumatized by losing a parent in some capacity.

Mental stress: Grandparents almost always take on the responsibility of caring for their grandkids because of a family emergency or tragedy. This means that they have to deal with their own emotional reaction to the circumstances along with those of their grandchildren. Once they overcome the initial shock of the situation, there is still the general stress of parenting. Their grandchildren may also have special medical, educational and psychological needs that require special attention.

Physical stress: As seniors age and require more medical attention, those raising their grandchildren often have less time and money to spend on their own health. In addition, the high physical demands of raising children (especially those under age 5) can take a serious toll on a caregiver's health.

Financial stress: Perhaps the most immediate (and often most stressful) challenge for many grandparents is the financial burden of raising children, especially unexpectedly. Grandparents who are raising their grandchildren are 60% more likely to live in poverty than those who are not. And even if a grandparent is able to sufficiently support themselves, the cost of children can be overwhelming. Many are retired or living on fixed incomes, but they are suddenly forced to feed more mouths, fit more people into their home and pay for the endless other necessities associated with raising a child.

Day-to-day challenges: If the child's original mother and father are absent, grandparents who do not have legal custody of their grandchildren might have trouble enrolling them in school, providing them with proper medical care and accessing their records. But obtaining custody and/or guardianship can be expensive, emotionally draining and confusing.

Grandparents can overcome these challenges! Parenting can be tough. The second time around it might even seem impossible! But there are steps grandparent caregivers can take to make the transition smoother and the new family unit stronger. Children in this situation-regardless of why their parents are no longer there-may be dealing with serious issues of abandonment, parental confusion and emotional detachment.

The most important piece of advice for grandparents raising their children is the same thing we tell all parents: Parenting is TOUGH. And asking for help shouldn't be.

Please see the Tip of the Month at the end of the Inter-rater Reliability Section for Specific Resources for Virginia's Grandparents Raising Grandchildren

To Find the Fact Sheet that is the source document for this Update, please go to https://www.scanva.org/wp-content/uploads/2016/05/Grandparents_English.pdf

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Precious's Age: 27 months **Adjusted Age: NA**

Referral Information, Medical History, Health Status: Precious has been receiving a variety of developmental services since May of 2014. She was originally referred due to a birth history significant for extreme prematurity with a gestational age of 24 weeks, 4 days, 99 days in the NICU and multiple diagnoses including bronchial pulmonary dysplasia, bilateral IVH grade 1, ROP stage1, respiratory distress syndrome, patent ductus arteriosus and GERD, among others. Since that time, her ophthalmological, endocrine, gastroenterological and pulmonary concerns have resolved. Precious has a health history significant for numerous ear infections. She had tubes placed in both ears and has had only one ear infection since that time. An audiological evaluation revealed normal hearing bilaterally. Precious also has a history significant for clinical reactions to penicillin drugs including a rash. Allergy testing was asymptomatic however she was diagnosed with a penicillin allergy based on consistent clinical symptoms. She was also diagnosed with an allergy to mold. Precious has an intolerance for milk products unless they are lactose-free.She also has intolerance for apple products and bananas although no allergy was confirmed during recent testing.
Medical records from Precious's pediatrician indicate that her cardiologist expects her small ASD to close on its own.
At Precious's 2-year well-child visit her pediatrician indicated developmental delays in at least motor and language skills and atypical development related to sensory-seeking behaviors based on results of the MCHAT and the ADOS
Precious is up-to-date on her immunizations.

Daily Activities and Routines: Precious lives at home with her custodial maternal grandparents. She has a large extended family that she sees often. Her grandfather's sister helps care for Precious on a regular basis. Precious has had no contact with her mother since shortly after her birth. Precious's family likes to take her on errands, out to eat, visiting friends and neighbors and church but find it a challenge due to Precious's constant mobility, her impatience, her tendency to do what she wants rather than do what her grandparents ask her to do, her tendency to demand constant attention and her easily angered temperament. Precious's Grandmother also expresses concern about her limited attention span; particularly to verbal instructions which makes it difficult to modify her behavior. Another difficult area is Precious's messy eating habits. Grandmother reports that Precious takes an afternoon nap and sleeps well through the night unless she's not feeling well. She goes to bed at around 9:00 pm and wakes at around 6:00 am. She plays by herself in her crib for 15-30 minutes after waking which gives Grandmother a nice break as she does not demand

immediate attention any more. Precious eats her meals with her family but she likes to play with her food and crumbles crackers, spits her food out and drops or throws it which makes mealtimes disruptive. Precious spends the day with both of her grandparents, playing independently, playing with her grandparents and accompanying them on chores around the farm, visiting and running errands. Most evenings the three of them play a game of rolling a ball back and forth in the living room. Precious enjoys the company of her extended family including her uncle, his wife, her great-aunt, and their two grandchildren ages 7 and 10.

Family Concerns: The family's main concerns are that they are not able to take Precious on outings with them due to her temperament which tends to be restless, impatient, demanding and easily upset and angered as well as safety issues related to Precious's tendency to put everything in her mouth. Other concerns include the difficulty of raising a child without adequate financial resources as well as the difficulty inherent in being older caregivers for a young, active child.

Family Priorities: Precious's family always wants what's best for her and carefully attends to her health, safety and development. They're pleased with progress developmentally and medically but know that she has a way to go and are always on the look-out for resources. They'd like to take advantage of public school resources next school year. Right now they'd like to see her learn to attend better to what they're saying to her, use more words to communicate and learn to entertain herself better, particularly when out visiting, shopping or dining, without demanding constant attention or becoming angry. They would also like to see her sit in her booster seat for an entire meal and feed herself with a spoon or fork.The single most important thing for Grandmother is that Precious stop putting everything in her mouth as she's concerned for her safety.

Developmental Levels: Cognitive- 21 months Gross Motor- 16 months
Fine Motor- 18 months Receptive Language- 14 months Expressive Language- 16 months
Social/Emotional- 15 months Adaptive/Self Help- 13 months

Social/Emotional Skills including Positive Social Relationships: Precious's Grandmother describes her as a happy, affectionate little girl who loves to hug and kiss the familiar adults in her family spontaneously and when asked to. Grandmother reports that she will also show affection to her 7 and 1O year old cousins and that, for the first time yesterday, approached a child her own age to hug her. Grandmother reports that Precious is beginning to engage in simple role-playing and pretend behaviors. She pretends to feed her family food and pretends to be asleep.
Precious generally ignores the presence of children her own age when in a social situation and goes about her own business according to Grandmother but loves to spend time with older children and watches what they do and tries to follow along. She also likes to play a simple game of throwing a ball back-and-forth with her grandparents in the evening when on the floor in the living room. She is beginning to have a sense of personal possession and although she doesn't resist having a toy removed from her she does cry with anger when this happens. Precious is not, yet, taking the initiative to engage other children in play, or participating in simple games with other children. Although Precious is generally a happy, curious little girl, she expresses anger dramatically when things don't go her way and will yell, scream, frown and throw things. Grandmother reports that she is very skillful at manipulating the adults who care for her and knows which ones will give her what she wants and which ones will not.
Precious is extremely distractible and loses her attention to social games and social interactions or activities with toys after only a few seconds most of the time. She has a very difficult time self-regulating and often dissolves into fits of temper. She is constantly seeking sensory input by putting (non edible) things in her mouth, by running, throwing things, ripping, tearing and destroying things. She has a very difficult time sitting still and will fight being confined in her high chair or her car seat even when entertaining distractions are presented. All of this significantly affects her ability to attend to the language of others and to learn language for social communication purposes; attend to and engage in the social games and activities of other children; manage her behavior in social situations and in the daily activities of living including at mealtimes, when shopping or waiting in the doctor's office.

Child's Development in Relation to Other Children the Same Age: Precious uses many important skills that are necessary for the development of more advanced skills; she is not yet showing skills used by other children her age in this area. Her attention to social events and social communication is easily fractured and compromises her skill development. She seems to have a significant delay in processing social language information and due to her brief attention is off to something else before she processes the information at hand.

Acquiring and Using Knowledge and Skills, including early language/communication: Over the past year, Precious has begun to engage in constructive activities with toys some of the time. Grandmother reports that recently she has discovered that Precious can focus for longer periods of time if she plays with her with toys in the tent that's in her bedroom as there are fewer distractions there. She has also been seen to attend for more than a few seconds following 5 or 10 minutes of deep pressure massage. Grandmother reports concerns that Precious will eat non-edible items and mouths objects. Today Precious was observed mouthing and chewing on a bumpy ball the examiner brought. She held it between her teeth and shook her head with the ball in her mouth. She was also seen to lick other toys. Precious was seen to hold her arms back and out to the side with elbows extended, and wrists bent. She did this several times holding the position for a few moments before relaxing.She sought out the ball and rolled on it and hugged it to her tummy in what appears to be sensory seeking behavior. Grandmother has brought out her old teething rings in an attempt to redirect Precious to mouth them instead of other items.

Precious has always loved looking at pictures in a book and although she hasn't been able to attend to a story or the naming of or pointing to pictures, she enjoys scanning the pages. When asked "Where is the_", she generally stares for several seconds without reacting followed by continuing to look at pictures on her own. During this assessment, Precious attended, for the first time, to the examiner asking her to point to familiar objects in a book and she was able to complete 3 requests successfully (kitty, shoes and banana) before losing attention. Grandmother reports that when she can get her attention focused, Precious will point to several body parts on herself when asked to including eyes, nose, teeth and mouth. She is working on ear.

Precious was observed to place 5 rings on a stacking post with encouragement after repeatedly pressing the button to activate the music. She used two hands to place rings but was seen one time to place a ring with one hand following a deep massage. She stacked one small block on top of another and released it but then proceeded to line them up in a row and could not be encouraged to return to stacking. Grandmother reports that lining up objects is a new fascination for her. Precious placed a circle and a square in a form board after the examiner tapped the appropriate receptacle for the square. She tended to use trial and error for the square but visual matching for placing the circle. Precious consistently relies heavily on visual information rather than on verbal information. The examiner needed to pat the floor when saying “Sit down, please" before Precious would sit (momentarily) and tap the form board to keep her focused and attempt placement. Precious was also observed to solve the problem of removing a Gerber Puff from a bottle by rotating her wrist to dump it and then shaking the inverted bottle when it wouldn't fall out. She located an item hidden in one of the examiner's hands in one trial of three.

Precious inconsistently follows verbal directions but is more reliable with directions related to daily routines where a lot of repetition, familiarity with the event and context clues help her focus on the verbal information associated with these activities. Examples include getting ready to go outside, to eat, to brush her teeth, to go to bed and to take her bath. She attends better to non-routine directions, as mentioned previously, when gestures can be used to help her attend and understand or when in a quiet environment with fewer distractions. Precious always immediately reacts to someone mentioning her grandfather by going to the door to look for him if he's not in the house. Grandmother reports that she reacts mainly to the naming of other familiar people or favorite objects or events if they are routine or something she always loves (like food or a drink). Otherwise, she tunes out the speaker. When she is attentive to a direction, she can follow one part of it but not the other. For example, if Grandmother says "Throw the ball to Paw-Paw", Precious will throw the ball randomly.

Precious vocalizes mainly in short, one-syllable open-vowel utterances. She does not babble or jargon. She uses approximately up to 10 words to label, greet, request and call to her grandparents.Voicing of words is soft, limited to one- syllable, incomplete and indistinct. She consistently uses the words no, milk (spoken as mmmmm), mama, paw-paw, daddy {spoken as dadeeee}, ea(t), bubu (for bubbles) with a lip tap as demonstrated by her Grandmother, ball, kitty, see and hi. She's recently begun saying bye accompanied by a wave although this is not, yet, consistent.

Child’s Development in Relation to Other Children the Same Age: Precious uses many important skills that are necessary for the development of more advanced skills used by other children her age in this area. Her attention to tasks is so brief and her need for sensory stimulation so great that it interferes in her skill development; particularly in the areas of toy play, problem solving and language.

Use of Appropriate Behaviors to Meet Needs: Precious uses her eyes to track and focus on objects and people in her near and distant fields of vision without difficulty. She notices objects entering her peripheral fields and uses her vision

to direct her hand in reaching for an object. Precious notices loud and soft sounds in her environment as well as voices but often seems to tune them out or demonstrates a much delayed response. Her recent audiological evaluation revealed normal hearing bilaterally.Precious has learned to walk over this past year but tends to run rather than walk. She can throw a ball forward using both hands on the ball for a distance of up to three feet but directionality is compromised. She climbs up steps using her hands and knees or hands and feet and does not go down steps and needs to be carried. Grandmother reports that on one occasion she walked up a few steps with her hand held but this is not typical as she's not secure doing this. Precious does not shift her weight to kick a ball nor does she kick a ball by walking into it.

Precious reportedly sleeps through the night, now, and takes an afternoon nap. She talks to herself in her crib for 15-20 minutes after she wakes up and no longer needs immediate attention as she did when she was younger. Precious sits in a booster seat for meals and has a hard time sitting still. She shifts herself around in the chair constantly, plays with her food (including crushing crackers, spitting and throwing food) and wants to get down. Grandmother reports that mealtimes are a challenge because of this. Precious finger feeds all table foods but does not use a spoon. If Grandmother hands her a spoon with food on it she'll fling it. Precious drinks from a sippy-cup, primarily, but cannot drink from a cup without a lid.

Precious's self-help skills related to dressing include the ability to remove pants, shirt, diaper, socks and shoes. She can unzip a jacket and remove it, as well. She helps with dressing by holding out arms and legs but is not yet trying to dress herself. She prefers to be naked, according to Grandmother.

As was mentioned, previously, Precious uses some gestures some of the time including pointing but usually yells or screams for what she wants although she does use several words to make requests including milk, eat and bubble. Grandmother reports that she cannot leave Precious unattended due to her tendency to put everything in her mouth, break things and get into unsafe situations. She does not generally follow directions and when told to stop doing something, may stop momentarily but then returns to it. Precious is beginning to show an interest in toileting and Grandmother reports that she's recently been willing to sit on the toilet when Grandmother suggests it.

Child's Development in Relation to Other Children the Same Age: Precious uses many important skills that are necessary for the development of more advanced skills; she is not yet showing skills used by other children her age in this area.

Determining the outcome ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three outcome areas.

- ✓ Grandparents raising grandchildren is an increasing family situation here in Virginia. The Virginia Department for the Aging has put together a 66 page resource guide specifically aimed at helping grandparents raising grandchildren access available resources in Virginia.
- ✓ Additional Virginia resources can be found at www.vda.virginia.gov/kinshipcare/asp.
- ✓ A resource published by the Virginia Cooperative Extension, thru Virginia Tech and Virginia Commonwealth University discusses some of the legal rights and challenges for grandparents raising grandchildren.
- ✓ The following journal article reviews current research related to the increasing family situation of grandparents raising grandchildren especially those doing so with limited resources and living in poverty: www.ncbi.nlm.nih.gov/pmc/articles/PMC2888319/.
- ✓ Be sure to check out this month's Early Intervention Strategies for Success Blog written by Dana Childress which addresses concerns vs priorities: Priority or Concern What's the Difference and Why it Matters. Grandparents raising grandchildren often have very different concerns and priorities based on their life experiences, limited resources and their own aging health concerns. Precious's team was able to really focus in on the family's concerns, priorities and challenges related to their daily routines and activities, which resulted in meaningful, functional IFSP outcomes.

The Decision Tree

Child Outcome Seeds for Success

Why Culture Matters: Fatherhood around the World

Introducing July 2016 American Academy of Pediatrics Recommendations for Promoting Father Involvement

"Intervention programs with parents of developmentally delayed children have far better child outcomes when fathers participate in the parent training along with mothers." AAP July 2016

Having just celebrated Father's Day, we are reminded of the important role fathers play in their child's life through their positive involvement and the unique ways they contribute to their families and children. While we know cultural influences and expectations often dictate what the role of a father might look like, circumstances often lead to less than traditional roles. Excitingly, research on fatherhood around the world is changing. In the past, researchers have focused on two distinct trends—father-absence versus father-involvement and father-provider versus father-nurturer. And while these trends are still evident in modern fatherhood in many different countries throughout the world, including the United States, research seems to be shifting to ways fatherhood can be supported in its many forms. There is recognition that a father's participation leads to positive child outcomes. Below are three great resources that examine current research for fathers around the world.

July 2016 American Academy of Pediatrics Clinical Report reviews current research on father involvement and focuses on how pediatricians can support the role of fathers. Concerns driving the recommendations in the report **Fathers' Roles in the Care and Development of Their Children: The Role of Pediatricians PEDIATRICS Volume 1 38, number 1, July 2016: e2 0161128** are described as *"the field of pediatrics remains slow to incorporate these findings into practice and into the conceptualization of family-centered care. Although mothers continue to provide the majority of care for the well and sick child, fathers are more involved than ever before. Yet, cultural and structural biases still play a role; pediatricians still see a majority of mothers at clinical encounters and therefore may not have changed their practices to be family-friendly in terms of available hours, comfort in interacting with men, and addressing fathers' unique concerns regarding their children."* Recent studies have specifically explored the role of divorced fathers, stepfathers, adoptive fathers, teen fathers, low income fathers, gay fathers, incarcerated fathers, disabled fathers, fathers of children with special needs, immigrant fathers, etc. Based on the extensive review of current research, there are 14 recommendations provided for pediatricians to encourage father involvement in the ongoing care of their child.

Fathers in Cultural Context edited *by David W. Shwalb, Barbara J. Shwalb, and Michael E. Lamb,* **(available for purchase online)** *provides a compilation of the latest research on fathering across various cultural and situational contexts. The book's contributors provide an in-depth look at the diverse influences on fathering (cultural and historical,* policy*, economic, and social) from 14 nations around the globe.* The cultures were selected based on availability of substantial research on fathering; representation of worldwide geography; a balance between large, middle, and small populations; and significance for a global understanding of fathering. Each chapter features personal case stories, photos, and maps to help readers create an engaging picture for each culture.

Fatherhood in Brazil, Bangladesh, Russia, Japan, and Australia by *David W. Shwalb, Barbara J. Shwalb* illustrates that the roles of fathers are highly variable and context-dependent. Research data from five diverse societies (Brazil, Bangladesh, Russia, Japan, and Australia) show that fathers, fathering, and fatherhood differ within societies according to eight types of contextual influence. Examples are provided of each contextual factor: (1) geographical location (e.g., dispersion of fathers across huge land masses in Russia and Australia; impact of dense populations in Japan and Bangladesh); (2) long-term historical legacies (centuries of patriarchy in Brazil) and short-term historical events (fall of communism in Russia); (3) family characteristics (joint, extended families of Bangladesh; small Japanese families); (4) economic factors (high standards of living in Australia and Japan); (5) work-related conditions (long work hours in Australia; level of encouragement for paternal work leave); (6) societal norms and values (social expectations for Russian fathers to be disengaged and uninvolved); (7) ethnic groupings (homogeneity of Japanese; impact of Islam on Bengali fathers); and (8) patterns of immigration and emigration (emigration from Bangladesh; immigration to Brazil).

Test Your Inter-rater Reliability

Our state's focus on child indicator ratings has led many to wonder,
"Are we all rating children similarly?"

As part of our efforts to improve results for children, we are focusing each month on increasing our statewide inter-rater reliability. We are using examples of narratives from around the state that ideally will include observations of functional behaviors, parent/caregiver input, results from assessment tools and informed clinical opinion. Below is an example of a narrative from a recent Assessment for Service Planning. Using the limited information provided in the narrative and the process outlined in the child Indicator Booklet talk thru the scenario with your colleagues to determine a rating. The ratings given by the assessment team can be found at the end.

Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family? Was the family's cultural differences considered?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Jeremiah's Age: 11 months Adjusted Age: NA

Referral Information, Medical History, and Health Status: Jeremiah was referred by his mother due to her shared concern with the pediatrician that Jeremiah was not crawling by the age of 11 months. Jeremiah was born at 37 weeks gestational age weighing 6 pounds, 11 ounces. Jeremiah's prenatal history was significant for gestational hypertension, preeclampsia and gestational diabetes. Jeremiah was born in the posterior position following 37 hours of labor and presented with jaundice. After day one he was admitted to the NICU for "dusky episodes" and was put on oxygen. He was also diagnosed with significant reflux. He was diagnosed Failure to Thrive until he was 4 months old. He continues to have reflux as well as eczema. In addition, Jeremiah's pediatrician noted upper trunk and neck weakness at 4 months and recommended more tummy time in spite of his reflux. Jeremiah is up to date on his immunizations. Jeremiah received a musculoskeletal exam to check for Hip Dysplasia at his 9 month exam but nothing was found warranting further testing. Jeremiah also has had his tongue clipped. Mother reports that at his last check-up, Jeremiah was in the 15th percentile for weight and 61rst for height.

Daily Activities and Routines: Jeremiah's parents are currently separated. Jeremiah lives at home with his mother and aunt 4 days per week and stays with his father and paternal grandparents 3 days per week (Friday evening thru Sunday afternoon). Mother was born in Russia and moved here with her parents when she was 15 years old. Her primary language is Russian but she is also fluent in English. Father grew up in the heartland of Virginia. Both of Jeremiah's parents were present during the assessment although mother answered most questions. Mother is home with Jeremiah most days and he also accompanies her twice a week when she babysits. He spends one a day during the week with his maternal grandparents. Mother reports that Jeremiah used to be a good sleeper, sleeping 10-12 hours a night from 7 or 8pm to 7 or 8am. Now he wakes repeatedly in the night crying. Mother attributes this to having to spend two nights per week at his father's house. When he wakes in the morning at mother's home he plays in his crib quietly for a while and then alerts her he's woken up with happy squeals and talking. He'll then have his bottle and his draper changed (in either order) and has breakfast an hour later, usually yogurt. He then plays throughout the day with his activity cube (especially with the beads on a wire), bottles, balls, and various light-up toys. He's transitioning from two naps a day to one so on the days when he only takes his first nap (between 11 and 12:30) he will usually become a little cranky during the time he sometimes takes his second nap (between 3:30 and 4). He also will only nap well in his own crib, which is

difficult on the days he joins his mother babysitting or visits his father. Jeremiah's parents use the Gentle Parent Attachment approach, although mother feels Jeremiah's father does not follow through on his days. Typically, Jeremiah is able to self soothe and put himself to sleep at both naps and at bedtime. Father does not feel sleeping is a challenge when Jeremiah is at his house. For lunch he eats a homemade chunky puree, usually a fruit and a grain. He has been refusing some bottles recently. Then he plays until dinner time if he doesn't stop for his second nap.

Because Jeremiah has eczema he only takes a bath once or twice a week but he loves baths and sleeps really well after. Mother reports her bedtime routine is to read a book and have a bottle and then lay Jeremiah down to watch his mobile until he falls asleep. She feels father has a different ritual which is why he doesn't always sleep well after coming home from his visits. Jeremiah loves going outside, swinging, and playing with his cat Felix. He likes puffs and dried apples but doesn't like "slimy foods" and will gag if given rice. Recently he's started resisting diaper changes by trying to get away. Jeremiah's parents have trouble taking him places. He spits up a lot in the car. Mother is not sure if it is due to the buckle of his car seat putting pressure on his stomach or because he is afraid of going to father's home. Both parents' agree if he were able to move more independently, they would like to take him to playgrounds and the Children's Museum, but right now he has to be carried the whole time. Jeremiah would also be able to do more outside than sit on a blanket and mother would have an easier time babysitting without having to carry Jeremiah from room to room with her throughout the day.

Family Concerns: Jeremiah's parents are concerned their current situation may be impacting his development including his difficulty sleeping and walking.

Family Priorities: Jeremiah's parents want him to reach his milestones and to be able to get around the house more on his own, being more self-sufficient. They would both like to be involved in sessions so there is consistent carryover throughout the week. Jeremiah's father also participates in all doctor's appointments stating his supervisors are very flexible and understanding to Jeremiah's needs.

Family Resources: Jeremiah's parents are both committed to doing what's best for his development. They recognize consistency is needed. Both maternal and paternal grandparents are involved in his care. Mother's sister is also considered a primary care provider during the days Jeremiah is with mother. Both parents have transportation and private insurance.

Developmental Levels: Cognitive- 12 months Gross Motor- 7 months Fine Motor- 5 months
Receptive Language- 12-14 months Expressive Language- 11 months Social/Emotional- 12 months
Adaptive/Self Help: 11 months

Social/Emotional Skills including Positive Social Relationships: Jeremiah's mother describes him as a happy and friendly little boy who rarely fusses without a clear cause. Father agreed. Jeremiah's parents use an approach called Gentle Attachment Parenting that Jeremiah has responded well to. He is very playful and was observed initiating a game called "scrunch face" with parents to make them laugh. He is very attached to his mother and usually becomes fretful when she leaves the room for a few minutes, even if other people are in the room with him. He also has a hard time saying goodbye to his mom and dad when they have to leave him. He fusses when his father picks him up and he has to leave mother but also cries when father drops him off for the week. He is aware of the difference between familiar and unfamiliar adults but is not anxious about strangers so long as a parent is present. Upon meeting the examiner he looked to his mother first and then looked questioningly at the examiner, warming up immediately as the examiner approached. He did not hesitate to interact with a new person but initially looked back at his mother when he was asked questions or offered toys. Throughout the assessment he was smiling, laughing, and open to following the examiner's lead in changing activities. Mother reports he enjoys playing with the other children she babysits but he will defend a toy he is playing with if it's being taken away from him. This would be one of the few occasions that he gets angry and cries. He also becomes frustrated when he can't reach something he wants but usually settles quickly. He was observed to bounce while making a repetitive whining sound as he became inpatient, wanting a puff to be offered faster, but he quieted quickly once the puffs were offered and smiled as he ate one.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Jeremiah was observed to enjoy playing with a variety of toys, especially those with parts he can open, close, and move. He has an activity cube with five sides of activities including beads on a wire that he particularly enjoys. He was also observed showing great interest in the novel toys brought by the examiner, though he wanted to explore them without taking direction, such as to put the pieces in the form board. When asked to pull the string on his own toy he refused and Mother reported he's never shown any interest in that string at all. He easily uncovered a hidden toy, laughing as though enjoying the new version of "peek-a-boo". Mother reports that one of his favorite things to play with is a bottle that he's seen his parents drink out of, like a soda bottle. He also enjoys balls of any size and moving the levers and switches on toys that light up and play music. Mother reported that Jeremiah will clap and give kisses when requested and this was easily observed. Jeremiah gave his mother a kiss in response to a verbal request without accompanying gesture, and then clapped in imitation. Jeremiah also calls for his parents saying "mama" and "dada", spontaneously says "baba", "bubble", and "haha" with meaning and imitates other sounds in response to his parents.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Jeremiah has just begun crawling on his hands and knees a few feet to get to desired toys, as well as to get to his parents if he wants to be held. He's also just learned in the last week to get himself from his hands and knees into a sitting position so that he can play with the toy he was seeking. Jeremiah was observed to sit with more weight on his right side with his left knee hyper extended. When he becomes tired he will roll onto his back to play with the toy and is now learning to get back to sitting from this position after a rest. When Jeremiah was pulled up to sitting from his back (supine), he assisted with accessory facial muscles and did not lead with his head, working to keep his head In line with his body. When supported at his axillae vertically, there was a bilateral "slip through." Jeremiah was observed to show some preference for reaching for toys with his right hand rather than his left, even when toys were offered on his left side, but he will use both hands together to manipulate toys in front of him and to bring them to his mouth. Jeremiah is able to finger feed himself a variety of foods using multiple fingers but hasn't mastered the pincer grasp yet. He was observed to feed himself several small puffs and Mother reports he can also drink from a straw well. Jeremiah mostly eats homemade organic purees and fork mashed foods, showing better success with the mashed foods than smooth purees. Mother reports that he does occasionally gag and vomit and he has a history of severe reflux, though it's resolved some since starting solids. Jeremiah helps his mother with dressing by presenting his feet and helping put his arms through sleeves. He is not yet undressing himself except removing small articles like his socks. Mother reports that he sleeps well and will play by himself in his crib, usually watching his mobile, until he falls asleep on his own.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 6: Jeremiah has all of the skills we would expect in this area. There are concerns related to separation from parents due to their separation.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 7: Jeremiah has all of the skills we would expect in this area.
Use of Appropriate Behaviors to Meet Needs: Rating 5: Jeremiah shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

Team discussions should not only reflect careful and sensitive considerations about the child's developmental abilities but also consider the cultural expectations of both parents when it comes to parenting and father involvement.

Clearly Jeremiah's father wants to be involved in his care. There are several cultural considerations a team must consider when planning and providing services for Jeremiah and his family.

- ✓ Jeremiah's mother grew up in Russia. Her expectations for father involvement may be influenced by the cultural expectations she experienced as a child. In the article **Fatherhood in Brazil, Bangladesh, Russia, Japan, and Australia**, we learn according to Utrata et al. (2013, p. 298) fathers in Russia "*are often seen as less than secondary parents and even perceived by many as "infantile, weak, irresponsible, and even somewhat superfluous" (p. 289). Second, traditions of father absence and psychological detachment (Utrata, 2008) are now exacerbated because many men find it difficult to find or maintain employment, and because public policies do not encourage men to be caregivers or providers."* In addition, Russia has the second highest divorce rate in the world. How does the team use this information to promote involvement of both parents in Jeremiah's care?
- ✓ After review of the **American Academy of Pediatrics Recommendations for Promoting Father Involvement** are there strategies you and your team could implement to promote Father's involvement?

The Decision Tree

Child Indicator Seeds for Success

Why Culture Matters: Cultural Diversity in Developmental Screening Tools for Young Children

Cross-Cultural Considerations for using the ASQ-3/ASQ:SE

The ASQ-3 is one of the most widely used tools for gathering developmental information for eligibility determination in Virginia and has shown excellent validity and reliability within the general population. However recently there has been much attention placed on whether this is true for individuals from diverse cultural backgrounds. Since the ASQ-3 and ASQ:SE were developed in the United States (US), the data used to study their psychometric properties and to set cutoff points came primarily from families and children living in the US. The ASQ-3 is unique from other screening tools in that parents, as opposed to providers, complete the questionnaire. Therefore insights from immigrant and refugee parents are vital in understanding the potential difference in how parents may respond to ASQ questions depending on their cultural lens. The more the assessment team understands the cultural values of the family, the more successful the interactions and assessment will be.

The following presentation highlights the purpose, use and validity of the ASQ-3 and/or ASQ:SE for children from various cultures. It also includes research findings for expected outcomes and scoring for children from various cultures. Cross-Cultural Differences in Using the ASQ-3 and the ASQ:SE.

Equally noteworthy are findings from a study completed out of Canada Cross-Cultural Lessons: Early Childhood Developmental Screening and Approaches to Research and Practice. This study highlights cross-cultural lessons for early childhood service providers to consider. While mainly focused on the ASQ, the lessons that emerged from cultural experts and parents from three cultural backgrounds (Chinese, Sudanese, and South Asian, who reviewed in detail the content of each of the questions included in the ASQ) are suggestive of the relevancy of findings to other immigrant and refugee families whose cultural group was not specifically studied in this particular project. In evaluating the ASQ, the experts and parents identified problematic items and diverse cultural reasons that influence how a parent may respond to certain items. These are explored in detail and include implications for screening:

- Country of Origin and Conditions of Departure
- Context of Arrival
- Language
- Religion
- Oral vs. Written Culture
- Interdependent vs. Independent Cultures
- Adult-Child Interactions
- Parents' Expectations for Child Development
- Objects and activities used in screening tools including:
  - Food and Feeding Practices
  - Books and Writing Tools
  - Toys
  - Questions related to physical activities, sports, or sports equipment (e.g., a ball)

Finally, Brookes Publishing provides guidelines and appropriate steps: Guidelines for Cultural and Linguistic Adaptation of ASQ-3™ and ASQ:SE that are recommended for adapting and/or translating the ASQ-3/ASQ-SE screening tools when using with children and families from culturally diverse backgrounds. In addition to these cultural, linguistic, and interpreting guidelines, please scroll down to **Appendix A, Recommended Translation and Adaptation Process**, for further information about steps to follow, and see **Appendix B, References Associated with Cultural Adaptation and with Translation of ASQ-3/ASQ:SE**, for a list of relevant journal article citations.

Test Your Inter-rater Reliability

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Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family? Was the family's cultural differences considered?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Alzyr's Age: 23 months Adjusted Age: NA

Referral Information, Medical History, and Health Status: Alzyr is the only child of immigrant parents from Bangladesh, a country in South Asia. Alzyr's mother was 14 when her parents arranged child marriage to Alzyr's father. She was 15 when she delivered Alzyr at 37 weeks gestation via c-section. There were no complications. Alzyr passed his newborn hearing screening. Alzyr's pediatrician noticed vision impairment in both eyes when he was two months old. He had an MRI at 5 months of age with normal results. He was referred to the Infant & Toddler Connection by the Department for the Blind & Visually Impaired and was initially evaluated and found eligible September 2013. Alzyr has received developmental services by an educator and teacher of visually impaired students over the past year. Services have focused on supporting mother, the primary caregiver to meet Alzyr's basic needs including responding appropriately to his emotional demands, providing appropriate stimulation and early learning opportunities as well as supporting him in routines that are difficult based on his visual impairment. Alzyr's mother's primary language is Bengali. Over the past year her English has improved slightly and she is able to communicate with providers during sessions without an interpreter.

Alzyr has been a healthy child. He had a well child visit with his pediatrician in August. His growth has remained consistent at the 10th percentile. Lately he has not wanted to wear his glasses. Alzyr had a retinogram completed and received a diagnosis of Leber Congenital Amaurus.

Daily Activities and Routines: Alzyr is an active little boy. He lives with his parents. He is home with mother during the day, and she goes to work at the convenience store down the block from their apartment at 5:00 after father returns home. Alzyr wakes at 6:30am, takes a nap in the afternoon, and goes to bed at 8:30. He sleeps in his parent's bed. Meals are not at structured times, and Alzyr is good about letting parents know when he is hungry. He still breastfeeds on demand.

Parents have tried to have Alzyr stay with a babysitter (even in their home) but he gets too upset when he is not with either his mother or father.

Alzyr loves being outside, and enjoys going everywhere. He likes walking to the playground. He no longer enjoys the swings, but he will walk up the ladder of the slide and then needs support to slide down. It is a problem when he does not want to go back indoors, and he will run off so that he cannot be picked up.

Alzyr enjoys music and sings and dances along with songs, including ABCs. Parents have noticed marked improvement with his talking. His favorite toy continues to be his yellow ball. He has foam blocks that he tends to toss around.

Family Concerns: Parents are not certain about how Alzyr's vision will impact him as he gets older. They would like him to be in a daycare/preschool setting so that he can have fun and learn from the other children. They would appreciate information on resources available to help them. They would like Alzyr to be able to stay with them and not run off when they go places. Father shared that he is not comfortable with Alzyr having toys that may not be safe including puzzles and crayons and would prefer the therapist not bring them on their visits.

Family Priorities: Parents would like to feel comfortable with Alzyr being able to attend a childcare setting. For his safety, they also need him to be able to walk next to them and not run away.

Family Resources: Paternal grandparents may be able to come to the US in the next several months. If so, they will move in and help care for Alzyr. The family recently moved to a nice apartment area where they can walk to the playground, and sometimes socialize with other families.

They are connected to the Virginia Department for the Blind and Visually Impaired.

Developmental Levels: Cognitive- 22 months Gross Motor- 24 months
Fine Motor- N/A Receptive Language- 24 months
Expressive Language- 24 months Social/Emotional- 18 months Adaptive/Self Help: 22 months

Social/Emotional Skills including Positive Social Relationships: Alzyr is an adorable happy little boy who enjoys interacting with his parents. Alzyr is not shy and actively reaches out to new people. However, Alzyr is very attached to his parents and had a very difficult time when family tried to send Alzyr to a babysitter. The family was called to take Alzyr back home because he was crying too much. Alzyr is always smiling and makes some eye contact. Due to his low vision, Alzyr is unable to look straight at an object or people. Alzyr seems to see better using his peripheral vision. Alzyr will express his feelings by smiling and giggling, but will cry and physically show anger when he gets upset to his parents.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Alzyr is learning about his environment by using his sense of touch, hearing, and mouthing objects to gain information. Alzyr will readily reach out to familiar objects and play with them. His favorite toy is a yellow ball. Alzyr likes to dance and sing along to nursery rhymes. Alzyr has a large vocabulary and is putting two to three words together to talk in sentences. Alzyr will imitate new words when introduced by his parents and will use some of those words throughout the day. Alzyr understands and follows simple two step directions, but has difficulty identifying objects and colors due to his low vision. Alzyr is using words to express his wants and needs while physically moving his parents in the direction.

Child's Development in Relation to Other Children the Same Age:
Use of Appropriate Behaviors to Meet Needs: Alzyr will walk, run and walk up and down stairs independently by holding onto the rail or wall. Alzyr will sometimes bump into walls or furniture, but it is only when he is overly excited or upset. Alzyr will reach for things he wants or ask parents verbally using two to three word phrases. If parents say that

he cannot have something or if it is too dangerous, Alzyr will get upset very quickly and will bang on furniture or pull down the chair. Alzyr does not assist in dressing and has not had experience removing small articles of clothing.

Alzyr is a good eater, but likes to hold all food using both hands and stuff all into his mouth. Parents have to give finger foods one at a time and verbally ask him to finish eating one before putting others into the mouth constantly. Parents have not introduced a high chair or booster seat for feeding time. Therefore, Alzyr eats while sitting on the floor. Alzyr only uses his hands to eat and parents will spoon feed him certain foods. Alzyr continues to breastfeed on demand. Father shared that children in Bangladesh typically breastfeed well past 3 years of age.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 5: Alzyr shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 5: Alzyr shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.
Use of Appropriate Behaviors to Meet Needs: Rating 5: Alzyr shows many age expected skills. He also continues to show some skills that might describe a younger child in this area.

It is important for teams to understand the child and family's cultural expectations about child development. For example, some cultures value a parent spoon-feeding their child well after the age that many norm-referenced tools might suggest more independence. Team discussions should reflect careful and sensitive considerations about the child's developmental abilities within the cultural opportunities and expectations.

The Decision Tree

Child Indicator Seeds for Success

Why Culture Matters: What Research Tells Us

One of the theories of child development early interventionists should keep in mind when working with a child and family who are from a different culture is Lev Vygotsky's Socio-Cultural Theory. Lev Vygotsky's (1896-1934) saw child development as a form of social constructivism, which maintains that human development is socially situated and knowledge is constructed through interaction with others, and subsequently determined by culture. According to Berk and Winsler (1995) there are a number of factors that are unique to social constructivism. First, because children's culture influences the activities, language, and education to which children are exposed, these variables affect children's development. Second, while some development is innate or influenced by biology, higher level development is affected by culture. Finally, the theory incorporates the zone of proximal development, that is, the range in children's development between their ability to perform a task independently versus their ability to perform a skill with the assistance of a more competent member of their culture (adult or older child). This is very much like what we consider hand over hand assist and modeling for instance to build on existing skills.

With Lev Vygotsky's theory in mind, I recently reviewed a study *Maternal Expectations About Normal Child Development in 4 Cultural Groups (email me for full study: anne.brager@dbhds.virginia.gov)* that explored the maternal expectations about normal child development within 4 different cultural groups. The objective was to determine whether expectations about normal infant and child development are different among mothers from different cultural backgrounds. The participants in the study included 255 mothers (90 Puerto Rican, 59 African American, 69 European American, and 37 West Indian\Caribbean) whose children received health care at hospital-based pediatric clinics, private pediatricians and family practitioner's offices. Excluded from the study were parents who had a child with a known behavioral or developmental concern or a chronic medical condition, parents who were not members of the ethnocultural groups under study, and parents who had no child rearing experience (such as first-time parents at their first postpartum visit).

In the study, researchers verbally administered a questionnaire that included 25 questions in which mothers were asked to give their opinions about the age at which a normal child should begin to accomplish standard developmental milestones. The questions were administered in the parent's native language. **Significant differences were seen for the following developmental tasks: able to be fed from a spoon, smiling at a face, recognizing mother, able to feed self with a spoon, putting on own shoes, saying first word; naming colors, able to see shadows and shapes, and able to be toilet trained.** The developmental tasks for which there were no significant differences in expected ages among the mothers of the different ethnocultural groups included the following: crawling, taking first steps, rolling over, able to get to a sitting position and stay there, picking up head, pulling to stand, turning head to sound, grabbing a rattle, playing "pattycake" or "gimme sleeping through the night, knowing own name, putting 2 words together, knowing body parts, babbling, understanding the word "no," and feeling pain.

The data in the chart below shows months for expected skill attainment and suggests 2 noteworthy patterns of parental responses. First, parents from the different ethnocultural groups were most in agreement in their responses when asked about milestones that fit within the gross motor and language domains. Conversely, the greatest differences in responses among the mothers from different ethnocultural groups were seen in milestones that could be grouped under attaining positive personal-social relationships and using appropriate behaviors to meet needs. Second, when differences were found, the Puerto Rican mothers expected children to attain the milestones at a later age, compared with the mothers from the other ethnocultural groups. This was seen in 6 of the 9 items for which there were significant differences. Of the remaining 3 items with significant differences (age at toilet training, being able to see shadows and shapes, and first words), European Americans expected children to attain these at a later age than did mothers in the other groups.

Table 3. Maternal Developmental Expectations*

Expectation	Ethnic Group: Puerto Rican	African American	West Indian–Caribbean	European American	P†	Between-Group Analysis‡
Crawl	6.7	6.4	6.7	7.0	.30	...
First steps	10.7	10.5	10.0	11.6	.007	...
Roll over	3.7	3.6	4.1	4.0	.63	...
Get to sitting	7.0	6.1	5.9	6.9	.006	...
Pick up head	3.5	3.3	3.3	2.9	.43	...
Pull to stand	8.3	8.2	8.5	9.4	.04	...
Fed from spoon	7.3	4.1	6.1	5.5	<.001	PR>AA
Turn head to sound	3.2	2.7	2.1	2.3	.03	...
Grab a rattle	4.0	4.2	4.1	4.2	.95	...
Smile at face	3.6	1.9	2.2	2.2	<.001	PR>all
Pattycake or "gimme 5"	19.0	16.4	16.1	13.7	.04	...
Recognize mom	5.9	2.6	2.7	4.1	<.001	PR>AA and WI
Feed self with spoon	16.6	12.5	15.1	13.7	.002	PR>AA
Sleep through night	10.5	8.4	6.7	5.7	.006	...
Put on shoes	29.7	20.8	19.5	24.5	<.001	PR>all
Know his or her name	6.8	6.0	5.1	7.0	.11	...
First words	8.1	10.0	9.5	10.2	<.001	EA and AA>PR
Two words	17.6	17.0	17.5	19.2	.59	...
Name colors	30.1	25.6	23.3	23.8	.002	PR>EA and WI
Know body parts	20.3	18.3	18.0	19.2	.33	...
Babble	6.7	5.5	6.2	7.2	.07	...
Understand "no"	13.1	12.5	10.0	13.8	.17	...
Sees shadows and shapes	3.8	1.6	3.4	6.2	<.001	EA>AA
Feels pain	1.9	0.4	1.1	2.0	.10	...
Toilet trainable	22.2	20.2	21.6	28.1	<.001	EA>all

Maternal Expectations About Normal Child Development in 4 Cultural Groups by Lee M. Pachter, DO; Paul H. Dworkin, MD

The results of the study concluded that developmental expectations differ among mothers from different ethnocultural groups and determining parents' expectations is especially important for families from minority groups, in which traditional values, attitudes, and beliefs about family and child rearing may differ from those of the majority culture. When gathering assessment information providers should be aware that the general question, "How do you think your child is developing?" is important to ask recognizing parents' expectations for their child's development will influence their priorities and their concerns.

Findings from this study emphasize the importance of interpreting parents' opinions and concerns about their children's development within the context of their cultural beliefs and expectations.

Test Your Inter-rater Reliability

Our state's focus on child indicator ratings has led many to wonder
"Are we all rating children similarly?"

As part of our efforts to improve results for children, we are focusing each month on increasing our statewide inter-rater reliability. We are using examples of narratives from around the state that ideally will include observations of functional behaviors, parent/caregiver input, results from assessment tools and informed clinical opinion. Below is an example of a narrative from a recent Assessment for Service Planning. Using the limited information provided in the narrative and the process outlined in the child Indicator Booklet talk thru the scenario with your colleagues to determine a rating. The ratings given by the assessment team can be found at the end.

Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family? Was the family's cultural differences considered?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Emilio's Age: 13 months Adjusted Age: 11.5 months

Referral Information, Medical History, and Health Status: Emilio was born at 34 weeks gestation. He passed his newborn hearing screening (AABR). He was admitted to NICU after birth due to various diagnoses often associated with prematurity with the addition of intrauterine growth restriction. He stayed in the NICU for 20 days. Emilio was referred by his pediatrician due to concerns with his gross motor, speech and feeding development.

Daily Activities and Routines: Emilio goes to bed between 7:30 to 10:30 depending on his parent's schedule. He sleeps in the same bed and wakes up often during the night. He typically begins his day between 6:30 and 9:00 am. He typically takes a two hour nap between 10:00 and 1:00 pm. Emilio is at home with his mother while his brother, who receives special education services, is at school and his father is at work. Mother has requested services be provided after Emilio's father returns home from work, which is typically around 5:00 pm. Emilio likes to spend his time watching TV for a couple of hours at a time. Mother reports he cries if the TV is off or if he doesn't like the cartoon that is on. During play time, he likes to play with a baby activity set and a baby computer with sounds. He continues to keep his hands closed often and has difficulty holding onto toys, bottle and spoon. He is not holding his milk bottles by himself and is not using his fingers or spoon to eat. His mother feeds him all of his meals. He drinks 6 bottles of milk (6 ounces each) during a 24 hour period. He eats soft puree foods 2 to 3 times per day. He eats limited variety of foods (banana, carrots, potatoes, beans, rice).

Family Concerns: Emilio's family is from Puerto Rico and their primary language is Spanish. Father speaks limited English and acted as interpreter for the assessment. The family is concerned with Emilio's overall development. He began rolling over both ways at 11 months. He began belly crawling a week ago at 12 months of age. When placed in a sitting position, he is able to maintain his posture while manipulating objects/toys and is able to transition to the tummy

position but is not able to assume the sitting position independently. Emilio is able to produce the sounds “ma” and “pa” inconsistently and his mother reported he does not produce a variety of sounds nor does he communicate his wants and needs. Instead he cries and whines. He is not imitating actions or playful sounds. He keeps his hands closed often and has difficulty holding objects and toys. Emilio also has difficulty eating solid food, he gags and vomits. His mother reported that he is not able to chew on a small piece of solid food without gagging or vomiting.

Family Priorities: Emilio’s family is familiar with EI services as their older son received services for three years. The family wants Emilio to acquire age appropriate gross motor, feeding and communication skills.

Family Resources: Emilio has Medicaid to support his medical needs and WIC to support his nutritional needs.

Developmental Levels: Cognitive- 9 months Gross Motor- 9 months
Fine Motor- 10 months Receptive Language- 8-9 months
Expressive Language- 8 months Social/Emotional- 10 months Adaptive/Self Help- 3-4 months atypical

Social/Emotional Skills including Positive Social Relationships: Emilio has recently begun to crawl and is exploring everything he can reach. He looks to his mother for assurance, and notices when she leaves his sight, turning toward where she is. Emilio was comfortable approaching the evaluators, reaching for their papers and accepting their assistance with toys. Emilio let his mother know when he was unhappy with an activity by whining, vocalizing and he easily calmed with her reassurance. He enjoyed cuddling with her after his feeding, listening to her voice and engaging in a vocal play game, gigging and laughing in response to her. He is beginning to understand “no” and is especially watchful of mom’s face and her expressions.

Of concern is that Emilio is not responding to his name being called or using social gestures like waving. He prefers to be held by mother in the company of visiting family members and friends. We would like to see more independence including sleeping in his own crib.

Child’s Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Emilio is an adorable little boy who is learning so much about his environment through observation and exploration. When sitting independently, Emilio is able to manipulate toys, bang toys, shake toys and inspect them. He is mouthing some toys. Emilio is using both hands to reach for and grab at toys. Emilio shook and banged toys often to produce a noise. When a toy was hidden, he looked for it and removed a cloth to find it, showing object permanence. Emilio is repeating syllables “mamama, dadada, and gaga” and making vowel sounds to communicate. Emilio banged two blocks together in imitation and transferred that skill to banging spoons. Emilio is imitating familiar activities: he gets upset when he hears the bath water running, anticipates food preparation, and goes to the door when he hears a knock. Emilio is showing whole hand movements and is beginning to isolate his index finger. Emilio looked at pictures in his book when held open, but it took him some time to focus on the picture. Mother reported Emilio doesn’t show interest in books and prefers to watch TV. When told “no”, Emilio immediately looked at mother to regard her direction.

Of concern, Emilio is not yet calling “Mama” and “Papa” by name. We would like to begin seeing Emilio putting things is and out of a container during play. Emilio is not yet responding to simple instructions or when his name is called. We would like to see more variety in the sounds Emilio is making.

Child’s Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Emilio confidently crawls around his carpeted play area to get his toys. He pats, bangs, opens and hits his electronic toys that have lights and make sounds. Emilio pulls to stand at his sofa to reach purposefully for toys up high, and he has begun to cruise along the sofa (mostly stepping to the right). Emilio sits

on the floor with stability and transitions into other positions from sitting to reach for toys/items and play. He becomes excited when playing with toys he likes, patting and banging them together and attempting to put items into and take them out of a container. Emilio competently grabs and holds onto items with his whole hands. Sometimes, he takes time to focus with his eyes on what he's doing with his hands. His pincer grasp is emerging.

Of concern, Emilio demonstrated a delayed and inefficient swallow when eating crumbled cookies and milk. He has a wet, gurgly voice quality consistently. He coughs, gags frequently during eating. He vomits his meals at least one time per day according to mother. He is fearful of loud noises, crowds and bath time.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 3: Emilio uses many important skills that are necessary for the development of more advanced skills; he is not yet showing skills used by other children his age in this area.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 2: Emilio is beginning to show some of the early skills that are necessary for development of more advanced skills in this area.
Use of Appropriate Behaviors to Meet Needs: Rating 2: Emilio is beginning to show some of the early skills that are necessary for development of more advanced skills in this area.

Reflect back on one of the tips shared last month: **Respect and partner with the family.** Don't assume anything. A family may be nodding their heads "yes," but that might only symbolize that they heard you, not that they agree. Listen carefully. Be alert for cues from families. Don't be afraid to ask questions.

Considerations for Emilio and his family:

1. Are the concerns listed in each of the three child outcomes the family's concerns or the providers'? If both, consider putting them in the context of the child and family's routines. For instance, what is the functional purpose of container play and how can it be assessed and incorporated in relation to the activities that are important to the child and family?
2. Were the family's cultural values and beliefs considered? Consider including information regarding the family's expectations. Does the family consider independence sleeping in a crib? Is that skill important or appropriate to the family's cultural values and practices?
3. Reflect back to table 3 above. And while these expectations were the reflection of the 90 mothers of Puerto Rican descent included in the study, it does remind us of the importance of exploring the family's expectations of when their child should achieve a particular skill.
4. Emilio's father would like to participate in all services. The father's role in early intervention can be affected by many things, such as his parenting beliefs, his cultural values, his understanding of the child's delay or disability, his concerns for the child's future, or his thoughts on how to support his family. It is important to try to accommodate the family's schedule, including the father. If he is typically unable to join the visit because he works during the day, consider offering sessions in the evening, videotaping visits, or doing visits using Skype or some other teleconferencing. For insights on engaging fathers in early intervention services, check out Virginia's Early Intervention Strategies for Success Blog Don't Forget Fathers. Although from 2013, it has a lot of great information and would only take one post to revive the discussion.

The Decision Tree

Child Indicator Seeds for Success

Why Culture Matters: Understanding Cross-Cultural Differences

The information provided here about various cultures is meant to assist providers by offering a general framework/understanding of cultural awareness. Keep in mind that we are purposefully generalizing each presented culture's values and practices, and that individual families may vary from their cultural norms for many reasons. There are no strict givens in any culture as that simply does not allow for the variation and diversity of individuals and their unique experiences.

That said, why have we decided to put so much emphasis on cultural awareness? We know memorizing lists of characteristics or do and don'ts per culture is impractical and leads to stereotyping. When we stereotype people we tend to apply characteristics too rigidly, as if to say that ALL people from a particular culture believe the same things and behave in the same ways. We know that's not true. However, we also know providing family-centered services are dependent on successful communication between families and their early intervention team. Developing an awareness of the values and beliefs of families from different cultures and how these may differ from ours helps minimize misconceptions, miscommunication and unfavorable outcomes.

Let's look at the Asian culture for instance. There are three distinct ethnicities that make up the "Asian" community: 1. Pacific Islanders, mostly from Hawaii, Samoan Islands and Guam; 2. Southeast Asians, mostly comprised of Vietnam, Thailand, Cambodia, Laos, Burmese and Philippine; 3. East Asians, including Chinese, Japanese , and Korean (Trueba, Chang, & Ima 1993). Each of these ethnicities differs in socio-cultural traits, as do the subgroups within each. Nonetheless, people belonging to "Asian" cultures are generally accustomed to communication styles that may be significantly different than other cultures.

People from Asian countries are thought to be high-context communicators. High-context and low-context communication refers to how much speakers rely on things other than words to convey meaning. In Asian cultures, gestures, body language, eye contact, pitch, intonation, word stress and the use of silence may be as important as the actual words being spoken in conversation. Asians are typically polite in social encounters whereas Americans, typically being low context communicators, are more comfortable with very direct questions and answers. This is important to keep in mind, when working with Asian families, especially those who are relatively new to the US. They may see us as the authority and expect us to sort out their concerns, confusion, and hesitance within the context of their politeness. Avoid mistaking head-nodding, smiles and silence as an indication of understanding and agreement when in fact the opposite may be true. Asians may smile when confused or embarrassed. Smiling does not necessarily indicate agreement, pleasure or humor in all cultures.

In summary, checking for understanding when communicating with families from other cultures is critical. It is all too easy to misinterpret a common gesture, nod, smile or silence as agreement or understanding when the family is actually confused or even resistant to your assessment and/or recommendation for services or strategies. Avoid asking yes/no questions and keep in mind, that for cultural reasons, some families may be reluctant to disagree or ask for clarification. In addition, as you'll see in the narrative that follows family expectations for learning in young children may be heavily influenced by culture including family values, beliefs and parenting practices. It would be easy to jump to judgment about what we may see as unrealistic outcomes without exploring the family's cultural expectations.

If we fail to acknowledge the influence of culture on the work we do, we limit our ability to interact with and help families and children. Even worse, culturally incompetent practice can actually hurt clients (Harper & Lantz, 1989).

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Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family? Was the family's cultural differences considered?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Samyan's Age: 18 months Adjusted Age: NA

Referral Information, Medical History, Health Status: Samyan "Sam" was referred by his father for concerns related to his development. The referral was made by email and is copied from his email which listed the following concerns:

"Hmmm.... where do I start?
I've just acquired an 18 month old kid who has previously been brought up the Thai way and we need to correct this before it's too late. Therefore, I reckon I've got about 6 months to address this. There are a few specific areas that are problems in my western eyes.

1. He's a victim of the 'I want - I cry - I get' syndrome.
This is quite simple to remedy (in theory). He gets told 'no', if it's not appropriate. He's still a bit wary of me, so it's working quite well at the moment.

2. The grandparents used to give him milk all through the night whenever he woke up, which seems to be every 30 minutes or so. Also, milk seems to have been used as a substitute for food most of the time. The milk they gave us was soya milk with a sugar content of 10%. I have noticed that he is very mucusy and I believe the large quantities of milk are at least partially to blame for this.
Now he gets a bottle of milk at breakfast and one before bedtime. That's it. Otherwise he eats normal, non-spicy food, fresh veggies and a bit of fish or chicken. The milk he will be given in the future is semi-skimmed, normal milk. I also want to get him using those beakers with the little mouthpiece on top rather than a baby's bottle.

3. In a one roomed house, it is quite natural that the family all sleeps together. We don't live in a one roomed house, so that is going to stop too. Not yet though, as the poor little mite needs to settle in first and get comfortable with his surroundings and more importantly, get used to me.

I think the way forward with this is to put him to bed with the Midget until he falls asleep, then she can leave him. This will obviously have to wait until he is sleeping properly and not expecting to feed all night.

4. He can barely speak, which for 18 months is a bit poor. The Midget will get some books and start reading to him soon.

5. He still wears Pampers in the day time. I don't mind them at night, but surely he should be training to use a potty about now? We have tiled floors, so the odd accident isn't a problem.

Are there any other tips you can share with us to help the lad speak more and ultimately start reading?
The Midget is 100% behind all of this as she is worried about his development too, and we have talked a lot about the best way of being good parents and making the lad happy as well as strong & independent.
I'm sure more things will come to mind and of course, any other useful advice is appreciated."

Daily Activities and Routines: Sam lives at home with his newly adopted parents. His parents are from the Similan Islands, located off the coast of Thailand and have recently settled in Virginia. The family shares housing with other roommates. Sam stays with his mother "Midget" while his father is at work. When the weather permits they go for walks in the stroller and will sometimes go shopping in their community. Sam is still adjusting to his new environment and caregivers. The family reports bedtime and feeding routines are difficult.

Family Concerns: The family is concerned that Sam has only has a couple of words and communicates mostly by crying.

Family Priorities: Sam's parents are committed to making him happy and independent. Their priorities include getting him to sleep by himself, walk independently, use a sippy cup instead of a bottle, potty training and helping him learn to communicate his wants and needs.

Family Resources: Sam's family has a sponsor that has helped with housing and employment. The other roommates that share housing with the family are also from Thailand. They are getting to know one another and have taken an interested in Sam.

Developmental Levels: Cognitive- 9 months Gross Motor- 11 months
Fine Motor- 11 months Receptive Language- 8 months
Expressive Language- 8 months Social/Emotional- 10 months Adaptive/Self Help- 12 months

Social/Emotional Skills including Positive Social Relationships: Sam is a social little boy. He spends his day at home with his mother. He engages by making eye contact, smiling, laughing, and approaching others. Like most children his age he protests or shows he is upset by crying and falling to the floor arching his back. Sam's mother reports he is beginning to bond to her and seeks her out for comfort when strangers are present. He is also beginning to give her hugs when asked but has yet to independently offer a social hug. He has tried to bite her when in the midst of a "meltdown". He is very cautious around new people and is slow to warm up. The family reports Sam consistently responds to his name, both Samyan and Sam. Sam has not had the opportunity to be around other children since being adopted. Much of Sam's play is sensory based.

Child's Development in Relation to Other Children the Same Age:
Acquiring and Using Knowledge and Skills, including early language/communication: Sam learns by trial and error and exploring his environment. He mostly explores toys by mouthing and banging. Sam is able to uncover a hidden toy and dump a container to retrieve the items inside. Sam communicates with facial expressions, vocalizations and body movements. He smiles and reaches to accept an item and will cry and arch his back when denied something or when upset. Sam will sometimes try to imitate sounds or words or engage in back and forth vocalizing with his mother. Sam's mother has recently introduced him to books. He easily turns the pages and attends to the pictures. Mother has not tried labeling pictures to see if Sam will point or imitate a label.

Of concern, Sam is not yet showing an understanding of simple directions. He does not point to pictures in his books. His play is still very sensory based. He is showing emerging skills with container play. Sam often prefers to flick his toys with his fingers. He does not point to body parts or name familiar objects when prompted.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Sam crawls around the home environment. He is pulling to a stand and can cruise along surfaces. He will stand independently and squat to retrieve toys on the floor. More recently Sam has started taking 2-3 steps, although this is emerging and not demonstrated consistently. He is able to remove toys from containers and is starting to put them in, however his release is fast and not very controlled. He is using his index finger to point and poke, and at times this is his preferred method to manipulate items. Sam is able to use a grasp with his fingers and thumb, however he only does this with larger items. He still uses a raking motion to pick up smaller items. Parents report Sam got all of his nutrition from a bottle when he was in kinship care. He is learning to eat solid food. His diet consists of vegetables, chicken and fish. He is not yet using a sippy cup. His parents are trying to restrict his dependence on the bottle and have him independently use a cup.

Of concern, Sam is not walking independently and his feet are slightly pronated which may make walking independently more difficult. He explores toys with his mouth and by poking them with his index finger instead of using his entire hand to manipulate the toy. Sam is not yet following directives like "no" and "stop" consistently. He doesn't have an established communication system to indicate his interest, wants and needs. He is not using utensils to feed himself and still drinks from a bottle. Parents have expressed concerns over toileting, however it was explained that until Sam is able to walk independently and communicate his needs, he is probably not ready for potty training.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 4: Sam shows occasional use of some age expected skills. He has more skills of a younger child in this area.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 3: Sam uses many important skills that are necessary for the development of more advanced skills; he is not yet showing skills used by other children his age in this area.
Use of Appropriate Behaviors to Meet Needs: Rating 3: Sam uses many important skills that are necessary for the development of more advanced skills; he is not yet showing skills used by other children his age in this area.

The following resource may be helpful to support effective and appropriate intervention practices when working with children and families from culturally and linguistically diverse backgrounds.

Cultural Diversity Fact Sheet

Culture refers to those things that shape a person's sense of group identity. Factors that make up culture include race, ethnicity, language, religion, geographic location, income status, gender, sexual orientation, disability, and occupation.

As a service provider, your goal is to know your families and for them to know you. It helps to stand in the shoes of the families you serve. A five-step process to enhance cultural competence from the book, *Families, Professionals, and Exceptionality: Collaborating for Empowerment* by authors Ann and Rud Turnbull, starts with examining your own cultural self-awareness and sensitivity.

1. Enhance self-awareness. To be more culturally sensitive, look to yourself. What attributes best define you? Your race? Where you live? Your religion? Can you think of one piece of advice passed down in your family that reflects the

values your ancestors in another country had? How do these factors shape your views? Think of other people you know. What attributes define them? As you learn more about yourself, you will see how your views influence your thoughts about others.

2. Learn about other cultures. Within the United States, there exist several subcultures, such as Hasidic Jews, Amish, rural Appalachians—among many others. The U.S. Department of Education recognizes five racial and ethnic groups: Native American or Alaska native Asian or Pacific Islander, Hispanic, African American and White.

To characterize fully the typical Hispanic or Asian family is impossible. Every family differs. For instance, the 26 separate Hispanic nationalities, each with different acculturation levels, education, income, occupation, and geographic locations, obviously vary. Along the same line, Asian Americans come from three major geographic areas and at least 15 different countries. Their religions include Confucianism, Taoism, Buddhism, Catholicism, and several others. The U.S. Bureau of Indian Affairs recognizes over 300 tribes and over 200 Alaskan native villages. Even though they make up less than one percent of the population, Native Americans speak over 250 languages! The best you can do when familiarizing yourself with so many cultures is to be familiar with general traditions, customs, and values. But overgeneralizations lead to stereotyping. Remember, each family's culture is defined by factors that are as complex and varied as your own.

3. Enhance generic cultural awareness. Once you understand your own values and have learned about others' cultures, you can then compare and contrast basic traits. You will see how one family might value individualism, while another might emphasize family interdependence. Some families might rely on systems versus using personal relationships to solve problems. This also applies to cultural tendencies to take charge in the face of problems (versus accepting them). Such factors relate to disability specifically. Yet, you will find they do help set the stage for effective service provision.

4. Learn how different cultures view disability. A family's view of disability influences their expectations, achievement, medical interventions they choose (or do not choose), professional roles, and other service delivery issues. For instance, one family may view disability as a blessing. Others may view disability as retribution for previous sins or believe it may be due to the mother's behavior during her pregnancy. To these families, disability may mean embarrassment.

5. Respect and partner with the family. Don't assume anything. A family may be nodding their heads "yes," but that might only symbolize that they heard you, not that they agree. Listen carefully. Be alert for cues from families. Don't be afraid to ask questions. Include families in all stages of program services. Hold meetings at locations that are easily accessible to the family. Recognize your own cultural competency limits, and make referrals if necessary. Just remember, if you are sincerely interested in understanding and supporting families, that will be conveyed to them and your partnership will more likely "feel right" to all involved.

Information for this fact sheet came from the following source(s):

Turnbull, H.R., & Turnbull, A.P. (2001). *Families, professionals, and exceptionality: Collaborating for empowerment* (4th ed.). Upper Saddle River, NJ: Merrill/Prentice Hall.

Lynch, E.W., & Hanson, M.J. (1998). *Developing cross-cultural competence: A guide for working with children and their families* (2nd ed.). Baltimore: Brookes.

The Decision Tree

Child Indicator Seeds for Success

Why Culture Matters: Child Rearing Beliefs to Consider for Arab Americans

Disclaimer: The following information is based on research of possible cultural beliefs. As with all cultures, there will be variance in values and practices.

Last month we reviewed the challenges immigrants from the Middle East face when coming to the United States. In addition to recognizing what resources families may need, we need to be aware of the child rearing beliefs and practices Middle Easterners value. Arab immigrant parents tend to hold true to their culturally rooted child rearing values and traditions, while trying to adapt to the mainstream values of a new culture. They typically come from countries where an authoritarian parenting approach is viewed as the norm, where their children must respect and obey these values and where family honor is often most important.

Here are possible child rearing beliefs you may encounter when working with families from Arab descent:

- Boy children may be valued more than girls. Because of Muslim inheritance laws, a family without a male heir can lose a significant portion of their assets outside the nuclear family to other relatives (parents, other male relatives related to the father).
- Arab mothers may practice demand feeding. Girls may be weaned well before the development of significant language and once weaned; her needs may get relatively little attention. The boy, on the other hand, may continue to nurse until long after the establishment of language. He should be able to verbalize his desires and be instantly gratified when he desires to be breastfed.
- Weaning may occur over a few days. Techniques may include diversion, cajoling, and placing hot spices and dyes on the nipples. A weaned child may be expected to participate in adult routines for eating and sleeping. Since these adult routines include late bedtime, late dinners, tough, chewy foods, and much consumption of tea and sugar, a child's behavior may regress. They may use whining to gain attention.
- Middle Eastern parents may be very protective not only with respect to behavior, but also how the child thinks. A young child may become accustomed to suppressing his or her inquisitive and exploratory tendencies and sense of initiative. Children may become more passive about expressing their attitudes and have more limited decision making skills than other children.
- Toilet training may take place very early, often towards the end of the first year.
- Punishment may include spanking or teasing in front of peers or other family members.

Do you remember the "Step on a crack, break your mother's back" chant from childhood? While it seems like a silly superstition, many cultures hold true to cultural folklore. Some Middle Eastern generations have believed in and may continue to practice the following folklores:

- Some may believe the child's personality is shaped by the mother's behavior during pregnancy. The welfare of the unborn child rests on the mother; however, she is expected to continue her usual activities, including heavy routine work. There is no special dietary attention and bodily changes that come with pregnancy must be accepted.
- At birth, there may be a naming ceremony.
- Some may believe feeding baby sugar water soothes and protects the baby from hostile forces.
- There may be a belief that diseases, delays and misfortune are caused by the "evil eye". Some mothers may keep baby hidden under the mother's veil or wrapped in blankets to ward off cold, heat and the evil eye. Some mothers may believe compliments about their child's beauty may cause the evil eye and may prefer not to bathe the baby often. There may be a ceremony for the first bath occurring at day 40. Moving forward the baby may be bathed with mother.
- Arab boys are typically breast fed for 2 to 3 years while girls are weaned after only 1 year. There are complicated reasons for this including the folklores that support pampering the nursing infant and the belief that the mother will become pregnant (with a boy) more easily after the girl infant is weaned.

For more information on the multifaceted beliefs and values of different cultures, please reference Childrearing and Infant Care Issues: A Cross-cultural Perspective by Pranee Liamputtong.

Test Your Inter-rater Reliability

Our state's focus on child indicator ratings has led many to wonderr
"Are we all rating children similarly?"

As part of our efforts to improve results for children, we are focusing each month on increasing our statewide inter-rater reliability. We are using examples of narratives from around the state that ideally will include observations of functional behaviors, parent/caregiver input, results from assessment tools and informed clinical opinion. Below is an example of a narrative from a recent Assessment for Service Planning. Using the limited information provided in the narrative and the process outlined in the child Indicator Booklet talk thru the scenario with your colleagues to determine a rating. The ratings given by the assessment team can be found at the end.

Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family? Was the family's cultural differences considered?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Aaryan's Age: 30 months Adjusted Age: NA

Referral Information, Medical History, Health Status: Aaryan was born full term at an area medical center by scheduled c-section due to complications with mother. Mother was hesitant to share what those complications were. Aaryan, which according to father means "Of Utmost Strength", weighed 8 lbs 12oz, had no complications and passed his newborn hearing screen. Mother quietly shared that approximately one year ago, Aaryan was hospitalized for an ear infection with a high fever that was slow to respond to antibiotics. She said that a 2nd trip to the hospital revealed "the infection went to his brain" and caused a delay in learning how to walk and talk. The hospital treated him by giving him nutrition thru a g-tube. A review of medical records from the hospital indicates Aaryan has been diagnosed with acute encephalopathy, mitochondrial disease and hypoxemia. After being in the hospital the second time, mother reported Aaryan became crossed eyed. He needs to wear a patch on both eyes for two hours each as well as wear eye glasses. Mother reports Aaryan will not wear the eye patch or glasses. This summer, the family went home to Iran for three months; when they came home the doctors said that Aaryan is no longer hearing. He will need surgery to remove his tonsils and adenoids. Mother shared she is fearful about doing the surgery since bad things keep happening to Aaryan. They do not have a pediatrician and depend on the local hospital for Aaryan's care. Aaryan does receive private OT and PT.

Daily Activities and Routines: Aaryan lives with his parents and two older siblings. He likes toys with sounds and lights. He enjoys swinging at the play ground. Mother reports Aaryan has become fearful of the water and cries during his bath. She reports he struggled with breast feeding due to being in the hospital this last time. She was no longer able to produce milk so Aaryan has begun eating vegetables, rice, pasta, bread and meat. The family eats dinner around 8:00 or 9:00 once father gets home from work. Aaryan often cries during dinner and refuses to eat. He takes one nap during the day and sleeps from 10pm to 9am often waking up several times during the night.

Family Concerns: Mother expressed concern that she may be responsible for Aaryan's problems. She wants to do what is best for him but doesn't know how to without making things worse. Her other two children who were born in Iran had no problems. They are concerned that he lost skills due to his "disease".

Family Priorities: Aaryan's family's priority is for him to relearn the motor skills he lost including walking, running and going up the stairs without falling. They would like for him to develop appropriate communication skills so he can be able to communicate his needs and wants during his daily routines and community outings with words instead of using gestures including opening and closing his fist when reaching for an object.

Family Resources: Aaryan's father has an extended cousin that lives in the house to help pay rent. The older brothers help if asked. Father attends mosque while mother stays home to watch Aaryan as he is too active to sit quietly.

Developmental Levels: Cognitive- 14-18 months Gross Motor- 21-24 months
Fine Motor- 14-16 months with scatter to 18 months Receptive Language- 15 months atypical
Expressive Language- 16 months atypical Social/Emotional- 15 months Adaptive/Self Help- 18 months

Social/Emotional Skills including Positive Social Relationships: Aaryan is an active, sweet 30 month old boy who was seen at the Center today with his parents for an evaluation. He noticed the evaluators in the room and initially stayed close to parents. Once he was comfortable, Aaryan allowed the evaluator to present play activities to him. Per report, Aaryan loves to play with his two older brothers. He will try to climb into the middle of his brothers wrestling or rough house playing. He enjoys tickle games from father. Today Aaryan enjoyed praise and smiled when he was clapped for. Parents feel like he knows the differences between family members and strangers and he will stay close to his family out in the community. Aaryan has a number of favorite activities including playing with trains, cars, trucks, balls, musical toys with lights and books. Parents report they choose which toy Aaryan should play with. He has a few social gestures including waving hi/bye, giving "high 5" and giving kisses. When he wants something out of reach he will reach up with his arm and move his fingers in and out gesturing "give me". He used this in and out gesture of his hand frequently during the evaluation without clear intent.

Of concern: Aaryan's social skill development appears to be impacted by his significant medical history. His vision and hearing concerns are limiting his ability to fully take in information from his environment.

Child's Development in Relation to Other Children the Same Age:
Acquiring and Using Knowledge and Skills, including early language/communication: Aaryan is actively working to regain the skills he lost during his illness. Today he showed curiosity as he worked to open and close a box with a horse in it. He labeled it "beep beep" and moved it around the table briefly. He played with a car in the same manner calling it "beep beep". Aaryan did not have his glasses with him today. Even with his visual impairment, he worked to imitate block stacking and placing them in a cup and turning pages of a book. He appeared to look towards pictures but did not point when asked "show me doggy". He engaged in throwing the ball labeling it "buh". His favorite activity was coloring with crayons. He tried to imitate the "choo choo" line by moving his crayon horizontally. He colored with a fisted grasp pushing very hard on the paper often breaking the crayon. He has a few words (mama, dada, ball and bye). He does not have a name for his brothers instead gestures towards them opening and closing a fisted hand. He follows a couple of routine directions such as give me "kiss" or "high five".

Of concern: Aaryan is recovering from a severe brain infection that may have impacted his hearing and vision. He had had to relearn skills he lost during his illness. He is scheduled for doctors to address his middle ear dysfunction. Both vision and hearing have an important impact on a child's ability to develop expressive communication skills and to learn about his world.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Aaryan is described as a strong, happy boy. He is using his motor skills to explore his environment including walking, a wide stance run, climbing on and off of furniture, going up the stairs with hand held and playing on some playground equipment such as the slide with support. He can walk backwards a few steps while pulling his stroller. He squats when playing with his trucks. Father reported that Aaryan will stand on the bed and try to bounce up and down. He is using his hands to participate in play and some self-care activities. Today he was redirected to point to a desired object instead of flapping his hands. He was able to pick up a string with a pincer grasp and balanced a few blocks on top of one another after several demonstrations. Aaryan easily turned the pages of a book and held a crayon to scribble vigorously. Mother reports he has made progress with his feeding skills following therapy and is now eating a variety of table foods. He feeds himself with his fingers and is beginning to practice using a spoon. He has difficulty scooping foods up and getting the spoon into his mouth. Mother says he often misses his mouth. Aaryan does better at breakfast and lunch. Dinner time is often difficult and fussy. Aaryan can drink from a cup including an open cup, sippy cup and straw. He is dependent on his mother to dress him but will try to help if prompted to take off his socks and hat. Aaryan does not sleep thru the night. He shares the bed with his mother and father and wakes up several times during the night. Mother gives him his sippy cup with sugar water and he falls back to sleep. He does take a nap each day. Aaryan is making his needs known by reaching toward an item he wants and crying and sometime trying to get it himself. Aaryan enjoys being in the kitchen with his mother but his father feels like he does not understand safety or when something is hot.

Of concern is Aaryan's medical history and hearing and vision issues impacting his motor skills and self care skills. He falls frequently and his motor quality and overall hand skills are not at the level we would expect for a child this age.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 3: Aaryan uses many important skills that are necessary for the development of more advanced skills; he is not yet showing skills used by other children his age in this area.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 3: Aaryan uses many important skills that are necessary for the development of more advanced skills; he is not yet showing skills used by other children his age in this area.
Use of Appropriate Behaviors to Meet Needs: Rating 3: Aaryan uses many important skills that are necessary for the development of more advanced skills; he is not yet showing skills used by other children his age in this area.

Determining the outcome ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three outcome areas.

- Clearly, Aaryan has a significant medical history and is not functioning at age expected levels compared to his same age peers. In addition to his medical history, there may be some cultural child rearing practices impacting Aaryan's development. Here are just a few things to consider when determining ratings and coaching the family in a meaningful way:
    - What are the family's cultural expectations for a boy's level of independence especially as it relates to self-care, making choices and acting on ones desires?
    - The parents have identified bath time, dinner time and sleeping through the night as challenging times of the day. How can you balance the family's cultural practices when developing strategies to support Aaryan during these family activities?
    - Aaryan's mother has expressed concern over being responsible for Aaryan's challenges. Recognizing this feeling may be deeply rooted in folklore and cultural expectations, how would you engage her during the assessment and intervention sessions?

The Decision Tree

Child Indicator Seeds for Success

Why Culture Matters: The Influence Migration & Acculturation on Arab-American Families

Recently there has been much media attention focused on the migration of Syrian refugees to the United States. For the 2016 fiscal year, it is expected that the United States will be increasing the number of Syrian refugees. In addition, the Infant & Toddler Connection of Virginia has seen an increase in the numbers of children served from Middle Eastern Countries over the last few years.

Currently there are approximately 3.5 million Arab-Americans residing in the United States. The U.S. Census Bureau considers anyone who reported being Algerian, Bahraini, Egyptian, Emirati, Iraqi, Jordanian, Kuwaiti, Lebanese, Libyan, Moroccan, Omani, Palestinian, Qatari, Saudi Arabian, Syrian, Tunisian, and Yemeni to be of Arab ancestry. Arab Americans are found in every state, but more than two thirds live in just ten states, one of which is Virginia. The five top "Arabic" languages are Arabic, Persian, Turkish, Berber, and Kurdish. While many native Arab-Americans are well integrated into American society, many newcomers are just beginning to adapt to American life.

Moving to another country and raising children in a new culture, such as the U.S., with different cultural values can be complicated, challenging, and stressful. The influences and pressures of acculturation affect every family member and operate in every facet of family life including child bearing, parenting young children, school functioning, adolescence, marriage, the couple relationship and the health and wellbeing of family members. The process of acculturation to the U.S. can be impacted by several factors, for instance, the country of origin, length of stay in the U.S., reasons for immigration, the ability to return or visit the home country, the long-term plans for staying in the U.S., and language issues among others (Al-Subaie & Alhamad, 2000).

Since parenting styles are different across cultures, it is important to distinguish between these differences in other cultures and to examine parenting with respect to other nationalities (Chao, 2000.). Therefore, it is necessary to recognize cultural context issues in regards to the differences of parenting styles and to understand why these differences occur (Keshavarz & Baharudin, 2009). Arabic society is commonly known as a collective and authoritarian (Dwairy, 2004). Arab immigrant parents typically come from countries where an authoritarian parenting approach is viewed as the norm, where their children must respect and obey these values. (Dwairy, 2004, 2010). Arab immigrant parents tend to hold on to their culturally rooted childrearing values and traditions, while trying to adapt to the mainstream values of the new culture.

The following are insights into the values, beliefs, customs and culture that you may encounter when working with families from "Arabic" backgrounds:

- There is a cultural code among Arab countries regarding keeping emotions hidden and family life is guarded with fierce privacy and seeking help outside the family is seen as unacceptable and shameful (Al- Darkmaki& Sayed 2009, Kobiesy, 2004).
- It is traditional in Arab countries that the husband and father take on the role of the provider and "protector" and that the wife and mother carry out her husband's wishes as he sees fit. He also acts as the representative of the family to society at large, presenting the family's beliefs, values and morals (Mourad, 2010).
- It is traditional in Arab countries that the main duty of women is to marry, take care of her children, maintain her home and protect the honor of her family (Aroian, 2006).
- In the traditional Arab family structure, respect is obligatory towards elders (Baraket, 1993) and thus the mother in law has full authority over the wife when the husband is not present. Duty to one's family is critical, and frequent close contact with the family is still expected even after marriage (Aboul-Enein,

2010). Elder and ailing parents are expected to live with one of their children (normally one of the sons) (Aboul-Enein, 2010).

- Children are often taught from an early age that their actions are a reflection upon the family as a whole, and shame and honor are greatly stressed (Mourad, 2010, Haboush 2007). Barakat (1993) states that because children are taught that family is the most important commitment they have, they often feel "guilt feelings" if they somehow disappoint their parents.
- Sons and daughters are treated differently (Mourad 2010) and are allowed different degrees of freedom and responsibility. While most Arab families deny that sons are more celebrated over daughters, many Arab communities hold more lavish celebrations for sons (e.g. in the United Arab Emirates 2 goats are killed at the birth of a son instead of the 1 when a daughter is born) (Crabtree, 2007).
- Parents treat first-born children in a special way. Axelson (1999) claimed that first-born children "tend to receive more attention, are likely to carry the family's ambitions, and are assigned a dominant role with respect to later children" (p. 285).

Many newcomers to the United States struggle with balancing these strong familiar beliefs with having lost their position in their home country. They may be starting over in a new country with nothing but their family and the clothes on their backs. As reported recently in the news, many migrants and refugees of Arabic speaking backgrounds arrive in the United States after prolonged experiences of conflict, trauma, persecution, poverty and displacement. When working with families of Arabic speaking backgrounds, it is important to learn from them, what challenges they face as they transition across two cultures.

The following information regarding the assistance provided to refugees from the State Department may be helpful in supporting families:

- Refugees are sent to nearly every state and to different communities across the country. Syrian refugees have been sent to 138 cities in 36 states since the country's civil war began in 2011. Nationality of origin is not a factor in determining where people are placed. The US government does try to resettle refugees near family if possible.
- The State Department offers financial aid for the first 90 days. Other aid is available for up to 5 years.
- Refugees must pay back the cost of their flight to the U.S. After one of the nonprofit resettlement agencies receives the case of a particular individual or family, the International Organization for Migration coordinates their travel to the U.S. city where they will be resettled. The plane ticket is paid for at that time, but after they arrive and begin working, the refugees must pay back the cost of the ticket.
- Refugees don't get long-term subsidized housing. Each refugee receives a stipend of about $1,000 to cover their first three months in the U.S. Before an individual or family arrives, the local resettlement organizations work to find a suitable apartment. They ensure the rent will be affordable and are in charge of distributing the stipend to cover the costs of rent for three months. Refugees are not placed in special apartment blocks and do not receive special rates. After three months, refugees are responsible for paying rent as normal tenants in their apartment buildings and are also free to move elsewhere within the city or state or to another state altogether.
- Refugees have to apply for jobs. Resettlement agencies also aid refugees in applying for jobs. Syria was considered a lower middle-income country before the war, and many refugees are educated and trained. But that doesn't mean they can pick up where they left off.

Family-centered services are generally a new concept to families of Arabic speaking backgrounds. You will need to take the time to build rapport and trust with families to determine what their needs are and how you can best work with them.

For more information on the multifaceted beliefs and values of the Arab culture, please reference Ethnicity and Family Therapy, Third Edition. Next month we will be exploring child rearing practices of parents from Persia, an Arab country with many migrants settling on the east coast.

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Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family? Was the family's cultural differences considered?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Faruq's Age: 22 months Adjusted Age: NA

Referral Information, Medical History, Health Status: Faruq was born full term at his home in Syria with the assistance of a midwife. No complications were reported. Shortly after birth, once mother had recovered, the family fled Syria to seek refuge in a camp in Jordan. They joined Faruq's grandparents, uncles, aunts and other family members. The extended family lived in a tent together until Faruq was 20 months old. At that time, Faruq and his parent's were escorted to the United States leaving behind the extended family members. Faruq's family is currently living in an apartment and have sponsorship thru a community church. The sponsor family referred Faruq to ITC with communication concerns. The parents speak Arabic and must have an interpreter present. Father is learning some limited English. They report Faruq was ill often with vomiting and diarrhea while living in the refugee camp. Mother has continued to breastfeed but recently found out she was pregnant and plans to wean. Father explained it is customary to breastfeed until the age of two or until the mother becomes with child again. Faruq has had some "shots" while in the camp but parents do not know what they were. He is scheduled to see a pediatrician next week. Father expressed concerns about the visit not knowing what to expect. Faruq has not had his hearing checked but parents do not have any concerns.

Daily Activities and Routines: Faruq likes to play by his mother with the toys his church family has provided including blocks, shapes in a box, books, crayons and paper. Mother reports he is not sure what to do with many

of the toys but enjoys looking at the books. She does not read English so she makes up stories based on the pictures. Outside of the apartment, there is a playground. The family has recently started taking Faruq for sliding, swinging and running. He enjoys his bath time. He stays at home with mother while father seeks employment. Faruq is babbling saying baba, he has said ummi (mama) about 2-3 times only but not on purpose. He is not consistently pointing or vocally indicating his wants. He understands "no" and shakes his head for "no". He does wave for bye.

Family Concerns: Faruq's family is concerned with his limited use of words and how it may get worse now that he must learn a new language as well. They report he is not saying words and is getting frustrated and aggressive when he can't get what he wants. This upsets Faruq's father. He reports Faruq is disrespecting the family by showing bad behavior. They would like him to call them "Ummi" and "Abbi" (mother and father).

Family Priorities: Faruq's family's priority is for him to develop appropriate communication skills so he can be able to communicate his needs and wants during his daily routines and community outings without getting frustrated. They want Faruq to be able to go out in public at the playground without getting upset and displaying inappropriate behavior in front of others.

Family Resources: Faruq's family is new to the US. The only resource they have available to them is their church family. They need assistance in obtaining food and ongoing housing. Father continues to look for employment but is concerned about being displaced from their home if he does not get rent money. He is also concerned that his extended family is still in Jordan and does not know Faruq's mother is with child. It is customary for the grandmother, aunts and cousins to assist once the baby arrives.

Developmental Levels: Cognitive- 18 months Gross Motor- 18 months Fine Motor- 18 months
Receptive Language- 18 months Expressive Language- 10 months Social/Emotional- 15 months
Adaptive/Self Help- 20 months

Social/Emotional Skills including Positive Social Relationships: Faruq is a shy little boy who was evaluated at the center with his mother, father and member of their church congregation (who provided transportation). An interpreter was provided for the assessment. Faruq's father did most of the speaking. Faruq stayed very close to his mother but did make occasional eye contact with the new adults in the room. He was aware of the conversation around him and would look towards his father when he spoke. He eventually warmed up and separated from mother's side to participate in the activities. Even during play, his eyes immediately looked towards his father when he spoke. He was very cooperative and transitioned well between activities. Father reported Faruq enjoyed playing with his cousins. They have always lived with extended family. Since coming to the United States, father reports Faruq has difficulty separating from his mother. He is learning to wave bye and understands the word "no" and will shake his head in response. Father reported Faruq has unacceptable temper tantrums that he believes are related to missing his grandparents and cousins who are still in Jordan. Faruq self soothes by sucking on the collar of his shirt. He communicates his feelings with body language, facial expression, tantrums and vocalizations.

Of concern: Faruq is not yet using any words or approximations to communicate his feelings or communicate with his parents. He only briefly engages in constructive play with evaluators before needing to check in with his parents. Faruq appears to have a high anxiety for new environments, including unfamiliar adults. He makes limited eye contact.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: Faruq is a quiet child who learns by observing and listening to others. He imitates actions of his mother such as cooking. He has toys at home, but mother reported he does not play with them. He enjoys looking at pictures in the books. Father reported toys are novel to Faruq. They did not have any in the refugee camp. Faruq had a doll that was passed down from his cousins that he played with at times. Faruq is curious and attempts to imitate actions. When a crayon was placed in his hands he imitated making strokes and the examiner modeled with hand over hand. Faruq quickly responded to his name when called by his father. When the examiner called his name, he looked towards the floor. Father reports Faruq will respond to directions related to his daily routine such as when it is time to lay down. He does understand some common objects and their actions. When given a doll and brush he was able to brush the doll's hair. He is reported to have a few sound combinations that he uses combined with gestures to communicate with his mother. He does not consistently have a name he uses for his parents.

Of concern is Faruq does not have any real words in his native language or in English. He did not imitate words or name desired items or pictures from a book when asked. He does not have a name for his mother or father. He does not play appropriately with toys.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Faruq manipulated the environment without difficulty during the assessment. His family lives in a second floor apartment and he is able to go up and down the stairs holding a parent's hand. He climbs well and is able to get onto an adult sized chair. Parents report he kept up with his cousins back home and they have taken him twice to the playground at their apartment complex. He used both hands well together during the assessment but was not able to manipulate many of the toys. He was able to turn the pages of a picture book.

Mother reports that Faruq helps with dressing by removing his socks but needs help with other tasks. She reports sock removal is a new skill for him since coming to the US. In Jordan, he was always bare foot. Faruq is still breastfed but will be weaned as his mother suspects she is pregnant. Father reported Faruq will begin eating the same diet as the family which consists mostly of rice, vegetables and fruit. Although Faruq sleeps with his parents, he does have his own crib that was provided by the church. Father reported it is customary for many family members to sleep in the same bed in their country. Faruq wakes up during the night to nurse. Faruq does occasionally babble to try to get his needs met. He will sometimes point but often tugs on his mother. When his needs aren't met he demonstrates temper tantrums.

Of concern: Faruq is not using any words/approximations to communicate his needs and wants. He relies heavily on physical gestures to communicate those needs, often crying which leads to periods of frustration when unable to successfully meet his needs.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 2: Faruq is beginning to show some of the early skills that are necessary for development of more advanced skills.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 3: Faruq uses many important skills that are necessary for the development of more advanced skills; he is not yet showing skills used by other children his age in this area.
Use of Appropriate Behaviors to Meet Needs: Rating 4: Faruq shows occasional use of some age expected skills. Child has more skills of a younger child in this area.

Determining the outcome ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources and across different settings to identify an overall sense of the child's functioning at a given point in time in three outcome areas.

- Faruq's parents identified practices that some may question and may result in skills many may not feel are typical for his same age peers. This is where culture comes into consideration.
    - In a collective society, emphasis on close connections and collaboration over personal self-development is thought to be fostered by family routines such as co-sleeping, weaning at older ages, emphasizing obedience toward adults, and playing collectively (Schulze et al., 2001).
    - Some of the behaviors displayed by Faruq are accepted and expected by his family's culture. When determining how to weigh culture vs development compared to same age peers, it should be noted at this time Faruq is new to this country and has very limited interaction with same age peers. His parents report he played well with his cousins at home. As Faruq becomes more involved in activities outside of the home such as playground, church nursery, etc., the behaviors related to cultural influences will impact his development greater when compared to same age peers. In addition to the cultural expectations we must consider when determining ratings, Faruq has had limited experience due to being in a refugee camp. For children showing delays due to lack of exposure, we do not make adjustments in the rating when comparing to typical peers.
- Cultural Goggles: Everybody Got "Em" a webinar to explore the way your cultural "goggles" enhances or inhibits your ability to develop cross cultural relationships in service delivery. Key definitions were defined; a look at current Virginia demographics and predictions made about populations you may begin to work with. A three prong model was used to discuss strategies for effective communication and suggest ways to apply this new knowledge to your work in cross cultural service delivery.
- Use the following checklist to test your awareness and acceptance of the Arabic culture: Cultural Competence Checklist Personal Reflection.
- An interpreter was used for Faruq's assessment. Do you know how to pick a good interpreter or how to inform an interpreter of your expectations? Here is a useful evaluation form: Interpreter Evaluation Form.
- Are you interested in sharing and learning more about the experiences of other providers who are addressing cultural values and differences? Check out the Early Intervention Strategies for Success Blog Are Cultural Differences Truly Developmental Delays?

The Decision Tree

Child Indicator Seeds for Success

Why Culture Matters: The Influence of the Hispanic Culture on Child Development

Humans are cultural beings. We learn to communicate and understand our world through the context of our languages, traditions, behaviors, beliefs and values. Our cultural experiences and values shape the way we see ourselves and what we think is important. Cultural perspectives also influence how we parent, how we understand children, how we help them grow up and how we teach them new skills. This month we will be exploring the development of children from the Hispanic culture and its' relevance to the Child Outcomes Rating Process.

The Hispanic culture is one of the fastest growing cultural groups in the United States. The U.S. Census data indicates that Hispanics will be the largest minority group by the year 2050. Recent findings from the Childhood Autism Risk from Genetics and the Environment (CHARGE) Study, a population-based study of factors that increase risk for autism or developmental delay in children 24 to 60 months discovered that over 6 percent of Hispanic children enrolled in the study, which were selected randomly out of the general population met the criteria for developmental delay, compared with only 2.4 percent of non-Hispanic participants, which is the expected percentage. This raised concerns among the researchers that many Hispanic children with developmental delays are going undiagnosed and may not be getting the services they need. This concern was also echoed in the executive summary Addressing the Needs of Latino Children A National Study of State Administrators of Early Childhood Programs.

Some research studies cite acculturation, or the process of adaptation that occurs through continued contact with a culture distinct from one's culture of origin (Berry, 2006), as a factor that may contribute to a parent's decision to engage in programs and services. Studies investigating psychotherapy treatment patterns have found that less-acculturated Latino families are less likely to enroll and more likely to terminate services prematurely compared with more-acculturated or U.S.-born families. Lara, Gamboa, Kahramanian, Morales, and Bautista (2005) found that families with low levels of acculturation to the U.S. are least likely to access quality health services, and Moreno and Lopez (1999) found that lower acculturation to the U.S. was associated with less knowledge about school activities and greater barriers to parental involvement at school. In addition, Mexican-American mothers reported that acculturation differences between parents and children, separation from extended family, discrimination against immigrants, and concerns about legal status negatively influenced their parental involvement (Leidy, Guerra, & Toro, 2010).

According to Virginia Department of Health 2014 data, there are 73,345 children birth to 60 months identified as Hispanic. It is expected Virginia will continue to see the number of Hispanic children needing early intervention services rise. Understanding what typical development for children from the Hispanic culture looks like is critical for early identification of children, completing the child outcome ratings and providing evidenced based services.

Learning From Latinos: Contexts, Families, and Child Development in Motion, a review of two decades of research put together by the American Psychological Association based on child development in the context of Latino families, provides us with the following information:
"Research with Latino children and families does not suggest that the physiological workings of the Latino child's mind or underlying cognitive development differ from others. The cognitive processing capacities of Latino infants, not surprisingly, appear to equal those of other groups (Fuller et al., 2010). But differing mentalities do emerge as Latino parents bring forward their "cultural products of prior human activity" (Cole, 1996, p. 34) and blend heritage and novel practices in raising their children, at times struggling to negotiate quite foreign surroundings."

Key Points on Hispanic/Latino Culture
Hispanic is a term created by the U.S. federal government in the early 1970s in an attempt to provide a common denominator to a large, but diverse, population with connection to the Spanish language or culture from a Spanish-speaking country. The term Latino is increasingly gaining acceptance among Hispanics, and the term reflects the origin of the population in Latin America.

Respect
Respect is an important but complex value in the Hispanic culture. Parents with traditional Hispanic values may believe that children should be obedient to authority figures. They may describe obedience as not making oneself the center of attention; not being loud or talkative; not asking too many questions; working in a collaborative manner; never questioning authority; and more. It also means they should obey rules without talking back to their parents. Latino parents often subscribe to the idea of affiliation obedience; this is the idea that children are expected to obey their parents in exchange for their love and care. Thus they may feel they have succeeded as a mother/father when the child learns to be obedient and may feel the way their child behaves in the presence of others reflects their parenting skills.

Rituals and Religions
Some Hispanic families may believe it is important to teach their children the beliefs and history of their culture. Parents want their culture to continue and stay strong within future generations of their family. This can depend on their level of connectedness to their cultural roots. If the family has immigrated from somewhere else, this value may depend on how far they are removed from that immigration experience.

Discipline
Depending on multiple variables, such as acculturation, socioeconomic, or educational levels, Hispanic parents' ways of punishment sometimes differ from the beliefs of other cultures. There is a traditional belief that when a child is misbehaving parents must discipline them immediately or the child will not learn right from wrong. This belief also maintains that if the child constantly continues to get away without being disciplined, then the child may learn to walk over the parent. Depending on the age of the child, a parent's expectations of their child's behavior will vary. There is an idea in traditional Hispanic culture that by the age of 4 or 5, a child should have an understanding of what is expected of him or her.

Etiquette
Etiquette in any culture is multifaceted and complex. It is based on the context, the people in the room, the roles they play in the setting, how well they know one another, and the purpose of the encounter. Latino culture views time in a polychronic fashion as opposed to monochronic way that westerners view time. Polychronic time is often time adjusted to suit the needs of people. For them, maintaining relationships and socializing are more important than accomplishing tasks. These individuals usually see time in a more holistic

manner; in other words, many events may happen at once. Ex. Making sure that your mother in law feels like you have spent quality time with her is more important than being on time to the dinner you have planned with your friend. Because of the importance of respect of authority, eye contact can be mechanism for deference or an expectation of respect, therefore it can be interpreted as a challenge or intimidation in traditional Hispanic culture. Traditional Latino culture tends to be fairly formal. It is usually expected to greet someone and leave someone by giving them a handshake. Even the Spanish language has a formal form and it is used in professional, medical, and other settings that are not with family or friends. Titles of respect before people's names and using Señor, Señora, Don or Doña are important to set the right tone.

Education

In general, Hispanic parents feel that education is very important for their children to have. Many foreign born Latino parents immigrated to the United States for the primary purpose of providing more opportunities for their children's future (Reese, L., Balzano, S., Gallimore, R., & Goldberg, C. (1995). Early intervention programs are developed on the premise that parents or primary caregivers are their child's best teacher. The diverse characteristics of children reinforce the need to consider the needs of each child within his or her broader social, cultural, and familial context. Effective assessment and intervention strategies require the integration of many factors including cognitive, linguistic, and cultural influences.

Communication in the Home

There is no evidence to support bilingualism as confusing or too taxing on the language-learning abilities of children with communication disorders. The research available thus far clearly shows that intervention in the home language does not impair or significantly slow the learning of a second language. To the contrary, there is evidence that children can benefit from an intervention that acknowledges the home language and culture and supports bilingual development, with gains in both the majority language as well as the home language (Restrepo, Morgan, & Thompson, 2013. The efficacy of a vocabulary intervention for dual-language learners with language impairment. Journal of Speech, Language and Hearing Research, 56, 748–765). Because of the importance of affiliation obedience, some Latino parents may be more likely to communicate with their children in a direct style than to engage their curiosity by talking with them and reading to them. Consequently, it may be important to broach this subject with traditional Latino parents.

Eating Habits

As with many cultures, meals are often a time for socializing and connecting with friends, family, and cultural roots. For young children, research indicates Hispanic practices include prolonged bottle feeding, preference for heavier babies, influence of extended family especially grandparents. Research has also shown some trends towards an acceptance for children to have sweets, breastfeeding with formula supplementation, and influence of learned culture on diet. Additionally, for Hispanic families that grew up in poverty, it may not be acceptable to leave food on your plate. (Evidence to Guide Feeding Practices for Latino Children, Houston, Waldrop & McCarthy 2013).

Bed Sharing:

In the United States, twenty-eight percent of Hispanic parents report sharing the same bed with their young infant and/or children. Parents report bed sharing in order to be close to their infants. This closeness is seen as emotionally beneficial for parents and infants.

Test Your Inter-rater Reliability

Our state's focus on child indicator ratings has led many to wonder,
"Are we all rating children similarly?"

As part of our efforts to improve results for children, we are focusing each month on increasing our statewide inter-rater reliability. We are using examples of narratives from around the state that ideally will include observations of functional behaviors, parent/caregiver input, results from assessment tools and informed clinical opinion. Below is an example of a narrative from a recent Assessment for Service Planning. Using the limited information provided in the narrative and the process outlined in the child Indicator Booklet talk thru the scenario with your colleagues to determine a rating. The ratings given by the assessment team can be found at the end.

Disclaimer: This activity is for learning purposes only and is not intended to be an endorsement of any particular narrative. It is intended to help you reflect on the questions that follow.

Questions to Consider:

1. Was there enough information provided to determine a rating? What additional information did you need?
2. Was there input into the narrative from all members of the assessment team including the family?
3. Was the child's functioning across settings in each indicator clear?
4. Were functional skills listed under the correct indicator?
5. How close were your ratings compared to the ratings given by the assessment team? One or two off, in the same color family or way off? Did you agree with the ratings given by the team? Why or Why not?

Henry's Age: 26 months **Adjusted Age: NA**

Referral Information, Medical History, Health Status: Henry was born at 36 weeks gestation. Henry stopped breathing a few minutes after he was born and need to be resuscitated. He stayed 7 days in the NICU after this episode for observation. No other complications arose and he was discharged from the hospital with no concerns. He passed his newborn hearing screening. He was referred by his parents for speech concerns. The parent's primary language is Spanish. Henry's father speaks some English. Henry's mother speaks only Spanish.

Daily Activities and Routines: Henry wakes up between 9:00 to 10:00 and goes to bed around 11:00pm. He sleeps with his parents. His mother works at night from 10:00 pm to 6:00 am; she takes care of Henry all day while his father is at work. His mother tries to sleep in the morning while Henry is still sleeping and when he takes a nap in the afternoon. Henry is a light sleeper and wakes up easily with sounds. He continues to wake up between 1:00 am and 3:00 am to drink a bottle of milk. He drinks 6 bottles of milk in a 24 hour period. He is a good eater and eats a variety of table foods. He eats all of his meals sitting in a high chair that is placed next to the dining room table. He eats independently using a fork and/or spoon; he is able to drink from a "sippy" cup. Henry is attached to his parents and enjoys doing things with them (playing with balls and cars); he enjoys playing football with his father in the backyard and going for walks outdoors with his mother. During the weekends he enjoys going to the park and usually gets interested in the older children's activities (baseball and football). Henry also loves playing with Spot, the next door neighbor's dog.

Family Concerns: Henry's family is concerned with his speech and language development. His mother reported that when he was a baby, he used to babble a lot and used to make a variety of sounds ("mama" and/or "papa" to call his parents. To communicate his needs and wants, he makes the sounds "mmm" and "eee" sounds. Henry likes to put things in his mouth that are not food since he was a baby. He continues to put paper, cardboard, balloons, dirt, etc. and his mother always needs to supervise him. Henry has an older half sister who lives with her mother in Mexico.

Family Priorities: Henry's family's priority is for him to develop appropriate communication skills so he can be able to communicate his needs and wants during his daily routines and community outings without getting frustrated. They would like Henry to call his parents using "mama" and "papa", to use more sounds and words/approximations during his play time and daily activities when interacting with his parents, family, friends and other children in the community and park.

Developmental Levels: Cognitive- 18 months Gross Motor- 24 months
Fine Motor- 18-22 months Receptive Language- 18 months Expressive Language- 9 months
Social/Emotional- Atypical 18 months Adaptive/Self Help- 18-21 months

Social/Emotional Skills including Positive Social Relationships: Henry is an adorable and sweet 26 month old little boy, who came to today's assessment with his mother. An interpreter was provided for the assessment. His mother reported he shares a special bond with his parents, he regularly checked in with his mother as he briefly ventured off to play with toys as introduced. He lives at home with both parents, who alternate care depending on their work schedules. Mother shares that Henry is an active little boy, who is constantly on the "move". He loves going outdoors to play, i.e. backyard with his neighbors and to the playground where he joins in with other children. He loves playing football and other such games with his father and enjoys running around with him. Mother reports that he is now better with separating from her as she leaves for work, and enjoys his time with his father. When prompted, he waves "hi" and "bye" and uses a few gestures, i.e. hands up to get picked up and he uses some vocalizations to get his parents attention or help. Mother reports that he is much more "comfortable" with children rather than adults. But recently has started to play a bit more with grandmother when she visits. He seems to get anxious in a new/unfamiliar/non-routine environment, but today was able to briefly engage in play with the evaluators, especially when preferred games/items were introduced looking for Mother to join in and share in his praise. As seen today and based on Mother's reports, when upset or frustrated he seeks Mother for any attempts to self calm and/or for redirection.

Of concern: Henry is not yet using any words or approximations to communicate with his parents, peers and other familiar adults in his life. He is not yet calling for his parents, and doesn't have a name for the "special" people in his life. He is not using any words for greetings as he plays with other children and today, only briefly engages in constructive play with evaluators before needing to check in with Mother. Henry appears to have a high anxiety for new environments, including unfamiliar adults. He clings to his mother, grabbing/pulling her face to his as a means to avoid interactions with others and relies heavily on Mother's physical support to offer any calming influence. Subsequently, the above behaviors severely impact his ability to engage others socially, including interacting with adults and peers.

Child's Development in Relation to Other Children the Same Age:

Acquiring and Using Knowledge and Skills, including early language/communication: When interested, Henry shows curiosity for learning about his world. Henry is learning through observation, imitation and manipulation of objects and toys. Henry imitates some of the adult activities around the home such as wiping/cleaning, brushing hair and playing catch with the neighbor's dog. Henry follows simple directions within his family routines. He is able to point to four body parts upon request. Henry enjoys play with his cars and will play with them by himself for an extended period of time. He will sometimes imitate the sound of a car. He also recently has imitated the animal sounds for dog and lion. While playing catch with the neighbor's dog in the back yard, Henry has also imitated the word "go". In play, Henry hugs stuffed animals. He communicates through the use of facial expressions, vocalizations (m-m-m, grunts) babbling sounds (tete, papa, baba), gestures (pointing, pulling and adults hand up, head shake no), and verbalizations (approximation for "there it is", animal sounds).

Of concern is Henry's markedly limited ability to attend and focus on a task, especially when he is not in a place of comfort. Frequently, due to a state of increased emotion and apparent anxiety/stress, Henry is not able to demonstrate his understanding and/or use of language. Henry prefers to move from one activity to another, not attending or focusing on a task for an extended period of time. Henry does not readily show the ability to attend and imitate the actions or sounds of others, especially when his attention is not available due to his emotional state. Henry does not show interest in looking at books or pointing to pictures upon request. Henry is not able to follow requests given by others. Henry does not have any words he uses consistently on his own to communicate with others. He relies on gestures and others anticipating his needs or will do things for himself.

Child's Development in Relation to Other Children the Same Age:

Use of Appropriate Behaviors to Meet Needs: Henry is an active little boy who walks, runs, climbs and negotiates uneven surfaces without difficulty. Today, he sat in the toddler seat independently and climbed up the adult size chair without difficulty. Mother reports he is able to walk up/down stairs to enter the backyard and enjoys throwing a ball around with familiar "peers".
Mother reports that Henry helps with dressing by removing his socks and jackets but needs help with other tasks. He co-sleeps with his parents at times falling asleep in his "little" rocking chair and then parents carry him to bed. He wakes at nights to get a bottle, and is currently taking about 3-4 bottles (about 4 ounces) a day. Henry is described as a good eater, using utensils independently and is now drinking from a sippy cup or a straw cup, though he prefers the sippy cup. He finishes most of his meals and at times, waits to be offered more. Mother shared that when he starts "playing with his food", it is an indication that he is done. Henry is able to open the refrigerator to get some food items but more readily points and pulls parents to what he wants. He shakes his head "no" with some prompting, and uses a few vocalizations to communicate his needs and wants.

Of concern: Henry is not using any words/approximations to communicate his needs and wants. He relies heavily on physical gestures to communicate those needs, often crying which leads to periods of frustration when unable to successfully meet his needs.

Child's Development in Relation to Other Children the Same Age:

Assessment Team Ratings:
Social/Emotional Skills including Positive Social Relationships: Rating 2: Henry is beginning to show some of the early skills that are necessary for development of more advanced skills.
Acquiring and Using Knowledge and Skills, including early language/communication: Rating 2: Henry is beginning to show some of the early skills that are necessary for development of more advanced skills.
Use of Appropriate Behaviors to Meet Needs: Rating 4: Henry shows occasional use of some age expected skills. Child has more skills of a younger child in this area.

Determining the outcome ratings requires teams to synthesize an enormous amount of information about a child's functioning from multiple sources
and across different settings to identify an overall sense of the child's functioning at a given point in time in three outcome areas.

- Use the following checklist to test your awareness and acceptance of the Hispanic culture: Cultural Competence Checklist Personal Reflection.
- An interpreter was used for Henry's assessment. Do you know how to pick a good interpreter or how to inform an interpreter of your expectations? Here is a useful evaluation form: Interpreter Evaluation Form.
- Henry shows some atypical skills. Although we don't have a diagnosis of autism and only have a limited amount of functional information from our first observations and assessments, there has been much research completed over the past few years focusing on early identification and/or misdiagnosis of children from Hispanic/Latino cultures for autism. Referenced earlier was a study by Childhood Autism Risk from Genetics and the Environment (CHARGE) Study, a population-based study of factors that increase risk for autism or developmental delay in children 24 to 60 months. This study raised concerns among the researchers that many Hispanic children with developmental delays were going undiagnosed and may not be getting the services they need.
- Similar findings were reported in the study Prevalence of Autism Spectrum Disorders — Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008 published in March 2012 by the Center for Disease Control and Morbidity.
- Findings from the various research studies related to under diagnosis of children from the Hispanic culture were significant enough to bring forth recommendations from the American Academy of Pediatrics Pediatrician Identification of Latino Children at Risk for Autism Spectrum Disorder.
- Are you interested in sharing and learning more about the experiences of other providers who are addressing cultural values and differences? Check out the Early Intervention Strategies for Success Blog
  Are Cultural Differences Truly Developmental Delays?