Screening and Assessment Practices in Aboriginal Early Childhood Programs in British Columbia

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Executive Summary

Purpose of Study

This project documented current practices and perceptions of monitoring, screening, and assessing the development of infants and young children in 88 Aboriginal child care and development programs throughout British Columbia.

Background

A decade of conferences and training workshops organized by Aboriginal Head Start, the B.C. Aboriginal Child Care Society, and the B.C. Infant Development Program has evidenced a wealth of knowledge and opinion on the parts of practitioners in programs serving Aboriginal children and families. This project set out to gather this 'lore' from practitioners to inform decisions about approaches to emphasize in pre-service and professional development training, discern any significant variations in assessment preferences or needs for training or support in rural versus urban programs or in infant versus preschool programs, and to determine needs for creation of new tools, scoring criteria, or guidelines for assessment practices in programs serving Aboriginal children and families.

Most Aboriginal early childhood programs use one or more standardized tool, such as the Work Sampling System, the Ages and Stages Questionnaire, the Nipissing District Developmental Screen, Denver, or Gesell. Most program staff can offer perspectives on the relative merits, cultural appropriateness, procedural aspects (e.g., consent, parental involvement, feedback, records), and outcomes of using a variety of existing developmental monitoring, screening and assessment tools. In provincial and regional workshops and meetings, Aboriginal program staff have described an array of strategies they have created to adapt these tools to the requirements or preferences within their own program setting. Adaptations include selective administration of survey items, substitution of item content or props with material thought to be more relevant or 'fair' for the population served, elaboration of instructions and prompts to children being assessed, and collaborative approaches to communicating with parents and other caregivers before, during and after assessments.

The project reported here was funded in part by the First Nations and Inuit Health Branch of Health Canada, and by the B.C. Ministry for Children and Family Development, through the Human Early Learning Partnership. The views expressed are not necessarily those of the funders.

The project team thanks the 88 practitioners throughout British Columbia who contributed their experiences, ideas, and recommendations to the survey reported here. Corrine Lowen and Miranda Rosso contributed substantially to conducting the survey and ensuring a positive experience of the process for community-based practitioners who participated.

Method

Structured, 30 minute interviews were conducted by telephone with 88 Aboriginal child care programs in B.C., including: 64 programs on reserves (mostly Aboriginal Head Start); 9 Aboriginal Head Start programs off reserves, 5 Aboriginal Infant Development Programs (AIDP) on reserve, 8 AIDP off reserve, and 2 AIDP serving children living on and off reserves. The sample represented approximately 70% of provincially or federally funded programs in B.C. specifically serving Aboriginal infants and young children. Among survey respondents, 74% held the position of manager, coordinator, supervisor, or head Early Childhood Education worker in their program, 21.5% were the Infant Development Consultant, and the remainder were family outreach workers or teacher assistants. Over half of respondents (61%) self-identified as Aboriginal.

Respondents were asked about staff training in screening or assessment, what types of approaches were used in their programs for monitoring children's development and identifying children needing diagnostic assessment or extra supports and why, what happens after a screening tool or assessment has been done (e.g., parents' involvement, referral and follow-up), and their views about the roles and relatives merits of using various formal or informal approaches to monitoring, screening, or assessing Aboriginal children's development.

Findings

The high response rate and detailed verbal reports from practitioners confirmed their eagerness to contribute to programmatic decision-making, improved training and practice of screening and assessment in Aboriginal programs.
The project yielded an inventory of frequently used screening and assessment tools in Aboriginal early childhood programs, the perceived effectiveness of various tools, local adaptations to increase local receptivity to various tools and their practical value to practitioners, parents, and other service providers, and practitioners' recommendations with regards to the content, structure and process of developmental assessment in Aboriginal early childhood programs.

The Ages and Stages Questionnaires (ASQ and ASQ-SE) were used in 46% of programs and were by far the most positively accepted approach to developmental screening, even in programs where other tools were previously or concurrently used. One fifth of the programs sampled had a routine of using the ASQ with every new child enrolled. After enrolment, many practitioners described using the ASQ at least twice a year with each child, and as needed when "staff have a hunch that a child's development is not on track." Another 32% of programs relied primarily on "observation", often using some type of checklist or chart of developmental milestones. Most practitioners gave high ratings to their staff for their vigilance and skills in observing and discerning whether a child is on track compared to normative expectations for development, and said that a child would be referred for screening or assessment if staff observed a persistent difficulty or delay. An almost equal number of practitioners (31%) reported that they relied primarily on talking to parents or guardians about their impressions of their child's development in deciding whether to refer a child for formal screening or assessment.

Only 14 (16%) of programs reported using the Nipissing District Developmental Screen, often at the point when a child is initially enrolled. Comments about the NDDS were generally positive, focusing on its brevity, clarity, and "parent friendliness." Many practitioners had not heard about the NDDS. Several expressed interest in learning more about this and other potentially useful tools.

Two Aboriginal Head Start (AHS) programs on reserve and 7 AHS programs off reserve reported using the Work Sampling System (WSS). Practitioners in AHS programs off reserve explained that they "only use it because it is required by our funding agency." They described the WSS as cumbersome in its demand for details across a large number of ambiguously defined attributes and not suited to parents' involvement. They expressed frustration with the training in WSS they had received.

Twelve practitioners, all in Aboriginal Infant Development Programs, reported using the Gesell Development Assessment, but only one used this as their primary approach. Eleven of these programs used either ASQ or talking with parents as their primary approach to information-gathering and decision-making about referrals for assessment or early intervention. Negative comments about the Gesell included that it is expensive, requires training and practice that are hard to obtain, is not "user friendly" and is not well received by parents. The AIDP practitioners particularly emphasized using 'informal' approaches (e.g., observations, conversations) within the context of building working relationships with parents.

Three AIDP practitioners reported that their program had begun using the Battelle Developmental Inventory. They commented that because the Battelle has standardized scoring it yields more compelling evidence for securing specialists' services when a child is referred. All commented that it requires a lot of training, equipment, attention to detail, and time to administer, and therefore a regular staff member could not afford the time "off the floor" of their programs to undertake assessment using this tool.

Most practitioners expressed concern about not displacing the importance of relationships with parents as their first priority: listening to parents; engaging parents; and keeping parents fully informed and involved in monitoring, screening assessment, referrals and follow up activities. They described pacing the introduction of formal screening and assessment procedures according to the parents' readiness. Many perceived that parents involved in their programs are very far from being ready to accept formal screening and assessment, and that building parents' confidence and respecting their preferences were guiding principles in their programs.

In general, practitioners recommended that observations, screening or assessment are conducted within the context of the child's home or child care setting, rather than in "overly formal" or clinical settings or away from the community. They emphasized a multi-disciplinary, team approach characterized by good communication about how to involve parents in screening and assessment, plans for referrals, and follow-up. Frequent collaboration was described among the Early Childhood Educator, Aboriginal Infant Development Consultant, and Community Health Nurse especially in rural communities. In regions with an Aboriginal Supported Child Development Consultant, respondents were extremely positive about their coordinating, "make-it-happen" role in referral for diagnosis and intervention. Over half of the practitioners identified barriers to a fully effective team approach, especially: lack of consultants and services in rural and remote areas; parents' frequent preferences to '"go it alone" or "wait and see" without following up on referrals; and lack of connection between community-based practitioners and service providers beyond the community. Many described feeling isolated and not knowing who to involve or what services are available when a child's needs cannot be met by community-based practitioners.

Practitioners were reluctant to cite specific developmental challenges as particularly relevant or prevalent in referrals for screening and assessment. Many referred simply to 'developmental delays.' One exception was speech-language deficits, which came up often in practitioners' examples of the lack of consultants to conduct assessments or follow-up on referrals for early intervention. Only one practitioner mentioned screening or assessment to determine whether a child was exhibiting signs of FASD.

Only two practitioners responded positively to the question of whether there is a need for a culturally specific assessment tool. However, many practitioners qualified their overall positive support for the use of certain "parent-involving" formal approaches, such as the ASQ, emphasizing that their *first priority* is to develop a positive relationship with Aboriginal parents or guardians. They stressed that screening and assessment tools should be used within highly contextualized approach to working with "our families", only when parents are ready and signal their agreement through explicit consent.

Practitioners were positive about any training in developmental observation systems, screening or assessment that they had received, most often at conferences and in-service training workshops provided by their funding agencies and by B.C. Aboriginal Child Care. Describing waiting lists for training and lack of funding for travel out of their communities, many practitioners stressed a need for more training opportunities for all the staff in their program, not only in observation, screening, and assessment, but also to learn about where to refer children for different kinds of services, and how to follow up on referrals effectively. Practitioners in Aboriginal Head Start programs off-reserve were particularly vocal about a lack

of opportunities for training except in the WSS, and the need for training in ASQ and other types of screening approaches.

Action steps indicated by this survey include finding ways to increase opportunities for training in the use of ASQ, specifically, and in how to navigate within the complex system of federally and provincially funded and contract services for referrals and follow up to ensure a connection between a child or family and specialists outside of the community.
Appreciative comments and examples from practitioners about the navigational role provided by Aboriginal Supported Child Development workers reinforced the value of this innovation in provincial service. Noting long wait times for children identified as needing specialist services, particularly in rural and remote communities, practitioners advocated more staff training on how to work with children with developmental challenges within the context of their home, child care or Aboriginal Head Start program, while waiting or in lieu of specialist services.

Practitioners' strong caveats about ensuring strong relationships between program staff and parents before introducing any formal tools or referrals for assessment give pause to current enthusiasm in some parts of the ECD field about universal surveillance for early detection of development challenges. Community-based practitioners advocate a highly individualized pace and approach to serving Aboriginal families, introducing externally provided assessment technologies only when this would be perceived by parents as supportive and not as an intrusion that could detract from their emerging sense of control-mastery in their parenting role.

Project background

Increasing demands for early childhood programs and early intervention services for Aboriginal infants and young children calls for an understanding of how to identify children and families with needs and potential to benefit from extra supports to ensure optimal developmental outcomes. There is growing interest in deliberating the pros and cons of various standardized tools and procedures for screening and assessment. There is ongoing debate about whether it is possible, advisable or timely to innovate an 'Aboriginal-specific' method of screening and/or assessment. Meanwhile, the current expansion of the Aboriginal work force engaged in infant development and early childhood programs has occasioned the introduction of some innovative informal approaches to determining who needs special services and how to connect children and families to needed services.

The past decade has seen an increasing number of conferences and training workshops organized by First Nations and Inuit Health Branch Child Care Programs, the Public Health Agency of Canada Aboriginal Head Start Program, the B.C. Aboriginal Child Care Society, the B.C. Infant Development Program, and the B.C. Aboriginal Supported Child Development Program. Practitioners' participation in these workshops has given voice to the wealth of experience-based knowledge as well as strong beliefs, values and perspectives regarding developmental screening and assessment held by practitioners serving Aboriginal infants and children and their caregivers through community-based programs. Anecdotal evidence has suggested that most of these programs use one or more standardized tool to track children's development and to screen children who may require a diagnostic assessment or early intervention. Some programs have described 'bootstrapped' or customized methods for monitoring children's development, often reporting considerable success and satisfaction with this idiosyncratic, community-specific approach. And staff attending provincial and national conferences have described a varying array of creative strategies they use to adapt existing tools to the requirements of their program or the community they serve.

The current project was prompted in part by observations of the richness and intensity of discussions and innovations that are occurring among staff in Aboriginal infant and early childhood development programs. The project was intended to document this rich lore about screening and assessment practices and experiences 'on the ground.'

The results reported here may be useful to guide decision-making in communities and in development of federal and provincial programs of training and service delivery for Aboriginal children and families. For example, the report suggests that there are existing tools currently in use in communities that have been acceptable and useful to families and practitioners, provided that these tools are used in a timely and respectful manner. The report emphasizes that this respect must extend to considerations not only of families and specialists, but of front line service providers working with families through home visiting or with children through centre-based infant and early childhood programs.

Method

Project team
This project was conducted by Dr. Jessica Ball with a team composed of First Nations and Anglo-Canadian practitioners who assisted in recruiting and obtaining reports from program staff during 2006.

Phone, mail, or on-line survey?
The survey was conducted as an 'environmental scan' developed through consultations with selected First Nations early childhood program practitioners and focus testing of the interview protocol and recording method. Three methods were explored: phone interviews, email exchange, and fax. Phone interviews proved the most promising for yielding a high response rate and for allowing the open-endedness of a direct conversation with practitioners to obtain descriptions of experiences and innovative approaches to screening and assessment in various community programs..

Introducing the project
A letter introducing the project and establishing anonymity and confidentiality was sent to a total of 91 Aboriginal Head Start programs on reserves in B.C. receiving funding from the First Nations and Inuit Health Branch, 12 Aboriginal Head Start programs off reserves receiving funding from the Public Health Agency of Canada, and 33 Aboriginal Infant Development Programs supported by the B.C. Ministry for Children and Family Development and the B.C. Associatin of Aboriginal Friendship Centres.

Programs sampled
The scan was limited to B.C., which is home to a diverse population of First Nations and Metis peoples, and a geographically, linguistically and economically varied array of communities. Structured, 30 minute interviews were conducted by telephone with 88 Aboriginal child care programs in B.C., including:

- 64 programs on reserves (mostly Aboriginal Head Start);
- 9 Aboriginal Head Start programs off reserves;
- 5 Aboriginal Infant Development Programs (AIDP) on reserve;
- 8 AIDP off reserve;
- 2 AIDP serving children living on and off reserves.

The sample represented approximately 70% of provincially or federally funded programs in B.C. specifically serving Aboriginal infants and young children.

Programs represented in the survey are located throughout the province, in isolated, remote, rural, peri-urban and urban settings. More than half of the participating programs are in small rural communities where the early childhood program is the primary or only service for infants and/or young children.

Anonymity
A consent procedure was undertaken to assure program staff who were contacted by the survey team that the project was not intended as an evaluation of the staff or the program, and to assure them that

the information obtained would not be reported in a way that identifies the name of reporter, the program, or the community. It was understood that the information obtained via the interviews would be reported in summary terms, describing trends supported by anonymous quotes from practitioners.

Practitioner respondents

Among survey respondents, 74% held the position of manager, coordinator, supervisor, or head Early Childhood Education worker in their program (and were sometimes the *only* staff), 21.5% were the Infant Development Consultant, and the remainder were family outreach workers or teacher assistants. Over half of respondents (61%) self-identified as Aboriginal. The length of time they had been in their job ranged from 9 months to 21 years.

Table 1. Identity & Roles of Reporting Practitioners

Number of programs on reserves	71
Number of Aboriginal respondents	54
Roles of Aboriginal respondents:	
Manager, Coordinator, Supervisor, Head ECE	41
Infant Development Consultant	12
Outreach worker	1
Number of non-Aboriginal respondents	34
Roles of non-Aboriginal respondents	
Manager, Coordinator, Supervisor, Head ECE	24
Family Outreach worker	2
Infant Development Consultant	7
Teacher's Assistant	1

Survey Questions
The responding practitioner in each program answered a set of 8 questions, noted below, during a conversational interview conducted by phone. Questions explored how program staff identify children in need of extra developmental monitoring, assessment, or supports; what kinds of training program staff have received in screening and assessment; what happens after a child has been screened or assessed; experiences with referral follow-up; and the practitioner's views about the roles of screening and assessment in their particular program and community setting.

1. What types of screening and assessment tools or approaches are used in the program, if any?

2. When would these tools or procedures be used? (Under what circumstances, or at what age or what point in the program?)

3. Why would these tools or procedures be used? (What is their purpose, from the point of view of the reporting practitioner? How are they being used?)

4. Did the practitioner using these tools or procedures have any training in using them? If so, did the training help? If not, would training have helped?

5. What happens after the screening tool or procedure has been used?
Who, if anyone, is informed of the outcomes? Are results recorded? How?
Where is the child referred to?

6. When there is a positive identification of need for follow up, based on using the screening or assessment tools/procedure, what happens?
Who is involved in communications about the next step?

7. If there are referrals, what tends to happen in terms of service follow up? Examples?

8. Given these experiences, what does the practitioner think about the roles of screening and assessment? How does the practitioner think that program staff could identify when to refer a child for assessment or for special services?

Information derived from each interview was recorded, frequencies were tallied and themes were constructed representing frequently occurring perspectives of practitioners.

Project findings

The project obtained an inventory of commonly used screening and assessment tools and approaches, including formal and non-formal, standardized and community-specific, in Aboriginal community-based programs serving young children and families. The information gathered offers a differentiated view of the utility, validity, and suitability of various approaches based on practitioners' experiences in community-based programs serving Aboriginal children and families in a wide variety of settings. In addition, the project yielded a number of recommendations from practitioners with regard to the content, structure and process of developmental assessment in Aboriginal early childhood programs.

QUESTION 1. What types of screening and assessment tools or approaches are used in the program, if any?

Table 2. Frequency of Screening & Assessment approaches used in programs

Screening, Assessment Approach	Freq.
Ages & Stages Questionnaires	39
Observing	21
Talking to parents about their impressions	19
Nipissing District Developmental Screen	14
Observing & recording observations	5
General guide about development milestones	4
Preschool benchmark checklists	2
No screening or assessment done	2
Ages & Stages Questionnaire: Social & Emotional	3
Work Sampling II	9
Brigance Infant & Toddler Screen	2
Diagnostic Inventory for Screening Children	1
Infant Monitoring Preceptor	1
Portage Kit	2
Creative Curriculum	2
Battelle Developmental Inventory	3
Gesell Developmental Assessment	12

KEN: NEEDA LINE UNDER CREATIVE CURRICULUM
KEN: Move Gesell higher up on the chart

Clarifications on Table 2
A few programs reported use of more than one of the approaches shown on Table 2.

The Ages and Stages Questionnaires system was overwhelmingly the most frequently used and most favoured approach.

There were no systematic differences in reports from Aboriginal compared to non-Aboriginal practitioners.

Of the two programs that reported no screening and assessment activity, both reported that they were struggling to keep their programs open due to financial deficiencies and they were operating only as drop in play groups. One of these programs had fully qualified staff but no license to operate.

Qualitative comments about screening and assessment approaches

Ages & Stages Questionnaires (ASQ)

Extensive and exclusively positive comments were made by practitioners about the ASQ. Descriptions of the ASQ were replete with adjectives such as *"great", "user friendly", "simple", "necessary", "works well with parents."* Many described how this tool offers a *"common focus*" and *"conversation starter*" with parents.

One practitioner reported using both ASQ and Nipissing, and stated: *"Parents love ASQ. Some take it home and bring it back. Some do it right here. We discuss results and if there is a need for further services, we suggest options and we support the parents each step of the way and help them not to panic."*

Three programs mentioned that they had started with the Nipissing District Developmental Screen but have now moved to the ASQ. (It is possible that this was due to the availability of ASQ training through province-wide conferences in the last few years.)

Staff capacities for informal, observation-based monitoring of development

Several practitioners emphasized the confidence that program staff feel about their ability to observe a child's behaviour, monitor developmental progress, and notice difficulties or delays.

They also emphasized that the next step was to talk with parents to see if what was observed by staff was also observed by parents, or if parents had noticed any delays or disturbing changes in their child's behaviours.

"Our staff ability is good. We always do informal assessments, not always formal assessments, but we are on the ball."

"I would rather we use informal assessments, using milestones, observing, talking to parents, and working with the child by incorporating developmental tasks into our program. We need to be cautious when assessing, because some people get judgmental. Our staff is great at observing and recognizing delays, and we work towards common goals. If we notice a delay, compared to milestones, we talk to parents, and ask their consent to refer to an SLP, audio, or doctor."

Understanding the child in depth and in family context

There was a pervasive and articulate view expressed by a majority of practitioners about the need to understand children within and through their unique family contexts.

"I believe staff can identify when to refer a child to special service only after spending a great deal of time with the child in a one on one setting as well as in a group setting. Also I believe you need to meet with parents and other family members to discuss concerns they may have and see if you need to do a developmental screen. I believe really getting to know the children and families in your care as well as formal screening and assessment all play a vital role for all children and their developmental needs. I believe with these roles in place we have a much better opportunity to meet the individual developmental needs of all our children."

Infrequently reported screening and assessment tools

Battelle Developmental Screen

Three AIDPs reported using both the ASQ and the **Battelle Developmental Screen.** One program practitioner described who uses each tool, when, why, and with what follow up:
"*ASQ is used during home visits with a newer family and it helps to see where kids are at, but it is used by the health nurse as well, so we mostly use Battelle because it gives us a clearer picture and a better idea. The lines aren't so grey, but we need about 4 sessions to complete it. Two of us received training and are very comfortable with Battelle and the third fellow is learning. We all have the same training for ASQ."*

"For ASQ, it is a teaching tool to work with parents, and we give activities to have families work with their child at home, and to see the improvement and they all feel great for helping in the process."

"We use Battelle when we have a concern for a child. We build a relationship with a family. It takes 4 sessions to finish it. It is done either during a home visit or during the program, but away from all the other children. It is done one to one. Then we score it, do a report with a graph, meet with the parents again, discuss our findings, suggest a possible referral or suggest to re-do the Battelle in 6 months. We do a summary and give a photocopy of it to the parents. The Battelle has community wide standardization and it makes it easier to do referrals to SLP, physicians, Child Development Centre, physio or OT, with parents' permissions. We support families with rides to appointments, or we have therapists come to the centre for sessions with the child or parents."

- One program described use of the Battelle by one of the staff members who is currently receiving training in the use of this tool recently introduced to BC through the Supported Child Development Program. She described the system as requiring too much equipment, too much detail, and time she could not afford to be off the floor working in her program's daily routine.

Work Sampling System

Seven Aboriginal Head Start off-reserve programs reported use of the Work Sampling System, noting that it is required by funders. Most stated they *"only"* use it because it is required. They uniformly described the the system as cumbersome in its demand for details across a large number of ambiguously defined and questionably relevant dimensions. Although there are many optional features of the WSS that allow for customization of the approach, these practitioners expressed

frustration with the sense that the funders thing they are "not doing it right" but that the items were not sufficiently tied to children's behaviours.

"Some of the wording is very vague. What they are trying to determined is very hard to tell from the questions they are asking. It is very broad too, and doesn't look at very specific tasks to determine something about the child's abilities."

Dissatisfaction also focused on training in the WSS.
"WSS if fairly new for us. The version I have is different than two of my co-workers. We were all at the same training but came away with different understandings. The feedback we're getting is 'Just do what you can with your understanding.' But it makes it tough in the situation when you have three different understandings."

A cultural addendum to the standard WSS developed for AHS was not well received by practitioners in this survey.

"The cultural questions, like 'what territory child are on?' are not concrete enough. They're too abstract for children in this age group, and not relevant."

"Some of the cultural dimensions are just 'plug ins' and not a true integration of Indigenous knowledge. Its an issue for our staff."

"WSS is a very clinical tool. It would be better to involve the parent in the assessment process. I gather that in the US there is a WSS version for Spanish and for American Indian children, but we don't have that here. We only have the White mode."

Practitioners also expressed skepticism about being "*required"* to use any standardized, formal tool in the manner of universal surveillance and to submit the children's records to an overseeing agency with which parents had no relationship and had perhaps not given their explicit, informed consent for their child's observation record to be used beyond the program. They emphasized the importance of gaining parents' trust and offering parents the right to opt in or out of screening and assessment, and the right to decide whether to have their child's records sent to a centralized agency.

Gesell Developmental Assessment

The Gesell Developmental Assessment, noted on Table 2 as a relatively frequently occurring approach (12 programs), was used only in AIDPs. One practitioner reported using the Gesell as their primary approach, while 11 practitioners reported that the staff preferred either the ASQ or talking with parents as their primary approach, and described their experiences with the Gesell only in negative terms. Comments conveyed that it is too expensive, not well received by parents, requires training and practice in a context where training and practice opportunities are scarce, and it is not "user friendly."

"Gesell is supposed to consider 'many different cultures.' But it doesn't seem that way, or if it is, then it focuses on one socioeconomic group."

"Gesell is not used as much because it is just not as family oriented as the ASQ."

"Gesell is more 'professional' and creates more distance from the parent and can only be used for children who have a disability. ASQ and Nipissing are for screening, so we use those, and for example if a child wasn't walking at 18 to 24 months, we refer to the OT or PT, rather than do a Gesell assessment."

Two practitioners commented that the training for using Gesell is too theoretical and needs to be supplemented by videos and opportunities for practice.

Creative Curriculum

One AHS on-reserve and one AHS off-reserve reported using the Creative Curriculum Assessment tools. Their comments were extremely positive, emphasing the clear relationships between program goals and dimensions for assessment, "parent friendly" and easy to use.

"Literacy levels are an issue for many of our parents. I would never ever give parents a copy of our WSS form – they would never be able to decipher it. Whereas for Creative Curriculum, you do it with the parent and ask for their comments in a conversation. The Creative Curriculum form provides opportunities for supporting learning at home as well as with the copy of the report. Parents also have to sign it. We have an issue here with parent apathy. But this approach actually helps with parent involvement."

"It's really the best and I wish Health Canada would use it. It's much more user friendly than the WSS. It evaluates both the kids and the program environment. All the recording can be done on a computer. There are NO forms."

Other kinds of assessment

"A dental hygienist comes in twice a month and checks teeth. She does screening and fluoride varnishes. She also will recommend detail visits if the child needs it."

"The band's nurse uses the Ministry of Health: Child Health Record form and other child development tools."

Nine practitioners specifically mentioned hearing tests.

Two mentioned nutritionists who regularly assess children's nutrition through direct observation and discussions with program staff and with parents.

QUESTION 2. When would these tools or procedures be used? (Under what circumstances, or at what age or what point in the program?)

Table 3. Timing of Screening or Assessment

If a difficulty or delay is observed by program staff	20*
Just before the child starts school	3
At enrolment of a new child	9
Every week by Supported Child Care worker	5
Everyday we observe & monitor (Observations)	5
Constantly throughout the year (ASQ)	6
In the Fall	1
Twice a year (Nipissing or ASQ)	4
Once a year (Nipissing)	2
Beginning and end of the program year	2
Rarely use (lack of trained staff / parent sensitivities	1
Every 2 months	1
Just after the child starts school	1
Parents take ASQ home at various times	2
During home visits with parents	1

***** Several practitioners qualified their response, saying that when program staff recognize a difficulty or delay, they would only do assessments after discussing with the parents and securing their consent.

WHO does screening and assessments

About half of the practitioners spontaneously volunteered information about WHO conducts screening and assessment. Several of these respondents had strong positive or strong negative comments about 'agency' in carrying out assessment.
In retrospect, this would have been an important question to ask all respondents.

Supported Child Development (SCD) consultants, employed through the Aboriginal Supported Child Development Program funded by the Ministry for Children and Family Development, received many positive comments. Practitioners described SCD consultants as providing more investigative assessment after the ECE staff or home visitors had identified a possible developmental challenge through their observations or use of a basic checklist. The Supported Child Development program was said to offer the most readily available assistance with referrals and with establishing a firm hand shake between a family and a follow up service.

Aboriginal Supported Child Development Consultant's Roles

"Diane at SCD is our guru. We absolutely depend on her as a core member of our team."

"The Supported Child Development worker comes every week and works with the children. They use the ASQ to screen children. We talk to the parents, and so does the SCD. The SCD workers work very hard. They deserve the money and they need a raise."

Parents' Roles

Nearly every practitioner underscored the central roles of parents and other primary caregivers in helping program staff to understand their child and in helping to determine whether the child needs extra supports. Many practitioners described completing the ASQ or the Nipissing with parents. A few programs have the practice of sending these screening tools home for parents to complete on their own. In nearly all programs, parents were seen as the first and most important source of information about the child, and most practitioners expressed their view that screening and assessment can only be useful if parents are interested, involved, and willing to follow up if there is a positive identification of need.

Specialists' Roles

About one quarter of practitioners described relying on one or more specialists to conduct thorough assessments of children who are identified by ECE program staff as requiring a "closer look." Many of these practitioners specifically identified the Supported Child Development consultant or the specialists at the regional Child Development Centre.

A few practitioners expressed frustration about "out-sourcing" screening and assessment, stating emphatically that they are in the best position to characterize whether a child is developmentally on track or whether the child has changed over time (e.g., after a period of intervention/therapy), and yet they are not always consulted. Some said that they would like to be trained to do more screening and assessment as part of their job. Others said they would like to be included in decision making as part of a multi-disciplinary team.

Infant Development Consultants' Roles

Infant Development Consultants were mentioned as specialists within the community who had extra training in screening and especially in diagnostic assessment.

"I find that the questionnaires (ASQ every 3 months) only get done if I go in to the homes and assist the parents with them. Otherwise they don't get done."

Community Health Nurse's Roles

Community health nurses were identified by a quarter of the respondents as playing some role in monitoring children's development, conducting screening, and helping with referrals and follow-up.

Many practitioners reported that the CHN uses the ASQ. Several mentioned vaguely a number of 'other' tools and checklists used by the CHN to assess children's development.

Team Effort

Many practitioners happily described a team effort, involving parents and professionals from several disciplines.

"Screening is ongoing on a daily basis by staff in the program, by talking to parents, and by using the ASQ, which we now call the Individual Program Planning Process. When a change is noticed (in a child's development), we put a note into the child's confidential individual log. When we recognize a delay, we document it in the Individual Program Planning and confidential daily log. We contact parents, and ask for permission for further assessment by a doctor, the Aboriginal Supported Child Development consultant, or the regional Child Development Centre. It's a team effort."

Sensitive timing for introducing formal screening or assessment procedures.

"Our parents are very touchy about their child's development, so we take the time to build a relationship with them. We talk about our own children and some things that we have noticed. Then we offer the ASQ for them to do at home or with us. We introduce the ASQ to all parents."

A practitioner described how the program gives the ASQ to parents to take home and complete on their own, at their own pace, and to bring it back to the practitioner if they wish to discuss anything, including clarifications, concerns, or general comments. She noted that, to date, no parents have returned with a completed ASQ or has initiated a discussion about it.

One practitioner whose program relied exclusively on observation and dialogue with parents said: *"Screening and assessment have their place but sometimes they are over-used or mis-used. We need to be cautious when assessing. Some people get judgmental. Our staff are great at observing and recognizing delays. We talk to parents. We work with the child and their parents towards the common goals. And we work towards the common goals. If there is a need, we get consent from parents for SLP, audiology or physician services."*

A few practitioners described introducing and even conducting assessments at dinner meetings with all of the parents of the children in their program.

QUESTION 3. WHY would these tools or procedures be used? (What is their purpose, from the point of view of the reporting practitioner? How are they being used?)

Practitioners had somewhat less to say in response to this question compared to all the other questions. Many seemed to assume that the need and purpose of screening and assessment are self-evident; namely, identification of any developmental delays or difficulties that require a closer look through a referral for assessment by a specialist, or that warrant extra supports for the child and/or the parent(s). More elaborate explanations were provided by those few practitioners who chose to respond to the questions by email, rather than by phone interview.

- Screening activity as a focus for practitioner-parent dialogue.
- To track typical development, in order to spot atypicality as soon as it arises.
- To measure improvements since a previous assessment.
- To clarify practitioners' doubts about a child's development.

Screening activity as a focus for practitioner-parent dialogue

This was the most frequently occurring theme throughout all the interviews.
As a group, practitioners who participated expressed a strong orientation to family-centred practice, and a strong interest in involving parents in dialogue and home-based activities to promote mutually agreed upon goals for a child's development.

"We take the time to reassure the parent that this is best for your child, and we educate parents about the benefits of screening and assessment."

"It's the parents' responsibility to also be involved. We explain to them: 'We are doing these steps to benefit your child.'"

Thus, many practitioners described using screening and assessment activity to:

a. promote dialogue with parents

b. promote in-home activities by parents that will address identified developmental challenges.

"We feel the purpose of our screening process is to assist parents and the Head Start teachers in establishing goals and activities for the individual children as well as for the program on a whole. We feel the screens will help to ensure that each child's educational, physical, spiritual, emotional, mental and overall developmental needs are met."

"This program [Infant Development] is designed to encourage screening of large numbers of children in an economical way and an efficient way. It is designed to help identify children in need of intervention services in a timely manner and a cost effective manner. The screening helps me

identify which families need help improving and/or providing the extra help they [the children] need to develop according to their age appropriate skills on a daily basis."

Why screening and assessment might NOT be timely

A few practitioners called into question whether there is a need, or at least whether there is a priority, for screening and assessment, cautioning that the parents may not be ready for it, may actively resist it, or that it could be used to label children without any benefit to the child.

QUESTION 4. Did the practitioner using these tools or procedures have any training in using them? If so, did the training help? If not, would training have helped?

Table 4. Program staff training in screening and assessment tools

No trained staff on site	55
Program staff had training	51
Trained in ASQ	34
Traned in Work Sampling System	8
Gesell Developmental Assessment	12
Trained in Battelle	1
Trained in Nipissing	1
Trained in Home Portage	2
Trained in checklists	2
No training yet & it is wanted	16
In ASQ specifically	11
In Ounce of Prevention	1
Have training & want more	35
In ASQ	22
In variety of tools	8
Gesell Developmental Assessment	4
Observation	5
Creative Curriculum	1
Brigance	1
In supporting children with conditions	9

As shown on Table 4, more than half of the practitioners in the on-reserve programs sampled had received some training in at least one formal approach to screening and assessment. The most frequently mentioned training was in the use of the ASQ. In about half of these programs, only one staff member, typically the respondent (i.e., the ECE Coordinator) or the Outreach Worker, had received training. In the other half of the programs, several staff had received training. In a few cases, practitioners responded: *"We all do (have training)."*

Training for informal approaches

'Training' seemed to connote to practitioners the provision of formal training by an agency external to their program for practitioners to learn to use formal screening or assessment tools. Many added, almost as an after thought, that all the staff in their program were able to use informal checklists, or had learned about developmental milestones through their practitioner training programs or on the job. Many practitioners said that the staff in their program were very good at observing children and identifying delays.

Thus it would seem that there is in fact a great deal more 'training' occurring on the job than might be recognized by measuring participation in external training workshops on formal tools. Training as a matter of course, on the job, as well as in-service training that is more deliberate and structured, are two potentially accessible, inexpensive, effective, and appreciated avenues for introducing new ideas to program staff and boosting their confidence and accuracy. A few practitioners who expressed a desire for more staff in their programs to receive training noted barriers including:

- lack of availability or spaces in external training programs;
- the disruption to program staffing when someone goes away for training; and
- the cost of training.

Call for more training

As shown on Table 4, there was keen interest expressed by nearly half of the practitioners in obtaining training, or more training. Some specifically mentioned wanting training in the ASQ. Two commented that they had sought the training but *"it is always full!"* One practitioner said that no one in their program had received formal training, but *"the ASQ is user friendly – we use it anyway."* A few practitioners mentioned that the training they had received was during their ECE training program.

Collaborative approach

A majority of the practitioners described how their activities to monitor children's development and identify needs for formal assessments or extra supports included:

- dialogue with parents; and
- collaboration with itinerant specialists.

They described a team approach, such that whether they had received training in the use of formal procedures was just one consideration. Many described asking a parent if they had noticed anything atypical. Many described calling upon the expertise of the health nurse, the CDC outreach worker, an SLP, a Supported Child Care consultant, or family outreach worker, to piece together an assessment of a child's development.

QUESTION 5. How are the results of a screening or assessment procedure communicated? Who, if anyone, is informed of the outcomes? Are results recorded? How?

Most practitioners described a process whereby results of screening or assessment are recorded, for example, in children's files, booklets, or computer records.

"The completed assessment form is put in the child's file. If an assessment suggests the child may need help in a specific area, a referral is made."

A routine involving communication with parents was described for most programs.

Obtaining consent from parents to make a referral was noted by many practitioners.

"We use little white booklets to assess and record development. We talk to parents and get them to sign a permission form to refer the child to services if they need it."

"After the screening tool has been used I contact the mother or father or guardian to sit and talk about the child's needs and to receive input and approval for referral to the right professional services."

Responses to this question conveyed the inter-disciplinary team work that emerged as commonplace in the communities that were sampled. Typically, the ECE Program Coordinator and the Community Health Nurse had quite clearly defined roles, with the ECE practitioner more on the front end and the CHN more on the referral and follow up end of the screening-assessment-referral trajectory.

"Parents are informed. Results are kept in child's files. The community health nurse is also informed so she can work alongside the parents for support and make referrals as needed."

"After each individual screening, the information is placed in our health centre and input into our client computer program, and is screened by our local community health nurse. If there is a need to refer, the nurse is able to tell by the scores and after speaking with (the ECE program coordinator).

QUESTION 6. When there is a positive identification of need for follow up, based on using the screening or assessment tools/procedure, what happens? Who is involved in communications about the next step? Where is the child referred to?

Nearly all practitioners identified parents, ECE program staff, and the community health nurse as the primary, first response, front-line agents involved in communication and follow up about a screening result. Work then begins to connect the child and their family to specialists beyond this primary nexus. For example:

"If an assessment suggests the child may need help in a specific area, a referral is made. If it's a simple matter of needing to see a speech pathologist, then the Head Start Coordinator contacts the parent and discusses this with the parent. If the parent agrees, then the Head Start Coordinator fills out a request for services and submits it to Interior Health. If it is a more serious issue, the band's nurse would approach the parent and make the appropriate referral."

Parents' involvement

A majority of practitioners emphasized that parents need to be kept centrally involved in communication about assessment and decision making about follow up.

"We focus on how to continue helping the child both in our program and at home. Staff, parents, and the community health nurse are all involved."

"ASQ helps us as a quick reference to discuss with parents. It starts a dialogue. We share our recommendations and offer support services, but it's up to the parent to follow up with referral."

"We have a meeting with the parents, and bring in the Supported Child Development worker, the SLP, the Occupational Therapist, the Physiotherapist…whoever is needed. We change activities in our program to help the child develop in that area. Some families are hesitant to get help. Some children speak three languages so it gets confusing for them."

"We make suggestions to parents once trust is there. We might discuss developmental stages in an informal way to ask if this is happening at home or not. We may say your child may need extra help and here are some suggestions, for example, 'Little Johnny's hearing might need to be tested. Maybe you want to take him to see an audiologist?' We spend time modeling speech in a group, forming words, and articulating, showing kids how to speak."

Supported Child Development Consultant's Role

"We rely a lot on our SCD consultant to follow up with more in depth assessments, to get our children on wait lists for services, to connect families with services, to suggest and implement activities into our daily program."

Community Health Nurse's Role

"The community nurse will step in and has a procedure that she follows through with the individual family and she makes an appointment with the doctor if need be."

"The community health nurse is also informed to work alongside the parents for support and to make referrals as needed."

"If it is a more serious issue, the band's nurse would approach the parent and make the appropriate referral."

Contacts and connections

In addition to parent involvement, most practitioners described efforts to involve specialists locally in addressing the needs.

"We have to be very educated on the subject and well connected with all the community services and contacts with professionals that could help a child when they need it."

More than half of the practitioners described having these kinds of connections.

Common connections for referrals were with a:

- Child Development Centre nearby
- A larger First Nation that has more specialist services, especially SCD
- Supported Child Development (SCD) Consultant
- Family Outreach worker
- Speech Language Pathologist
- Physiotherapist
- Occupational therapist
- Learning Assistance
- Part-time worker who gives suggestions for activities in the ECE to address identified needs
- Physician
- Sunny Hill Hospital (Vancouver)

A large number of practitioners expressed the wish for more of these kinds of connections. Among those lacking connections, several mentioned being quite isolated from specialist services for children (e.g., 2 hours drive away from a town). Several mentioned that specialists rarely came to their community. For example:

"We identified a child who needed speech-language services but the contract for the SLP ran out in July 2005 and we haven't had any SLP come here since then."

QUESTION 7. If there are referrals, what tends to happen in terms of service follow up?

The following comment sums up the priorities and sequelae of positive identification that was heard from the vast majority of practitioners who had access to services (i.e., not those who described being isolated with few accessible services besides their own.)

"When we recognize a delay, we have a discussion with parents and share our recommendations and findings. Together we work with and support the families. We go over the ASQ with the parent and then call in Supported Child Care for a second assessment. Then we get back together with the parents. We might make a referral to a doctor, and to Supported Child Care for SLP, learning assistance, or for the Child Development Centre. Whatever it is that the child needs. Parents are always first and ongoing support from us for parents and children to get what they need."

Parents' roles in follow up

"If parents ask, they are more likely to be seen than if we ask for them."

"We follow up through the parents only. Because some parents are reluctant to go to town for services, we follow up by incorporating activities into the daily routine. And then we follow up after 6 weeks to review the child's progress."

"When we recognize a delay, we ask parents if they have noticed a similar challenge at home. We express concern and offer to contact the SLP at the Child Development Centre to assess hearing. We give parents the option to contact the agency. Meanwhile we continue working with the family and the child through our daily program."

Parents sometimes have other ideas

"Parents have not followed through on their part with appointments, check-ups, therapy, etc. For example, one girl was severely delayed in speech. Before going to Kindergarten, we referred her to a speech pathologist, made the appointment for them, talked with them about what was going to happen at the appointment, and they didn't show up. They chose not to go instead, because they felt their daughter did not need the help and they could help her at home. So staff gave the parents information and activities to do with the girl at home, and we would do the same things in the ECE program. None of it was done with the girl. They said she would 'grow out of it', 'it's just a stage she's going through.' At that time, we were referring to a speech pathologist out of town, but we now have a local therapist."

Supported Child Development Consultant's roles in follow up

"The Supported Child Development Consultant helps parents to get the help the child needs, and also comes right into the centre to do the work herself. This level of services – on an ongoing basis –

means that she can observe the child, work with the staff to implement activities, and see improvements. It's good for everyone."

"We refer to the SCD and they make all the arrangements."

Community health nurse or public health nurse roles in follow-up

"We see a delay in a child, discuss it as a team, use Portage, talk to the parent, and contact the doctor if necessary for referral, including the health nurse."

"Our CHNs are always on top of referrals made, and do make home visits with the parent if the child is referred to specialists, usually continuous follow-up home visits."

Speech-Language service referrals

Referrals for SLP services stood out as a very frequently occurring need.

"For example, a referral was made for a speech therapist. As a result, a speech therapist comes in twice a month and works with the child."

Many practitioners mentioned the difficulty of connecting children with SLP services, either because there were no contracted SLP services for the community, or there were access barriers, including long traveling distances, parents' lack of confidence that SLP services will help; or long wait lists.

QUESTION 8. Given these experiences, what does the practitioner think about the roles of screening and assessment? How does the practitioner think that program staff could identify when to refer a child for assessment or for special services?

Emphasis on the 'whole child'

"Screening and assessment is good to gage where a child is at, but we take into consideration if the child is speaking a First Nations language as well. We look at the whole picture. We don't want to label the child. We want to work with each child in a holistic way."

Emphasis on supporting parents and children, keeping assessment in perspective

In a majority of the programs sampled, family support takes precedence over identification of special needs and early intervention.

Many practitioners stressed that they and their program are there to support parents and children, as a primary sense of mission. Within this primary mission, there may be a time and a place for screening and assessment. Even when there is a 'positive finding', the focus should remain on

working with parents to support their child, rather than getting too caught up with the nature of the child's challenge and the intervention plan. One practitioner said:

"*Screening and assessment tools are valuable tools, but that's what they are is tools. A particular delay may be an area of concern, but we are here to support the parent and the child."*

"They (screening and assessment procedures) help us as staff, but the parents are struggling just to survive. There are cultural barriers. It is not a priority for some of them. We use it (screening and assessment) as a teaching tool to try to work with the parents. We have not a lot of success with parents following through. Staff can see delays, but we need to work with the parents and the Supported Child Development consultant together."

"The most important thing is the way you do it. You can't come on too strong. Most parents have not completed high school, many live under conditions of severe poverty, and most have multiple personal problems. It is very important to be respectful. Parents want to learn, but they are embarrassed about their situation. It is important to make parents feel a part of the developmental process. Some of the materials we present to them are not at a good level for them to understand. Many of these materials need to be re-developed to make them more comprehensible to the parents in our program."

"Parents in our program love and care about what's right and good for their children. If the parent is unable to follow up with my recommendations it becomes an added burden for them. They become unhappy and depressed when they can't provide or do the things that I recommend. I see the depressive cycle spiral downward and I begin to feel like I am part of the problem."

"Make sure the parent understand what you are doing and why you are doing it. I won't do something unless parents request it. I don't like to assess kids just for the sake of assessment."

Ambivalence about identification and targeted services

"In this community, there is some minor interest in assessment, but it must be paced according to parents' readiness and their consent. Family support is the first priority for us. Not so much labeling and involving parents in early intervention. That would be getting ahead of what the parents are ready for. Also there is a concern here with labeling. There has already been too much of that for First Nations kids. Before we got too far into this [screening and assessment] we would like to see a culturally appropriate tool developed."

Focus on strengths

"It [early identification through screening and assessment] is important but some staff focus too much on it and labeling is not good. We need to focus on the child's needs and strengths."

Addressing children's identified needs through ECE programs and home visits

A key theme in the practitioners commentaries was their eagerness to use the ECE program or the home visits to work with parents or other caregivers to engage in activities that will address the child's needs.

"Staff support parents and the child each step of the way and incorporate activities into the Head Start program."

It was often said that ensuring supports for optimal development through home visits and centred based programs is the most culturally acceptable, broadly effective, and feasible approach, particularly in rural and remote settings where there is no possibility of relying on specialists to provide therapeutic interventions targeted individual children. As noted above, several practitioners described how they introduce activities into the regular program for home visits or ECE programs that are intended to address particular needs or goals for children's development that have been uncovered through screening and assessment. Thus, practitioners were generally positive about early identification, but thought that regular programming is often the best approach to addressing identified needs. One practitioner summed up the perspective expressed by many:

"Screening and assessment are great tools. But what needs to happen is parents and families to buy in and follow through. It is up to them. Some do. Some don't. And if they can't get to the services, then bring the services to the children. Use the daily program to work with them on identified goals in an ongoing way in the program."

Early identification is a good thing

"I think the roles of screening and assessment are very important to have in our program to help the child before entering the public school system, where I feel it is much too late to start helping a child with delays. A child should not have to wait until Kindergarten to be assessed."

"I think that when a concern arises, when staff see a concern in development, if a parent asks for help…if a child continuously struggles to move forward developmentally, an assessment should be done immediately."

Conveying to parents that ECE staff are doing something helpful

"Sometimes parents think we aren't doing anything to help their child. The staff have been doing really well, and the assessment results can show that."

Call for more training

"We need our people trained in ECE first. Then in ASQ."

"We have a screaming need for training ECE workers in our area."

"We can't always get ECE staff here. They are either 'In Training' or they have no training at all. We need access to training in ECE, and as part of that training, they could get up to speed with the ASQ."

"We would like more training for staff in ASQ, but it's always full."

Three non-Aboriginal practitioners were particularly vocal about the need for training in ASQ and in the process of working with parents and referral sources to secure needed services for individual children. One was explicit that training for Aboriginal program staff would make it more possible for her to move on, turning over her position to an Aboriginal program coordinator.

Call for more resources for follow up on referrals

This was a recurring theme across programs, but more frequently heard from practitioners working in rural and remote areas. The greatest unmet need was for SLP services.

"We have huge waitlists for services. Our location is 84 kms on a dirt road. We ask that services are made more available to hard to reach communities."

In a great many cases, the Supported Child Development Consultant seemed to fill gaps in follow up services in diverse and very important ways, working with parents, staff, and referral sources, as well as directly with children on site.

One practitioner on Vancouver Island, and one on the northern border of BC, described driving children from their community over 200 km to a town centre (one in the Yukon) in order to access hearing screening and dental services for children, and paying for these services out of the program budget.

A variation on this theme was one practitioner's construction of a choice between supports for cultural learning versus supports for developmental challenges:

"The dilemma is with the Band school, which offers cultural teachings, versus the white school, which offers services for particular development needs. Parents aren't sure where to send their children. Do they choose culture, or services?"

Summary of Cross-Cutting Themes

Overall, there was strong convergence among senior practitioners in Aboriginal infant and early childhood programs in responses to the 8 key survey questions. There was little variability between Aboriginal and non-Aboriginal practitioners. There was little variability across urban, rural or remote programs, with two exceptions. Practitioners in rural and remote programs more frequently noted a lack of specialist services for referrals, and these practitioners more frequently commented on the difficulties for parents to follow up on referrals following screening, assessment, and diagnosis.

As a group, the 88 practitioners surveyed conveyed enormous commitment to carrying out their professions in ways that would best meet the particular needs of the families with whom they worked. This highly contextualized, flexible approach was grounded in an understanding of the key roles that parents played in supporting the health and development of children in their community, and the foundational role of building trusting relationships between program staff and parents (or other primary caregivers).

As the quotes illustrating common responses to the 8 key questions show, several key themes cut across responses to each question. Themes that can be constructed from the interviews are provided below.

Formal tool: ASQ

The Ages and Stages Questionnaires were by far the most widely used and generally accepted approach to screening and assessment, even in programs that had previous or concurrent experiences with other approaches. It could be inferred from the responses that practitioners saw benefit in using the ASQ at least twice a year and as needed when staff have a hunch, based on their observations, that something is not quite on track with a child's development.

Informal approach: Observations

Many practitioners extolled the capacities of the program staff to observe children quite accurately in terms of developmental milestones, and to detect possible developmental challenges that required further investigation. Several programs employed child development milestones checklists and charts as guides to monitoring children's development and identifying children for assessment or direct referral for services.

Training

Practitioners were overwhelmingly positive about training they had received, or wished they could receive, in screening and assessment tools and procedures and in how to follow up effectively when a child is identified as requiring extra supports. Most often, practitioners had received training provided through provincial Aboriginal child care or AHS conferences. While most of the practitioners who responded to this survey were senior staff (e.g., coordinators, head ECE) and said they had benefited from training, many stressed that there was a need and desire to extend training to reach a larger number of staff.

Family-centred practice

Working with parents emerged as the number one priority, as these practitioners see parents as children's number one resource for meeting the full range of developmental needs, including some special needs.

Parent-paced practice

Practitioners expressed a high degree of sensitivity about not displacing the importance of developing relationships with parents, listening to parents, engaging parents, informing parents when assessment will be done, gaining parents' consents to make referrals, involving parents in activities they can do at home to help their child, and most important, pacing these overtures in a way that parents experience as supportive and not intrusive, prescriptive, impractical, or threatening.

"I only do referrals when I have a relationship with the parents. I don't want them to be scared off. When we recognize a delay and we think the parents are ready, we talk to the parents during a home visit."

Addressing needs through population-based programming when possible

Practitioners underscored the benefits of working within regularly provided programming, especially infant development programs involving home visits and home-based supports, and early childhood education programs involving centred-based, structured activities. Reasons given for this as a preferred approach included:

- this approach is more 'normalizing' and less stigmatizing;
- many children can benefit from the same goal oriented activities introduced in the course of the daily routine of an infant development or early childhood program or at home;
- for many families or communities, there is little regular access to specialist services, making early intervention that can be delivered by their parents at home and/or through regularly offered, community-based programs the most likely way for a child to get the extra support that they need.

Another reason for the appeal of this approach that may be inferred is that it adds interest, challenge, variation, and opportunities for professional development for staff in community-based programs, with the potentially satisfying outcome of seeing a child benefit or progress from their innovative practice to meet a child's needs.

A multi-disciplinary, team approach

The survey yielded a vivid portrait of community-based supports for children that include:

- the Early Childhood Educator and other staff primarily working in Aboriginal Head Start and other centred-based programs;
- the Community Health Nurse primarily working to support children and family development through home visiting and health centre visits; and
- the Aboriginal Infant Development Consultant, primarily working with parents of infants and toddlers through home visiting programs.

Many practitioners described good communication and close collaboration on referrals and follow up among these three service providers.

Beyond these ongoing community-based resources, practitioners explained various circumstances surrounding access, communication and collaboration with specialist service providers. Most frequently mentioned in a positive way were:

- the Supported Child Development consultants for the region, speech-language pathologists, and physicians.
- a range of other service providers including physiotherapists, learning assistance, hospital-based services.

It was clear that practitioners had a strong appreciation for the contributions that various professions can make to supporting children's development, and a strong desire to collaborate.

However, many practitioners identified barriers to realizing a fully effective team approach.

Barriers to a team approach most frequently cited included:

- lack of consultants in rural and remote areas of the province,
- parents' apparent preference to 'go it alone' or 'wait and see' without following up on referrals; and
- lack of connection or lack of knowledge of who to involve in situations where needs cannot be met by community-based practitioners.

Rare occurrences

In any survey it is interesting to note expected themes that did not materialize. Two themes that were conspicuous by their absence were FASD and culturally specific tools for screening and assessment.

FASD. It was striking to this reporter that there was only one mention of Fetal Alcohol Spectrum Disorder among 64 practitioners' responses. On the other hand, most practitioners used the term 'developmental delays' and a large number referred specifically to speech-language delays and difficulties.

The frequent use of the term 'developmental delays' may reflect practitioners' reluctance to label children with the names of specific disorders because they are not qualified to do so or because they resist the use of pathological terms applied to children. The emphasis on speech-language delays and difficulties is consistent with comments heard at meetings and conferences of Aboriginal child care practitioners across the country. Reflecting the widespread recognition of the inadequate supply of SLPs to serve children in rural and remote communities, there has been an increasingly vocal call for training to enable community-based practitioners to incorporate language facilitation strategies into home- and centre- based programs for young children.

Culturally specific screening or assessment tool. Only two practitioners – both non-Aboriginal - commented that it would be preferred or necessary to have a culturally specific approach to screening or assessment.

"It's (screening and assessment) okay but we really need an assessment tool that specifically takes our culture into consideration. ASQ would not be effective in India or China."

Lack of comment on this topic contrasts with comments frequently heard in workshops and meetings of practitioners in Aboriginal early childhood programs, where the wish for an Aboriginal-specific tool has sometimes been expressed. On the other hand, most practitioners communicated a highly contextualized approach to working with 'our families', grounded in positive relationships, guided by parents' explicit consent as well as their apparent readiness and expressed needs for various kinds of supports. Thus, it could be said that practitioners strongly implied a need for a culturally sensitive, respectful, responsive and personalized approach to screening and assessment practices.

Possible Next Steps

Following on the strengths, preferences, and needs identified in the current scan, areas for practical action that could be explored with community-based program staff are suggested below.

- What do practitioners as well as primary caregivers need in order to be assured that they are accurately understanding the child's developmental needs?
- What kinds of training do program staff need in order to use standard tools for monitoring children's development effectively?
- What kinds of training works well to hone the skills of practitioners in ongoing observation of development, family conferencing, case management, and referral skills?

- How can communities be assisted to develop internal capacity to manage the screening and assessment process in ways that are sensitive to parents' abilities and willingness to follow up with in-home, externally guided interventions?

- How can team work be harnessed to strengthen the capacities of community based program staff, particularly in rural and remote areas, to incorporate early intervention strategies into the daily routine of a child's early childhood program and experiences at home?

- What steps can be taken to help community-based program staff secure and consolidate their networked connectivity to specialists (e.g., SLPs), agencies (e.g., Child Development Centres), and institutions (e.g., children's hospitals) that they need to call upon to follow up on the findings of screening and assessment?

Project Conclusions

This project reinforced the view that front-line staff in community-based programs can offer valuable feedback and guidelines, based on experience, about the relative merits, appropriate use (e.g., consent protocols, parental involvement, sensitive timing, feedback, records), challenges, and outcomes of using a variety of standardized and non-formal developmental screening and assessment tools.

The project yielded an inventory of frequently used screening and assessment tools and approaches, including formal and non-formal, standardized and community-specific, in Aboriginal community-based programs serving young children and families in a wide variety of geographic and cultural settings within the province of British Columbia.

Practitioners' reports and recommendations place priority on actions to:

- Strengthen practitioners' capacities to identify children in need of extras supports for optimal development;

- expand the scope of practice in home-based and centred-based programs to incorporate remedial and enrichment activities; and

- secure connections between children and families and early intervention services.

Developmental Tools Cited by Practitioners

Many screening and assessment instruments are described at:
http://www.earlychildhoodmichigan.org/articles/7-03/DevScrTools7-03.htm

Ages and Stages Questionnaires (ASQ) and ASQ: Social & Emotional Development (2nd Ed.)
www.brookespublishing.com/store/books/bricker-asq

Nipissing District Developmental Screen: http://www.ndds.ca/
Also see Chilliwack Developmental Screening Project at: www.earlylearning.ubc.ca/CHILD

Gesell Developmental Assessment: www.childsday.com/gesell_assessment.htm

Portage Kit. New Portage Guide: Birth to Six: http://www.portageproject.org/npg/npg_2.HTM

Creative Curriculum Developmental Continuum Assessment Toolkit for Ages 3-5 (4th Edition).
www.teachingstrategies.com

Battelle Developmental Inventory (2nd Edition): www.riverpub.com

Ounce of Prevention (a few practitioners indicated an interest in learning about this)
http://www.pearsonearlylearning.com/research_docs/ounce_fusing.pdf

Infant Monitoring Preceptor: This instrument preceded the Ages & Stages Ques.

Diagnostic Inventory for Screening Children: Reportedly in common use in Alberta.

Work Sampling System:
http://phcatalog.pearson.com/program_multiple.cfm?site_id=1021&discipline_id=802&subarea_id=0&program_id=941

A community-university project exploring First Nations' views about screening and assessment and the feasibility of culturally specific developmental measures was completed in 2006 by Dr. Jessica Ball (UVic) and four First Nations in B.C. For reports on this *'Indigenous Child Project'* visit:
www.earlylearning.ubc.ca/CHILD

The B.C. Aboriginal Child Care Society offers "*A Guide for Culturally-Focused Early Intervention Therapy Programs For Aboriginal Children and Families in British Columbia."* It includes recommendations about processes and procedures for screening and assessment involving First Nations children and families.
http://www.acc-society.bc.ca/index.html