Social and Emotional Screening for Infants, Toddlers, and Preschoolers in Colorado

Summary of Recommendations from Colorado Workgroups • October 13, 2004

project bloom
growing healthy kids
a complete system of care
for Colorado's young children

Kelly Stainback-Tracy, Editor
A collaborative effort including:

• **Project BLOOM, Colorado Department of Human Services and JFK Partners, University of Colorado Sciences Center**
  Claudia Zundel, Principal Investigator
  Corry Robinson, Co-Principal Investigator
  Sarah Davidon, Project Director
  Kelly Stainback-Tracy, Training and Technical Assistance Coordinator

• **Harambe, University of Colorado at Denver**
  Laurie Beckel, Project Director
• **Kid Connects, Colorado Department of Human Services, Division of Mental Health**
  Tracy Kraft-Tharp, Project Specialist

Screening for Social and Emotional Development for Infants, Toddlers, and Preschoolers in Colorado

Purpose

Social and emotional screening is an important component of a comprehensive early childhood mental health system of care. In September 2003, Project BLOOM, Harambe and Kid Connects convened a group of stakeholders to discuss and make recommendations about screening tools, practices, and resources needed to support social-emotional screening in Colorado. This report summarizes the findings and recommendations of the project and suggests policy strategies to support the implementation of social and emotional screening in three settings: early care and education, Child Find, and primary care.

Social and Emotional Development in Infants, Toddlers and Preschoolers

Social and emotional development describes the way a child begins to regulate his or her internal states and relate to the world around him. An infant's social-emotional development hinges on his inter-actions with parents or caregivers (Lyons-Ruth and Zeanah, 1993). An infant's smile charms parents. His cries may indicate that he is hungry or uncomfortable. Within the context of early relationships, these cues help the infant to get the care he needs. As infants grow older, they begin to develop their own identity. Toddlers and preschoolers begin to be more comfortable separating from their parents. They develop social relationships with their peers and are able to express emotions of happiness, sadness, anger, frustration, and empathy (Emde, 1999).

However, social-emotional development in young children does not always proceed as expected. In some instances, infants or toddlers may not give clear or consistent cues about their needs, making it difficult for parents to know how to respond. Other times, parents or other caregivers may not be able or available to respond to the cues that their infant or toddler provides. When this happens, typical social-emotional development can be interrupted, creating social, emotional, or behavioral difficulties (Emde, 1999). For children and families impacted by such difficulties, problems may spiral. Young children may be expelled from preschool, setting them up for later school failure. They may not be able to establish close relationships with family members or friends, which may lead to antisocial behavior, violence, or severe depression.

Consistent with national trends, many young children in Colorado have social and emotional difficulties that impact their early learning experiences. According to a survey of Colorado early care and education providers, more than one in six children from birth to eight years of age have emotional or behavioral problems severe enough to disrupt classrooms and distress teachers (Center for Human Investment Policy, 2000). A survey of Colorado's kindergarten teachers shows that 99% rate "the ability to interact positively with other children" as extremely or very important (Educare Colorado & Colorado Children's Campaign, 2002).

Early childhood science suggests that well-designed early intervention improves the odds of positive developmental outcomes for young children who are at developmental risk due to biological or environmental risk factors (National Research Council, 2000). Additionally, research indicates that early intervention can improve social and emotional functioning and reduce later violence and antisocial behavior in school age children (Sprague & Walker, 2000). Clearly, early identification of young children who may benefit from early intervention programs such as Early Head Start, Head Start, home visitation, or Part C early intervention services, is a critical step toward preventing later problems associated with social and emotional difficulties.

Social and Emotional Screening

Because even very young children show signs of social and emotional challenges (DeGangi, 1991), screening is often an effective way to identify children who would benefit from early intervention. Screening is a quick, low-cost assessment of a child's current behavior. Screening alone does not determine if a child has a diagnosis or is eligible for services; rather it indicates whether a child should receive more in-depth evaluation (Frankenburg, 1984; Squires, 2000). Screening includes the use of a reliable and valid screening tool that is able to distinguish children who need further evaluation from children who do not (Squires, 2000). However, screening involves more than the use of such a tool. The screening process also includes gathering input from parents, teachers, and others who may know the child (Printz, et. al, 2003) and providing referrals to evaluation and intervention resources if the screening process identifies concerns. When well-implemented screening programs are available in places where young children and families typically go, such as primary care or early care and education settings, it may help to identify children with social and emotional concerns and assure that their families receive appropriate supports and services.

Formation of Colorado Work Groups

The group convened by Project BLOOM, Harambe, and Kid Connects in September 2003 to discuss screening for social-emotional development in young children in Colorado included representatives from state and local education, public health, and mental health systems, and a developmental pediatrician. The groups' discussion focused on the training and supports that would enable early childhood professionals from a variety of disciplines to competently identify children with social and emotional concerns. The group identified a number of action steps needed to improve social and emotional screening practices in Colorado. The action steps are outlined in Figure 1.

Figure 1

Action Steps to Improve Social and Emotional Screening Practices in Colorado

1. Identify screening tools that are useful for identifying social-emotional difficulties in young children in a variety of early childhood settings.

2. Provide training to early childhood professionals on typical as well as atypical social-emotional development.

3. Provide training to early childhood professionals on skills needed to implement screening, including:
    - Administering screening tools;
    - Listening, observation, and interpretation skills;
    - Conveying results to various audiences;
    - Providing anticipatory guidance to parents about concerns.

4. Link training on social and emotional screening to community resources, including:
    - Materials to assist in providing anticipatory guidance in the setting where the screen occurred;
    - Where to refer for social and emotional/mental health evaluation;
    - Where to refer if the child is identified as needing special services.

The group recognized that different settings have different needs and requirements for screening tools and processes. The group agreed to form three workgroups to develop strategies needed to implement the action steps:

- **Early Care and Education**
- **Child Find**
- **Primary Care**

Each workgroup examined and made setting-specific recommendations for social-emotional screening tools, training, and other supports to ensure the successful implementation of screening programs. When examining screening tools, all of the workgroups considered criteria such as age range covered, qualifications needed to administer the tool, time required to administer the tool, cost, and the tool's psychometric properties. The tools selected were based on the workgroup members' assessment of which tools best fit the special considerations of the early childhood setting they examined. The tools selected by the screening committees are summarized in Table 1.

Summary of Workgroup Recommendations

Early Care and Education

Special considerations: Early care and education settings include childcare and family home care settings, Head Start, Early Head Start, and preschool programs. In selecting social and emotional screening tools for this setting, the group determined that a tool that included classroom strategies to help teachers meet the needs of children with social and emotional challenges would be helpful. Since many early childhood providers may not have the background or training to interpret screening tools independently, the group agreed that it would be important for early care and education settings to have access to ongoing support. A mental health clinician or an early childhood educator with expertise in social, emotional, and behavioral development might provide such support.

Suggested Tools: DECA and ASQ-SE

The group determined that the Devereux Early Childhood Assessment (DECA) was an appropriate screening tool to be used in early childhood programs. While other screening tools could also be used, the DECA is particularly well suited for early childhood settings because it was developed for and tested with early childhood teachers and was designed to be interpreted by early childhood teachers in conjunction with mental health professionals. The DECA Program includes classroom strategies for promoting positive behaviors and reducing concerning behaviors in young children. However, because the DECA is designed for children 2-5 years old, another tool, such as the Ages and Stages Questionnaire – Social-Emotional (ASQ-SE) would need to be used for children younger than two years of age.

Training and Support:

The workgroup recommended that training include specific information on using the DECA and ASQ-SE, interpreting the results, and discussing the results with parents. In addition, ongoing consultation and supervision from a mental health clinician or an early childhood educator with expertise in social, emotional, and behavioral development should be available to promote the use of strategies to support children with social-emotional concerns and to help determine when children should be referred for further evaluation.

Child Find

Special Considerations: In Colorado, Child Find is responsible for the screening, evaluation, and assessment services required by the Individuals with Disabilities Education Act (IDEA). Typically, Child Find consists of multidisciplinary teams who conduct screenings or assessments in home, community, or education settings. When Child Find teams conduct a screen, they are typically meeting the family for the first time, so they need tools that allow them to gather information through a one-time observation and/or parent report. The workgroup determined that parent report tools may be the most useful for Child Find teams, because they allow the team to gather information about the child's typical behavior, which may be different than the "snapshot" observed by the provider during the screening process.

Suggested Tools: TABS Screener, BITSEA, ASQ-SE

The Temperament and Atypical Behavior Rating Scale (TABS) Screener, Brief Infant Toddler Social-emotional Assessment (BITSEA), and the ASQ-SE are all based on parent report and have suggested cut-off scores for when further evaluation is indicated.

Training and Support:

The Child Find workgroup outlined a training process that would be helpful to Child Find teams to begin to integrate the use of social-emotional screening tools and practices:

• Provide regional training days that review each of the three tools, discuss the interpretation of the tools and integration of the results with other information, and highlight resources for children whose screening indicates a need for further evaluation.

• Implement a pilot social-emotional screening program in self-selected Child Find teams. The purpose of the pilot would be to create learning opportunities among Child Find teams who are using the screening tools and to collect data to determine the impact of using the tools, such as the percent of children needing further evaluation, where the children receive subsequent evaluation and services, and involvement of mental health centers.

Primary Care

Special Considerations: Ideally, screening in primary care is a multifaceted approach with the ability to detect "significant problems affecting adaptive, motor, speech, and social-emotional development" (Frankenburg, 1984). The American Academy of Pediatrics recommends that all young children be screened for developmental delays (American Academy of Pediatrics, July 2001) and that pediatricians address psychosocial issues that effect children's health, including child behavior, development, and family function (American Academy of Pediatrics, November 2001). A survey conducted by the Academy of Pediatrics determined that 7 out of 10 pediatricians identify potential problems via clinical assessment without the use of a screening tool (American Academy of Pediatrics, undated). However, research shows that physicians who relied on their clinical judgment to screen failed to identify 83% of the children who actually had diagnosable emotional or behavioral problems (Costillo et. al, 1988).

The workgroup agreed that promoting the use of screening tools in primary care settings was important. They also agreed that the tools they recommended should be feasible to implement in a primary care office setting. The group determined feasibility would increase if the tool: 1) could be completed by the parent while in the waiting room; 2) is relatively quick to administer and interpret; and 3) provides an indication of what is needed next, such as anticipatory guidance, a more in-depth screen, or referral for evaluation.
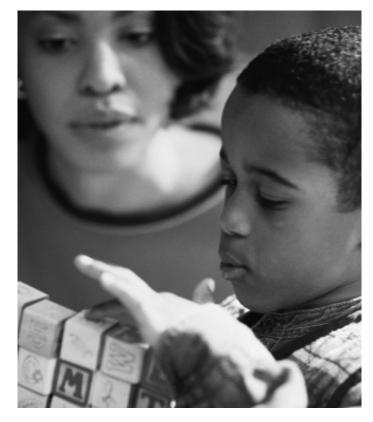
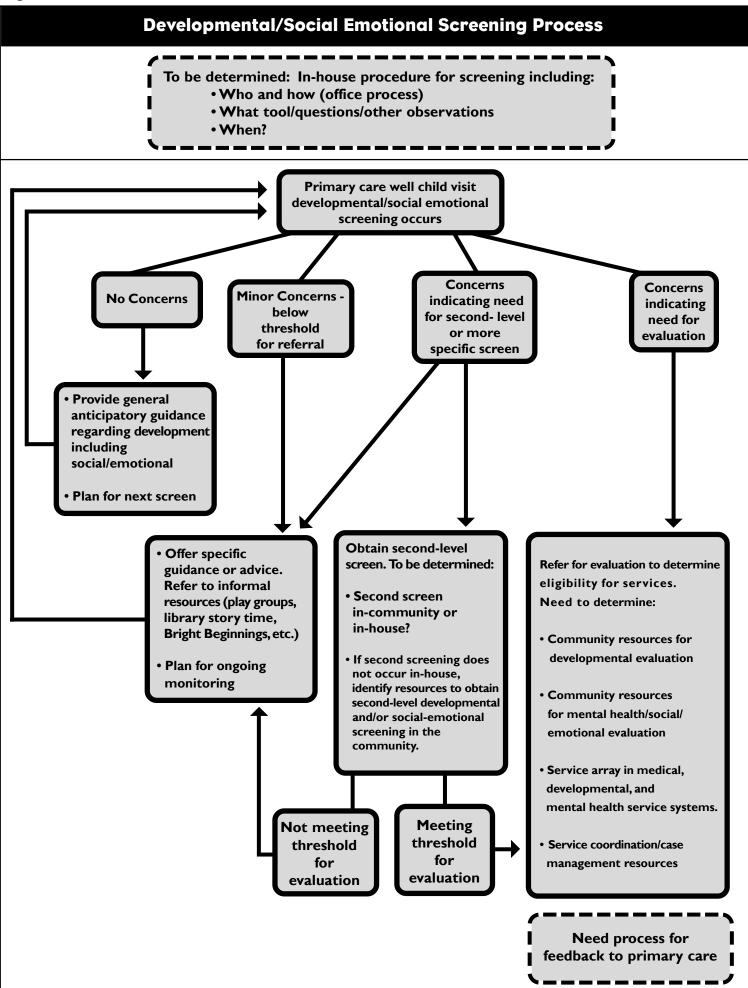*Suggested Tools:* PEDS, ASQ and ASQ-SE, and Family Psychosocial Screener
The Parents' Evaluation of Developmental Status (PEDS), Ages and Stages Questionnaires, and (ASQ); Ages and Stages Questionnaires: Social-Emotional (ASQ:SE) and the Family Psychosocial Screener all rely on parent report. Studies show that parent-report tools improve communication between the parent and the provider during an office visit (Triggs and Perrin, 1989) and that standardized parent-report screening tools are a reliable method of detecting developmental problems (Glascoe, et. al, 1991; Glascoe & Dworkin, 1995). Also, parent-report tools have been shown to be less expensive to implement in practice settings than observation-based tools (Dobrez, et.al, 2001). Frankenburg (1984) recommends a two stage screening processes in primary care settings, with the first stage consisting of a quick, simple screening method resulting in few under-referrals, followed by a more lengthy second-stage screen.

Applied to social-emotional development, the screening process might include: 1) A first-step developmental screen that includes questions about social, emotional and behavioral concerns and 2) a more in-depth social-emotional screen as indicated by the outcome of the developmental screening tool (Glascoe, 1998).

In addition to screening children for social, emotional, or behavioral concerns, primary care practices are well suited to examine family risk factors that may increase the child's risk for social and emotional difficulties. The Family Psychosocial Screening was designed to help primary care providers understand the risk factors families may be facing and help in determining when referrals to outside resources may be indicated.

Training and Support: The workgroup discussed the importance of having the entire practice receive training on implementing the screening process, including screening tools, anticipatory guidance, and referrals for evaluation and/or services. In addition, the group highlighted the need for communities that provide training on social-emotional screening in primary care to include information on community resources available for children identified as needing further evaluation. Figure 2 provides a template for designing a primary care-based screening process. As the figure suggests, community-level resources are critical to the success of screening programs based in primary care settings.

Figure 2

Developmental/Social Emotional Screening Process

To be determined: In-house procedure for screening including:
- **Who and how (office process)**
- **What tool/questions/other observations**
- **When?**

Primary care well child visit developmental/social emotional screening occurs

No Concerns

Minor Concerns - below threshold for referral

Concerns indicating need for second- level or more specific screen

Concerns indicating need for evaluation

- **Provide general anticipatory guidance regarding development including social/emotional**

- **Plan for next screen**

- **Offer specific guidance or advice. Refer to informal resources (play groups, library story time, Bright Beginnings, etc.)**

- **Plan for ongoing monitoring**

Obtain second-level screen. To be determined:

- **Second screen in-community or in-house?**

- **If second screening does not occur in-house, identify resources to obtain second-level developmental and/or social-emotional screening in the community.**

Refer for evaluation to determine eligibility for services. Need to determine:

- **Community resources for developmental evaluation**

- **Community resources for mental health/social/ emotional evaluation**

- **Service array in medical, developmental, and mental health service systems.**

- **Service coordination/case management resources**

Not meeting threshold for evaluation

Meeting threshold for evaluation

Need process for feedback to primary care

Barriers

Workgroup participants identified a number of barriers to implementing social-emotional screening programs. Barriers in early care and education include lack of training and expertise in child development for some providers, lack of access to early childhood mental health consultation, and lack of administrative and other resources needed to implement the screening process. In Child Find settings, barriers include lack of knowledge to recognize social-emotional concerns for some Child Find team members. In primary care settings, identified barriers were consistent with those found by an American Academy of Pediatrics (undated) survey, including the short duration and competing mandates during well-child visits, lack of medical office staff to implement screening, and lack of reimbursement for administering developmental or social-emotional screening tools. Across all of these settings, workgroup participants identified another major barrier: a shortage of community resources to provide evaluation and intervention services for children identified with potential social-emotional concerns.

Summary and Policy Implications

Social and emotional screening can be a first step in ensuring that young children with social-emotional concerns receive the early interventions that may improve their later success in school and in life. Screening programs may help to defer later costs by helping early childhood providers recognize those children who need further evaluation. The workgroups determined that it is feasible to implement screening programs in places where children and families typically go, such as early childhood and primary care settings. In addition, it makes sense to incorporate social-emotional screening into the existing Child Find developmental screening system.

Ideally, all infants, toddlers, and preschoolers in Colorado should receive ongoing social-emotional screening through primary care, early care and education program and/or their local Child Find team. To achieve this, screening programs must be designed at the community level and be tailored to the specific screening, evaluation, and intervention resources that exist locally. Screening programs can only achieve their goals when resources are available to serve the children with identified needs. Thus, policy changes across early childhood programs, Child Find, primary care, mental health systems, and community-level early childhood systems are needed to assure that social-emotional screening leads to appropriate intervention and improved outcomes for children and families. Figure 3 outlines a number of policy strategies to support the availability of social-emotional screening for Colorado's young children and their families.

Figure 3

Policy Strategies to Support Social Emotional Screening in Colorado
Early Care and Education Adopt the Head Start and Early Head Start Performance Standards related to developmental and social-emotional screening for child care program receiving dollars through publicly funded child care or preschool programs.
Child Find: Include social-emotional screening as a component of a comprehensive screening process in Child Find Screening Guidelines.
Primary Care (Including Public Health, Health Care Policy and Finance, and Professional Organizations) Advocate for adequate third-party payer reimbursement for the implementation of a developmental and social-emotional screening. Incorporate social-emotional screening as a part of the medical home concept and include availability of care coordination to provide follow-up when referrals are needed.
Mental Health: Assure that the delivery of services to very young children with social-emotional problems and their families is a high priority of Colorado's mental health system. Deliver early childhood mental health consultation in early childhood settings including early childhood programs, Child Find teams, and primary care through the mental health centers and community providers. Provide community education/social marketing related to the social-emotional development of young children, the importance of early intervention, and where to access resources.
Community-Level Early Childhood Systems: Coordinate and integrate local social and emotional screening efforts across early childhood programs, Child Find, primary care, and other relevant early childhood settings in the community.

References

American Academy of Pediatrics, Committee on Children with Disabilities (2001). Developmental surveillance and screening of infants and young children. Pediatrics 108(1), 192-195.

American Academy of Pediatrics, Committee on Psychosocial Aspects of Family Health (2001). The new morbidity revisited: A renewed commitment to the psychosocial aspects of pediatric care. Pediatrics 108(5) 1227-1230.

American Academy of Pediatrics, Division of Health Policy Research (undated). Periodic Survey #53, Executive Summary, Identification of Children <36 Months at Risk for Developmental Problems and Referral to Early Identification Programs. Accessed at www.aap.org/research/periodicsurvey/ps53exs.htm on 9/09/2004.

Center for Human Investment Policy (2000). Summary of Findings from the Colorado Survey of Incidence of Mental Health Problems among Young Children in Early Childhood Programs.

Costello, E.J., Edelbrock, C., Costello, A.J., Dulcan, M.K. Burns, B.J. and Brent, D (1988). Psychopathology in pediatric primary care: the new hidden morbidity
Pediatrics 82: 415-424.

DeGangi, G. (1991). Assessment of sensory, emotional, and attentional problems in regulating disordered infants: Part I. *Infants and Young Children*, 3:1-8.

Dobrez, D., Lo Sasso, A., Holl, J., Shalowitz, M., Leon, S., Budetti, P. (2001). Estimating the cost of developmental and behavioral screening of preschool children in general pediatric practice. *Pediatrics,* 108:913-922.

Emde, R.N. (1999). Early emotional development: new modes of thinking for research and intervention. In J.G. Warhol (Ed.) *New perspectives on early emotional development* (pp. 29-45). Johnson and Johnson Pediatric Institute.

Educare Colorado and Colorado Children's Campaign (2002). First-Ever Statewide K-1 Teacher Survey on School Readiness (Power Point Presentation available from the Colorado Children's Campaign, Denver, CO).

Frankenburg, W.K. (1984). Developmental screening. *Primary Care*, 11(3): 535-547.

Glascoe, F.P., MacLean W.E., Stone W.L. (1991). The importance of parents' concerns about their child's behavior. *Clinical Pediatrics*, 31(1) 8-11.

Glascoe, F.P. & Dworkin, P.H. (1995). The role of parents in the detection of developmental and behavioral problems. *Pediatrics*, 96(6): 829-36.

Glascoe, F.P. (1998). Collaborating with parents, Using Parents' Evaluation of Developmental Status to detect and address developmental and behavioral problems. Nashville, TN: Ellsworth & Vandermeer Press LLC.

Lyons-Ruth, K. & Zeanah, C.H. (1993). The family context of infant mental health: Affective development in the primary caregiving relationship. In C.H. Zeanah (ed.), *Handbook of Infant Mental Health* (pp. 14-37). New York: The Guilford Press.

National Research Council and Institute of Medicine (2000). *From neurons to neighborhoods: The science of early childhood development.* Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth, and Families. Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

Printz, P.H., Borg, A., and Demaree, M.A. (2003). *A look at social, emotional, and behavioral screening tools for Head Start and Early Head Start.* Education Development Center under contract number 90-YQ-0010 of the Head Start Bureau, Administration of Children and Families, Department of Health and Human Services.

Sprague, J. and Walker, H. (2000). Early identification and intervention for youth with antisocial and violent behavior. *Exceptional Children*, 66(3): 1367-379.

Squires, J.K. (2000). Identifying social/emotional and behavioral problems in infants and toddlers. *The Transdisciplinary Journal* 10(2): 107-119.

Tirggs E.G. & Perrin E.C. (1989). Listening carefully. Improving communication about behavior and development. Recognizing parental concerns. *Clinical Pediatrics* 28(4): 185-192.

APPENDIX A: SELECTED TOOLS

Selected Tools - Early Care and Education: ASQ-SE, DECA						
TOOL	**AGE RANGE**	**DESCRIPTION**	**SCORING**	**ACCURACY**	**LANGUAGE**	**ADMINISTRATIVE COSTS: TIME & DOLLARS PER ADMINISTRATION**
Ages and Stages Questionnaires: Social-Emotional (ASQ:SE) [1] Paul H. Brookes, Publishers, 1-800-638-3775 http://www.pbrookes.com $125.00 (able to copy)	**6-60 Months**	Designed to supplement the ASQ, this parent completed questionnaire consists of 30-item forms for 8 age ranges between 6 and 60 months. Items focus on self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people.	Single cutoff score indicating when a referral is needed	Sensitivity rated from 71-85%. Specificity from 90-98%. Test-retest reliability 94%	English	10-15 minutes if interview needed. Materials - $.40 Admin - $4.20 Total - $4.60
Devereux Early Childhood Assessment (DECA) 1-800-334-2014 www.kaplanco.com $199.95 for kit (includes classroom and parent strategy guides).	**2 - 5 Years**	A 37-item, standardized, norm-referenced behavior rating scale that measures protective factors and behavioral concerns in preschool children. Four subscales measure attachment, self-control, initiative, and behavioral concerns.	Provides a raw score that converts to a t-score and percentile for each subscale (including behavioral concerns) and the total protective factor score.	Sensitivity and specificity not reported. All four DECA scales detect statistically significant differences between children identified with behavioral problems and a community sample. Test-retest reliability for teachers is .94 for protective factors and .68 for behavioral concerns. For parents, it is .74 for protective factors and .55 for behavioral concerns.	English and Spanish	5-10 minutes No cost data available.

[1] Information taken directly from Glascoe, F. (undated). Developmental, Mental Health/Behavioral and Academic Screens (including cost estimates), and supplemented as needed from information in the test manual.

Selected Tools - Child Find Teams: ASQ-SE, BITSEA, TABS Screener

TOOL	AGE RANGE	DESCRIPTION	SCORING	ACCURACY	LANGUAGE	ADMINISTRATIVE COSTS: TIME & DOLLARS PER ADMINISTRATION
Brief Infant Toddler Social-emotional Assessment (BITSEA)[1] Soon to be available through Psychological Corporation http://www.psychcorp.com.au/	12-36 Months	42 item parent-report measure for identifying social-emotional/behavioral problems and competence. Problem scale measures activity/impulsivity, aggression/defiance, depression/withdrawal, general anxiety and separation distress, sleep, negative emotionality, eating, and sensory sensitivity. Competence scale measures compliance, attention, imitation/play, mastery motivation, empathy, pro-social peer and social relatedness.	Single cutoff score indicating when a referral is needed	Standardized on two samples: Community and Early Intervention. Community sample: Sensitivity rated from 81-97% Specificity from 80 to 88% EI sample: Sensitivity rated from 97-99% Specificity rated from 50-71% Test-retest reliability 82% on the problem scale and 72% on the competence scale.	English, Spanish, French, Dutch, Hebrew	5 - 7 minutes Materials - NA Admin - $.88
Temperament and Atypical Behavior Rating Scale (TABS) Screener[1] Paul H. Brookes, Publishers, 1-800-638-3775 http://www.pbrookes.com $40.00 for manual and $25.00 for protocols	11 - 71 Years	Parents complete a 15-item, single-sheet form. Specifically designed to identify temperament and self-regulation problems that indicate risk for developmental delay. Items focus on pathology and spectrum disorders.	Cut off of 2 yes answers indicates a concern and an assessment with the full TABS is recommended	Screener yields false negative at a rate pf 2.2% and false positives at a rate of 1.4% Test-retest reliability not reported for the screener. Reliability coefficients range from 0.73-0.94 on the full TABS	English	About 5 minutes Materials - $.10 Admin. - $.88 Total - $.98

Selected Tools - Primary Care Practices: ASQ, ASQ-SE, PEDS

TOOL	AGE RANGE	DESCRIPTION	SCORING	ACCURACY	LANGUAGE	ADMINISTRATIVE COSTS: TIME & DOLLARS PER ADMINISTRATION
Parents' Evaluation of Developmental Status (PEDS).[1] Ellsworth & Vandermeer Press, Ltd. 615-227-0411 http://www.pedstest.com $30.00 for start up kit	Birth to 9 years	Ten questions eliciting parent concerns. Written at the 5th grade level. Determines when to refer, provide a second screen, provide patient education, or monitor development, behavior, and academic progress.	Identifies children as low, moderate, or high risk for various kinds of disabilities or delays	Sensitivity ranging from 74% to 79% and specificity ranging from 70% to 80% across age levels Test-retest reliability is 88%.	English, Spanish, Vietnamese	About 2 minutes Materials - $.31 Admin - $.88 Total $1.19
Ages and Stages Questionnaire[1] Paul H. Brookes, Publishers, 1-800-638-3775 http://www.pbrookes.com $125.00 (able to copy)	4 to 60 months	Parents indicate children's developmental skills on 30-item forms for 19 age ranges between 4 and 60 months. Domains include communication, fine motor, gross motor, problem-solving, and personal-social.	Single cutoff score for developmental status	Sensitivity ranged 70-90% at all ages except the 4-month level. Specificity ranged from 76% - 91% Test-retest reliability is 94%	English, Spanish, French, Korean	About 15 minutes if interview needed. Materials - $.40 Admin - $4.20 Total - $4.60
Family Psychosocial Screening[1] Ambulatory Child Health. 1996, 4:325-339. Downloadable at www.pedstest.com	Screens parents. Best used with a child screener	A two-page clinical intake form that identifies psychosocial risk factors associated with developmental problems including: a four item measure of parental history of physical abuse as a child; a six item measure of parental substance abuse, and a three item measure of maternal depression.	Refer/nonrefer scores for each risk factor.	All studies showed sensitivity and specificity (compared to longer inventories) at greater than 90%.	English	About 15 minutes if interview needed. Materials ~ $.20 Admin ~ $4.20 Total ~ $4.40

APPENDIX B: PARTICIPANTS

Initial Social and Emotional Screening Meeting
Laurie Beckel, Harmabe Colorado, University of Colorado at Denver
Ana do Valle, District RE-1J Vrain Valley Child Find
Sarah Davidon, Project BLOOM, JFK Partners, University of Colorado Health Sciences Center (UCHSC)
Kat Emmons, Colorado West Mental Health Center
Karen Fehringer, JFK Partners, University of Colorado Health Sciences Center (UCHSC) and Health Care Program for Children with Special Needs (HCP),
Colorado Department of Public Health and Environment (CDPHE)
Penny Gonnella, Tri-County Health Department, HCP
Mary Grimmer, Mental Health Corporation of Denver
Rachel Hutson, Child Health Section, CDPHE
Tracy Kraft-Thorp, Colorado Department of Human Services, Kid Connects
Jim Ledbetter, JFK Partners, UCHSC and HCP, CDPHE
Bonnie Markman, District 5 Cherry Creek Child Find
Corry Robinson, Project BLOOM, JFK Partners, UCHSC
Betsy Rogers, Aurora Mental Health Center
Theresa Shrotberger, Exceptional Student Services Unit, Colorado Department of Education (CDE)
Susan Smith, Early Childhood Connections, CDE
Kelly Stainback-Tracy, Project BLOOM, JFK Partners, UCHSC
Nan Vendegna, Exceptional Student Services Unit, CDE

Early Care and Education Workgroup
Karen Fehringer, JFK Partners, UCHSC and HCP/CDPHE
Mary Grimmer, Mental Health Corporation of Denver
Kelly Stainback-Tracy, Project BLOOM, JFK Partners, UCHSC
Carolena Steen, Cheyenne Mountain School District 12

Primary Care Workgroup
Barb Deloian, JFK Partners, UCHSC
Ana DaValle, District RE-1J Vrain Valley Child Find
Karen Fehringer, JFK Partners, UCHSC and HCP/CDPHE
Rachel Hutson, Child Health Section, CDPHE,
Linda Kahl, Colorado West Mental Health Center
Tracy Kraft-Tharp, Colorado Department of Human Services, Kid Connects
Jim Ledbetter, JFK Partners, UCHSC and HCP/CDPHE
Carol Rieder, Health Care Policy and Finance, EPSDT
Corry Robinson, Project BLOOM, JFK Partners, UCHSC
Kelly Stainback-Tracy, Project BLOOM, JFK Partners, UCHSC
Leslie Tremaine, West Central Mental Health Center
Karen Umemoto, Project BLOOM, JFK Partners, UCHSC

Child Find Workgroup
Lynn Bindel, HCP, CDPHE
Mary Grimmer, Mental Health Corporation of Denver
Sheri Katzman, District 1 Denver Child Find
Tracy Kraft-Tharp, Colorado Department of Human Services, Kid Connects
Theresa Schrotberger, Exceptional Student Services Unit, CDE
Kelly Stainback-Tracy, Project BLOOM, JFK Partners, UCHSC
Melissa Waggoner, District 5 Cherry Creek Child Find
Pam Walker, District RE-1 Canon City Child Find

Final Meeting: Workgroup Recommendations and Report
Theresa Schrotberger, Exceptional Student Services Unit, CDE
Anne-Marie Braga, HCP, CDPHE
Tracy Kraft-Tharp, Colorado Department of Human Services, Kid Connects
Pam Hansen-Gausman
Margie Marshall
Rachel Hutson, Child Health Division, CDPHE
Laurie Beckel, Harmabe Colorado, University of Colorado at Denver
Melissa Wagoner, District 5 Cherry Creek Child Find
Susan Smith, Early Childhood Connections, CDE
Sheri Katzman, District 1 Denver Child Find
Jim Ledbetter, JFK Partners, UCHSC and HCP/CDPHE
Penny Gonnella, Tri-County Health Department, HCP

Feedback on report also elicited by email through:
Consolidated Child Care Pilot Email List
Colorado Interagency Coordinating Council for Part C
Project BLOOM Local Community Governance Teams in Aurora, El Paso County,
Fremont County, Mesa County

Special thanks to Larry Edelman, JFK Partners, UCHSC for valuable contributions and suggestions.

Project **BLOOM** is funded by the Substance Abuse Mental Health Services Agency, Child Adolescent and Family Branch.

Project **BLOOM** is administered by:

Colorado Department of Human Services, Division of Mental Health
3824 West Princeton Circle
Denver, CO 80236

JFK Partners, University of Colorado Health Sciences Center
4200 East Ninth Avenue, C234
Denver, Colorado 80262

For more information about Project **BLOOM**:
Sarah Davidon, M.Ed., Project Director
JFK Partners, University of Colorado Health Sciences Center
303-315-2152
www.projectbloom.org