

CHAPTER 6
RESOURCE MATERIALS



Understanding Children

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Child Development Chart (1 of 3)

AGE	COGNITIVE	PSYCHOLOGICAL	MORAL	SEXUAL	MOTOR
0 to 6 Months	Recognizes primary caregiver; no concept of past or future; reaches for familiar people or toys	Attachment to primary caregiver; totally dependent; totally trusting; learns intimacy	None	Erections possible; both sexes can be stimulated	Sucks; hands clench/grip; neck muscles develop; pulls at clothing; laughs/coos; head is unsteady
6 to 12 Months	Can hold objects in memory; learns through routines and rewards; recognizes name; says two to three words besides "Mama" and "Dada"; imitates familiar words	Separates from primary caregiver; begins to develop a sense of self; learns to get needs met; trusts adults; stretches arms to be picked up; likes to look at self in mirror	None	Generalized genital play	Rolls over; stands with support; creeps/crawls; walks with help; rolls a ball in imitation of adult; pulls self to standing position and stands unaided; transfers object from one hand to the other; drops and picks up toy; feeds self cracker; holds cup with two hands; drinks with assistance; holds out arms and legs while being dressed
12 to 18 Months	Experiments with physical environment; understands the word "no"; comes when called to; recognizes words as symbols for objects (cat—meows); uses 10 to 20 words, including names; combines two words such as "Daddy bye-bye"; waves good-bye and plays pat-a-cake; makes the sounds of familiar animals; gives a toy when asked; uses words such as "more" to make wants known; points to his/her toes, eyes, and nose; brings objects from another room when asked	Early social development; egocentric; accepts limits; develops self-esteem (dependent on love from family); plays by self	Fears authority figures	Continued generalized genital play	Creeps up stairs; gets to standing position alone; walks alone; walks backward; picks up toys without falling; pulls and pushes toys; seats self in child-size chair; moves to music; turns pages two or three at a time; scribbles; turns knobs; paints with whole arm movement; shifts hands; makes strokes with writing implement; uses spoon with little spilling; drinks from cup with one hand; chews food; unzips large zipper; indicates toilet needs; removes shoes and clothing
18 to 36 Months	Can conduct experiments inside head but limited to experience; rapid language growth; copies adult chores in play; carries on conversation with self and dolls; asks "What's that?" and "Where's my . . . ?"; has 450-word vocabulary; gives first name; holds up fingers to tell age; combines nouns and verbs ("Mommy go"); refers to self as "me" rather than by name; tries to get adult attention, exclaiming "Watch me"; likes to hear same story repeated; may say "No" when meaning "Yes"; talks to other children as well as adults; names common pictures and things	Autonomy struggles; learns system of meeting needs; social development increases; points to things he/she wants; joins in play with other children; shares toys; takes turns with assistance	Knows preferences of authority figures	Continued generalized genital play; early sex-role development	Can run, throw ball, kick ball, jump; goes up stairs with one hand held by adult; turns single pages; snips with scissors; holds crayon with thumb and fingers (not fist); uses one hand consistently in most activities; rolls, pounds, squeezes, and pulls clay; uses spoon with little spilling; gets drink from fountain or faucet independently; opens door by turning handle; takes off and puts on coat with assistance; washes and dries hands with assistance



Child Development Chart (2 of 3)

AGE	COGNITIVE	PSYCHOLOGICAL	MORAL	SEXUAL	MOTOR
3 to 5 Years	Can conduct experiments inside head; cannot sequence; capacity to use language expands; understands some abstract concepts: colors, numbers, shapes, time (hours, days, before/after); understands family relations (baby/parent); can tell a story; has a sentence length of 4 to 5 words; has a vocabulary of nearly 1000 words; names at least one color; understands "tonight," "summer," "lunchtime," "yesterday"; begins to obey requests like "Put the block under the chair"; knows his/her last name, name of street on which he/she lives, and several nursery rhymes; uses past tense correctly; can speak of imaginary conditions "I hope"; identifies shapes	Can cooperate; self-perceptions develop; cannot separate fantasy from reality; has nightmares; models on same-sexed parent; experiences and copes with feelings (sadness, jealousy, embarrassment); plays and interacts with other children; dramatic play is closer to reality, with attention paid to detail, time, and space; plays dress-up	Self-esteem depends on authority figures; follows peers' fads; negotiates to get needs met	Generalized genital play in males; masturbation to orgasm in females is possible; early experimentation; gender identity established	Swings/climbs; uses small scissors; jumps in place; walks on tiptoes; balances on one foot; rides a tricycle; begins to skip; runs well; bathes and dresses; runs around obstacles; walks on a line; pushes, pulls, steers wheeled toys; uses slide independently; throws ball overhead; catches a bounced ball; drives nails and pegs; skates; jumps rope; pastes and glues appropriately; skips on alternating feet; pours well from small pitcher; spreads soft butter with knife; buttons and unbuttons large buttons; washes hands independently; blows nose when reminded; uses toilet independently
6 to 9 Years	Can think using symbols; can recognize differences; makes comparisons; can understand another's perspective; defines objects by their use; knows spatial relationships like "on top," "behind," "far," and "near"; knows address; identifies penny, nickel, dime; knows common opposites like "big/little"; asks questions for information; distinguishes left from right	Early close peer relationships; presence of well-developed defenses; develops identity outside family (school, friends); has likes and dislikes (food, friends, games); chooses own friends; plays simple table games; plays competitive games; engages in cooperative play with other children involving group decisions, role assignments, fair play	Has a conscience; refinements in moral development	Defenses reduce experimentation, but some continues	Increases small muscle motor skills; cuts foods with a knife; laces and ties shoes; dresses self completely; ties bow; brushes independently; crosses streets safely



Child Development Chart (3 of 3)

AGE	COGNITIVE	PSYCHOLOGICAL	MORAL	SEXUAL	MOTOR
10 to 15 Years	Can engage in inductive and deductive logic; understands hypothetical situations	Increased autonomy struggles; increased focus on identity; increased focus on peer relationships; rebellious; often moody; has romantic feelings; struggles with sense of identity; feels awkward or strange about his/her body; worries about being normal; frequently changing relationships; conflicts with parents increase	Moral development is legalistic; recognizes principles (e.g., justice); selects role models	Puberty; sex organs mature; males ejaculate and have wet dreams; both sexes can masturbate to orgasm with fantasies; girls develop physically sooner than boys; may display shyness, blushing, and modesty	Greater body competence (e.g., physical coordination); manual dexterity; growth patterns vary
16 to 21 Years	Uses formal logic (e.g., opposes racism); debates and can change sides of debate; understands probabilities; uses more flexible abstract thinking	Demonstrates interest in relationships; solidifies personal identity; becomes goal directed; is sometimes rebellious; has increased concern for others; has increased concern for future; places more importance on his/her role in life; conflicts with parents begin to decrease	Identifies with moral principles, rules, and limit testing; experiments with sex and drugs; examines inner experiences	Experiences feelings of love and passion; develops more serious relationships; sense of sexual identity established; has increased capacity for tender and sensual love	Heightened physical power, strength, coordination

Chart compiled by Katie Thompson, Elon College student intern, North Carolina Guardian ad Litem Program. Modified for 2007 revision. Sources include "Infant and Toddler Development," Dr. Maureen Vandermaas-Peeler, Elon College; "Child Development," Ray Newnam, PhD; "LD In Depth," LD OnLine, www.ldonline.org; "Growing Up," Pasternak and Kroth; "Your Child's Growth: Developmental Milestones," American Academy of Pediatrics, www.aap.org; and "Normal Adolescent Development," American Academy of Child and Adolescent Psychiatry, www.aacap.org.



The Implications of Culture on Developmental Delay

by *Rebeca Valdivia*

Developmental delay refers to a lag in development rather than to a specific condition causing that lag. It represents a slower rate of development, in which a child exhibits a functional level below the norm for his or her age. A child may have an across-the-board developmental delay or a delay in specific areas.

When a child's development appears to lag, many service providers prefer to apply the less specific term "developmental delay," rather than a more specific disability diagnosis, since symptoms of specific disabilities may be unclear in young children. It is possible that a child with a developmental delay who receives services will not develop a disability; whereas if the same child did not receive services, the delay would become a disability. Because it is based on a comparison of the child's functional level with that of other children of the same age, "developmental delay" can be seen as a statistically defined, socially mediated construct that depends on cultural expectations and the definition of what constitutes a delay.

DEVELOPMENTAL DELAY UNDER THE LAW

Prior to 1997, IDEA (the Individuals with Disabilities Education Act) defined infants and toddlers with disabilities as individuals from birth through age two, inclusive, who need early intervention services because they

- Are experiencing developmental delay as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or
- Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

The 1997 reauthorization of IDEA added that "for children 3 through 9, the state and local education agency (LEA) may define 'child with disability' as

a child who is experiencing developmental delays and needs special education and related services." Thus, these children do not have to be labeled with a specific category to receive special education services.

Developmental delay is often interpreted as the precursor to the label "disabled" for children from birth to nine years old. For children of diverse cultural and linguistic backgrounds, professionals must be careful to avoid errors in diagnosis that stem from differences among various cultures and professionals about what constitutes a disability or delay.

ASSESSMENT/DIAGNOSIS

When determining whether a child has a developmental delay, the law requires use of appropriate diagnostic instruments and procedures. Professionals working with young children have long accepted the shortcomings of standardized tools, since young children with or without delays are in a process of constant growth and change, which makes it difficult to capture the child's development accurately at any one "measurement" or observation. In addition, young children seldom "cooperate" according to the expectations of the developers of the assessment tools, thus contributing to a possible misdiagnosis.

Many professionals have chosen to use instruments and procedures referenced to local norms in order to obtain a more reflective picture of the child's development (i.e., they develop a tool that reflects the norms of their community rather than national norms). In determining the appropriateness of norm-referenced instruments for children from diverse backgrounds, it is essential to examine the populations on which the norms were based. The following questions apply:

- Were the norms inclusive of the diversity of families found in the communities across the United States with which the tool will be applied?
- Did these "diverse" children also represent variations that typify the communities in which



the tool will be applied? For example, children within a group may vary in socioeconomic status, languages spoken, immigration status, and diversification within a more global category (e.g., Hispanic [Spanish-, Cuban, Puerto Rican-, Peruvian-, Salvadoran- or Mexican-American]).

In addition, professionals involved in this step of the child's developmental evaluation should ask themselves the following:

- Does the tool or process include provisions to conduct the assessment in the child's dominant language(s)?
- Will specially trained personnel familiar with the family's culture, practices, and beliefs conduct the assessment?

If even one of the answers to any of the four questions was "no," then either the instrument or the process may be inappropriate for use with culturally and linguistically diverse families.

Furthermore, the domains of development (e.g., cognitive, self-help, etc.) and the items subsumed in each area are predominantly reflective of a Western approach to the discussion and examination of early childhood development (Srinivasan & Karlan, 1997; Hehir & Latus, 1992). Although early childhood professionals may recognize the totality of the child, they may still feel comfortable separating aspects of the child's development into these component parts. Not only that, specialists (e.g., speech therapists) may address each component (e.g., speech and language) separately from the other components (e.g., gross motor). This may be in direct contradiction with monitoring the child's development from a more holistic, functional, situational approach common in other cultural groups (Kagitcibasi, 1996).

The age norms assigned to these various developmental domains are also quite arbitrary; they are primarily reflective of white, middle-class child rearing norms (e.g., Lynch & Hanson, 1992; Mangione, 1995). For instance, the entire self-help paradigm is indicative of the value of "early independence" in these skills promoted by families in this group. Many families feel just as comfortable encouraging their child to independently spoon-feed shortly before the child attends public school at 5 or 6 years of age instead of at 18 months as expected in many developmental checklists. Many families also see no purpose in having their child drink from a cup before 3, 4, or 5 years of age. When there are other family members around to help the child dress, there

is no pressure to encourage independent dressing early in the preschool years. These are a few examples of different attainment of developmental milestones influenced directly by different child-rearing values and practices.

Professionals must determine if they are truly measuring all the skills that this child has learned or if they are only measuring those skills they value based on their upbringing and professional training. For example, Garcia Coll (1990) examined developmental skills such as tactile stimulation, verbal interaction, nonverbal interaction, and feeding routines. These skills were studied in multicultural families, including African-American, Chinese-American, Hopi, Mexican-American, and Navajo families. The study found that "minority infants are not only exposed to different patterns of affective and social interactions, but that their learning experiences might result in the acquisition of different modes of communication from those characterizing Anglo infants, different means of exploration of their environment, and the development of alternative cognitive skills." (p. 274). Therefore, teachers and other service providers must distinguish between a developmental or maturational lag and behaviors that can be brought about by learning. For example, if a child is unable to spoon-feed, is it because she lacks the needed musculature and fine motor skill? Is it because she is neurologically unable to perform the complex movement? Or is it simply because she has not learned that skill and will easily learn it given the opportunity?

DISABILITY OR DELAY WITHIN A CULTURAL PERSPECTIVE

The discussion has thus led us to accept that disability is a socially and culturally situated construct (Danesco, 1997; Harry, 1992; McDermott & Varenne, 1996). Therefore, families of children of diverse cultures (and languages) may not identify a certain series of behaviors or symptoms as being descriptive of a "delay" or "disability." For instance, in her review of the literature, Danesco (1997) found that many culturally diverse parents explained their child's condition as a combination of biomedical and sociocultural or folk beliefs. Families often saw their child's condition as temporary or something that could be remedied. Therefore, it is not uncommon to see families following a combination of "professional/medical" prescriptions along with home remedies, folk or alternative practices in order to help their



child. It should be noted that families varied in how much weight they ascribed to professional, educational, or medical interventions as compared to alternative interventions. Because families had different interpretations of what constituted a delay or disability, even having their child labeled led to misunderstandings and mistrust between them and the professionals who were attempting to be helpful. For example, if everybody else in the family had followed similar developmental patterns, what would the label “developmentally delayed” given to the youngest child say about the rest of the family? If the child functioned well in the life of the home and community and the concern only existed in the clinic, school, or agency, was the child truly delayed?

IMPLICATIONS FOR PRACTICE

The cultural implications of the developmental delay category underscore the importance of having a broad array of tools for assessment and instruction as well as a good understanding of the child’s culture. Responsive, family-centered programs and professionals have taken many steps to ensure effective communication between them and the children they serve. These have included making interpreters available, making printed as well as audio/audio-visual materials available in the families’ dominant language, and connecting parents to a network of other parents with similar issues.

Instruction for children with developmental delay should reflect the goals identified and mutually agreed upon by the interventionist, educators, specialists, and, of course, the family. The learning objectives should include the child’s strengths as the foundation. They should be aimed at bridging the gap between what the child is currently able to do in his or her environment and what he or she needs to learn to do in order to be optimally successful in the current or upcoming environments. For instructional strategies and materials, professionals and families are encouraged to implement multicultural practices which honor and respect every child’s culture and language.

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A Call to Action: An Integrated Approach to Youth Permanency & Preparation for Adulthood

By Lauren L. Frey, with Sarah B. Greenblatt and Jim Brown

GETTING US ON THE SAME PAGE: UNDERSTANDING THE NEED FOR CHANGE

The Problem

“Aging out” without a permanent family and/or adequate preparation for adulthood is a crisis. It is a personal injury to each and every youth in care and a public emergency for our national child welfare system.

“Each year, as many as 25,000 teenagers ‘age out’ of foster care, usually when they turn eighteen. For most of their lives, a government agency has made every important decision for them. Suddenly they are entirely alone, with no one to count on.”¹ Exiting the system as an older adolescent by “aging out” without a permanent family is correlated with a range of deleterious outcomes as a young adult such as early pregnancy or parenthood, criminal involvement, homelessness, lack of employment or dropping out of high school.²

Martha Shirk and Gary Stangler described this situation in their book, *On Their Own: What Happens to Youth Who Age Out of the Foster Care System*:

*The reality is that young people who leave foster care at age eighteen are no more ready to become independent than our own children. In fact, most are probably less ready. Many youth in foster care do not benefit from normal growing-up experiences, such as holding down a part-time job, watching a parent balance a checkbook or learning the meaning of household responsibility by performing daily chores. Without basic life skills, youth who leave foster care often have difficulty negotiating more complex tasks like finding safe housing, getting and keeping a steady job, staying healthy and avoiding financial or legal trouble. Too few undertake the education and training necessary to compete in today's economy. In fact, four years after leaving care, only one in five former foster youth is fully self-supporting.*³

To “age out” of the foster care system means youths are discharged to “self” rather than to a family they

can count on and call their own. While displaying remarkable resilience, resourcefulness, courage and determination, the majority of youth “aging out” have neither the safety and security of a family, nor the skills and resources necessary for adulthood. Thus, they are not adequately equipped for life’s responsibilities and they lack an essential network of relationships and resources to rely on when the going gets tough.

“Aging out” has become an unintended casualty of well-meaning permanency law, policy and practice. Too many youth continue to grow up with no place to go.

Robert, age 13 and Deanna, age 11

After three years in foster care, Robert and Deanna were referred for youth permanency planning services. Their birth parents had a history of substance abuse, incarceration and homelessness. At the time of referral, both parents were in treatment programs. Having informally cared for them at times during their childhood, their maternal grandmother was included on the planning team and agreed to take legal guardianship with subsidy. As permanency team planning continued, Robert's and Deanna's birth parents demonstrated significant gains in recovery, located stable housing and secured jobs. They very much wanted their children to return home fulltime. When their grandmother's poor health resulted in an extended hospital stay, Robert's and Deanna's birth parents moved into her home and assumed primary parenting of the children, with the support of social services. Once the grandmother was discharged from the hospital, the birth parents continued to parent the children in her home. It became very clear to the planning team that since coming into state custody, Robert's and Deanna's developmental needs had changed and they no longer required



the same level of care and supervision. Once their grandmother had recovered more fully, Robert and Deanna were successfully transitioned back to live with their birth parents. Their grandmother supported the team's permanency plan of reunification and remained closely involved, once again resuming the role of grandparent rather than primary caregiver.

THE RATIONALE FOR CHANGE

Regardless of age, race or cultural background, special need or complex circumstances, all youth need and deserve a family to count on for a lifetime, and all youth need and deserve to be adequately prepared to face the adult world. For youth growing up in family foster care or congregate care settings, it is the moral responsibility, ethical obligation and legal mandate of the child welfare system to make sure they have both.

When youth grow up within a family, that *family* is the major vehicle for preparing them for the world of adulthood. For better or worse, the values, skills, challenges and opportunities that shape and define adulthood are woven into the very fabric of their everyday family lives. Through family relationships and experiences they discover what it means to learn, love and live. Their path to being prepared for adulthood is “permanency.”

Not so for many of our youth growing up in the foster care system.

For youth in foster care, an artificial line is all too often drawn between those who get “permanency” services and those who get “preparation for adulthood.”⁴ The system is compartmentalized for youth in a way that precludes holistic attention to the range of their needs.

A youth's service plan goal of “independent living” or “another planned permanent living arrangement” (previously known as “long-term foster care”) reflects one or more of these four basic sets of circumstances:

1. the youth cannot be safely reunited with his or her birth family,
2. recruitment of an adoptive or guardian family has not been successful,
3. a decision is made that adoption or guardianship is incompatible with a youth's age, special need or complex circumstances, and/or

4. a youth says “no” to reunification, adoption or guardianship.

A service plan goal of “independent living” or “another planned permanent living arrangement” does not mean a youth no longer needs family permanency, but that the system does not succeed in achieving it for or with them. All too often youth with a goal of independent living do not have a concurrent plan for permanent family relationships, and youth with a goal of alternative planned permanent living arrangement (APPLA) may have the commitment of a permanent *place*, but not a permanent *person*. Consequently these youth lose out on two fronts: they will more than likely “age out” of the system without a permanent family, *and* be launched into adulthood unprepared and unsupported to successfully meet its challenges.

Wanda, age 32

Wanda came into care at age six, with five subsequent residential placements and five foster families. After dropping out of high school, she “aged out” of the foster care system at 18. She experienced multiple psychiatric hospitalizations in different states and survived many nights homeless on the streets. She was adopted at age 20 by her former social worker. Wanda now lives in a mental health group home, after serving five years in prison, and is taking psychotropic medication and participating in counseling. She works part-time as a hostess and spends time with new friends in her group home. Through the rough years of young adulthood, her only consistent advocate was her adoptive mother. If they had not had a legal family relationship, Wanda's adoptive mother would not have had the right or legal standing to be included in psychiatric inpatient consultations, discussions with prison staff, mental health department eligibility appeals, private courtroom sessions and access to Wanda's public defender regarding her legal case. Wanda would have had no one to effectively advocate for her when she could not advocate for herself.



THE CONTEXT & LANGUAGE OF CHANGE

“Permanency” is a term that requires consistency not only in how it is implemented, but also in how it is interpreted and understood.

While permanency planning was initially intended as a process to limit entry into and time spent in out-of-home placement, achieving “permanency” is not the same as having a permanent plan, a permanency planning process, a permanency goal or a permanent placement. According to literature prevalent in the field of permanency planning today, achieving “permanency” means having an enduring family relationship that

- is safe and meant to last a lifetime;
- offers the legal rights and social status of full family membership;
- provides for physical, emotional, social, cognitive and spiritual well-being; and
- assures lifelong connections to extended family, siblings, other significant adults, family history and traditions, race and ethnic heritage, culture, religion and language.⁵

Over the past four years, the California Permanency for Youth Project has hosted national youth permanency convenings where participants (including child welfare professionals, advocates, youth and young adults who have experienced the foster care system) reached collective agreement about the specific elements of permanency that are important to older youth. Those elements include:

- the involvement of the youth as a participant or leader in the process;
- a permanent connection with at least one committed adult who provides a safe, stable and secure parenting relationship, love, unconditional commitment, lifelong support, a legal relationship if possible; and
- the opportunity to maintain contacts with important persons, including siblings.⁶

“Permanency” outcomes span a wide range of relationships and must be individualized.

In weighing the pros and cons of any permanency situation, it cannot be emphasized enough that when working with older youth in foster care, customized outcomes must be the rule. A “one-size-fits-all” philosophy is entirely inadequate.

Youth involvement in permanency planning and decision-making is absolutely essential. Planning must genuinely be guided by each youth’s wishes, hopes and dreams and must respectfully honor their feelings about past and current relationships. The involvement of caring adults in permanency planning and decision-making is also essential. The process must include those adults who represent the role of the state as custodial agent (*acting in loco parentis*), those adults who know the youth best and care about them the most, as well as those adults who can contribute to creative problem-solving and a successful permanency outcome. A partnership is crucial, and active and meaningful participation of each partner is critical.

In achieving any of the permanency outcomes, the objective is the optimal balance of physical, emotional/relational, legal and cultural dimensions of permanency within every child’s and youth’s array of relationships.

- Physical permanency relates to a safe and stable living environment.
- Emotional/relational permanency relates to the primary attachments, family and other significant relationships that offer trust and reciprocity.
- Legal permanency relates to the rights and benefits of a secure legal and social family status.
- Cultural permanency relates to a continuous connection to family, tradition, race, ethnicity, culture, language and religion.

While some older youth report that they have found satisfying emotional permanence through relationships without a legal status, other youth report that they have only truly felt secure when a committed emotional relationship was legalized through adoption. The particular dynamic mix of all dimensions of permanency that best suits each older youth in care can only be realized as a result of a truly collaborative and totally customized planning process.



All youth need and deserve an opportunity to achieve permanency and can benefit from a comprehensive exploration of the options. However, all too often some specialized populations of youth are excluded from these efforts. For example, youth in group homes, youth who are parenting, lesbian/gay/bisexual/transgender/questioning youth, youth with serious mental health needs and youth with cognitive limitations and/or serious medical/physical challenges need to be fully engaged.

The following considerations about permanency outcomes offer additional guidance for collaborative and customized permanency planning that includes youth and adults:

- Safe, stable and secure permanency with a youth's family of origin is a priority.
- Family preservation, reunification, adoption and legal guardianship are permanency outcomes that offer a secure legal status and the full legal rights and benefits of family membership.
- When permanency with a youth's family of origin can not be achieved, adoption or legal guardianship should be explored with both relatives and non-relatives. This could include adults known to a youth from within his or her network of significant relationships or previously unknown adults.
- When a legal permanency outcome cannot be achieved, a plan of alternative planned permanent living arrangement (APPLA) can be made more secure by assuring the permanent commitment of a *person* (not merely a *place to live*) and reinforcing that relationship with rituals, ceremonies, a legal name change, inclusion in a family's legal will and/or other symbols of "belonging" or "claiming."
- In some circumstances, permanent kinship placement, informal adoption and customary adoption (such as those found in some African American and Native American communities) may best honor a youth's emotional attachments as well as preserve continuity of connections to family, culture, ethnicity, religion and language.

"Preparation for adulthood" is a phrase that clarifies and normalizes the distinct dimension of child welfare practice aimed at strengthening the present and future well-being of youth in foster care.

Terms like "transition," "emancipation" and "independent living" have historically been common language used to describe a youth's passage from state custody to self-support after age 18. Such terms perpetuate a limited view of child welfare practice related to youth in care by focusing on the *event* of transitioning or emancipating, rather than the *process* of being prepared for it. Such terms all too often prompt us to ask questions such as:

- "Where will he live?"
- "Where will she go to school or work?"
- "How will he get there?"
- "How will she support herself?"

The answers to those questions are often more indicative of short-term changes in a youth's temporary circumstances than long-term outcomes associated with a youth's ongoing well-being.

The phrase "preparation for adulthood" offers an alternative to the common language of the past and more readily guides us to considering the opportunities, skills and resources necessary to be successful in the adult world. The phrase "preparation for adulthood" prompts thoughtful and thorough planning that includes but is not limited to questions such as:

- Has he had consistent and nurturing parenting that provided the opportunity to develop strong personal values, a solid sense of integrity, a positive sense of self, an extended network of family support and the capacity to build and maintain healthy relationships?
- Has there been consistent stability, quality and opportunity in her education over the past 18 years to adequately prepare her for college or a vocational program?
- What job opportunities and job skills training has he had or will he need that will prepare him to get and keep a job, develop a career path and assure sufficient income?
- Has she had the opportunity over time to see the importance and learn the discipline of saving and budgeting money?
- Has he had broad exposure and equal access to community experiences and opportunities that will maximize his network of relationships and resources?



“Preparation for adulthood” outcomes have definable and achievable dimensions.

Comprehensive “preparation for adulthood” is a conscious, purposeful and collaborative process which must be systematic, developmentally appropriate and continuous. In assuring that youth in care are successful in adulthood, the following outcomes are desired:⁷

- **Employment:** Young people generate a sufficient income to support themselves by obtaining and retaining steady employment leading to a viable career path.
- **Education:** Young people acquire sufficient education, training and opportunities that provide them with choices to pursue post-secondary education and/or the means to obtain and retain steady employment.
- **Housing:** Young people have access to safe, stable, appropriate, affordable housing in the community that is near public transportation, work or school.
- **Life Skills:** Young people demonstrate mastery of basic study skills, work skills, money management, social development, self-care and practical daily living skills.
- **Personal and Community Engagement:** Young people have in place supportive relationships, are able to access services in the community to achieve their personal goals and are supported in their efforts to contribute to the civic life of their communities.
- **Personal and Cultural Identity:** Young people demonstrate a healthy sense of ethnic or cultural identity, personal identity (including sexual orientation and gender identity) and spiritual identity.
- **Physical and Mental Health:** Young people have sufficient and affordable health insurance for both physical and mental health.
- **Legal Information and Documents:** Young people have the skills, information and assistance to access essential legal documents pertaining to their personal, family, medical and educational histories.

Tyrone, age 15

Tyrone had lived in a residential program for two years when he was referred to a youth permanency initiative. In his early years, he was raised in a multi-generational household. When his mother died and his grandparents were unable to continue raising him, an uncle stepped forward as a kinship caregiver. This placement disrupted within two years because of discord between Tyrone and his younger cousin. When the youth permanency worker explored his network of relationships, Tyrone revealed that a maternal aunt and her husband regularly visited with him at the program. Although they had expressed interest in him in the past, they were never formally explored for placement. Still, they continued their informal contact with him on weekends. Ultimately through a youth-centered teaming process Tyrone, his family members and professionals designed a permanent plan identifying his uncle and aunt as his permanent family. He moved in and a legal guardianship is in process.

THE PROMISE OF CHANGE

Despite the unprecedented number of older youth exiting the foster care system on their own, experience has taught us more about an integrated approach to youth permanency and preparation for adulthood than we have institutionalized. Over the past three decades, innovative youth permanency practices within the special needs adoption and intensive family preservation/reunification movements have resulted in successful reunification, adoption and guardianship outcomes for older youth in care. In recent years, additional innovative youth permanency practices have achieved increasing national visibility through expanded implementation and evaluation. These practices have facilitated family permanency outcomes for older youth in family foster care and congregate care who had previously “said no” to family, or who were thought to be “too old,” “too troubled” or “not ready” for a family (see *Model Programs* booklet cited in endnote).⁸

Equally, systematic and comprehensive efforts to prepare older youth in care for adulthood have long been championed by many foster care, independent living and adolescent service providers.



These professionals have been determined to raise the bar on stability for youth who had not only been historically subjected to multiple moves and relationship disruptions, but also chronically ill-prepared to face adulthood. In recent years, practices focused on preparing youth for adulthood have been further concretized, systematized, expanded and evaluated (see selected resources cited in endnote).⁹

Child welfare reforms of the 1980s and 1990s made significant attempts to prevent entry of children and youth into care, decrease time spent in out-of-home placement, increase adoptions and expand support to older youth in care through the legislated mandates found in the Adoption Assistance and Child Welfare Act of 1980, the Adoption and Safe Families Act of 1997 and the (Chafee) Foster Care Independence Act of 1999. Each of these pieces of legislation missed the opportunity to comprehensively define permanency, institutionalize and incentivize the full continuum of permanency outcomes *and* integrate the currently parallel tracks of services to youth in out-of-home care. This **Call to Action** holds the promise for change that blends the compartmentalized youth-serving system, and makes a commitment to achieve the best of both “permanency” and “preparation” for each and every youth in foster care.

GETTING TO THE HEART OF THE MATTER: INTEGRATING OUR WORK

Guiding Principles of Change

The following principles are essential to a holistic and integrated approach to serving youth in care:

- 1. Embrace sound definitions of permanency and preparation for adulthood and a comprehensive approach to integrated outcomes.**
 - An integrated and strategic approach to planning for permanency and preparation for adulthood must be guided by a sound understanding of both dimensions. It must begin at the point of system entry, remain continuous until system exit and change dynamically and strategically according to developmental age and need.
 - At its best, a permanent family relationship enriched by community-based supports serves as the foundation for comprehensive preparation for adulthood within a “real world” context.
- 2. Blend youth-related policies and practices in the process of integrating customized permanency outcomes and comprehensive preparation for adulthood.**
 - Strategic systems integration is essential. Elements must include funding streams, systemic policies, case practice guidelines and tools, as well as social work roles and functions that address youth “permanency” and “preparation for adulthood.”
 - The collective voice and active leadership of youth, parents and families is essential in guiding this systemic process of integration.
- 3. Be youth-centered, family-focused and collaborative in customized planning and decision-making.**
 - An integrated and customized planning process must be guided by a comprehensive assessment of each youth’s individualized need for safety, permanency and well-being. It must include proactive and strategic casework that shares thorough information about the options for both permanency and preparation for adulthood:
 - exploring youth’s feelings and fears about family relationships and hopes for the future,
 - honoring a youth’s wishes,
 - giving youth support in moving forward, and
 - providing clarification of systemic procedures (court hearings, planning meetings, agency documents, etc.).
 - An integrated and customized planning process for each youth must include participation by the youth, parents, family members, other significant adults and professionals who have a commitment and contribution to a successful outcome.
- 4. Insure comprehensive, continuous, customized and collaborative services for youth and families.**
 - Provide and/or promote a customized service array that will support secure family permanency and comprehensive preparation for adulthood regardless of whether a youth’s goal is reunification, adoption, guardianship,



alternate planned permanent living arrangement or independent living.

- Assure that developmentally appropriate, holistic and individualized *youth-centered*, *family-focused* and *community-based* services are available and accessible (both prior to and after achieving a permanency outcome) to:
 - maximize the success of a youth's integrated plan for permanency and preparation for adulthood, and
 - strengthen the capacity of parents, family members and significant adults to sustain permanent family commitments to youth over time and expand their role in preparing youth for adulthood.
5. Promote a vision of shared responsibility for change.
- Raise public awareness, collective understanding of and community support for responding to a youth's comprehensive needs for family permanency and preparation for adulthood.
 - Engage strategic community partners with potential to provide opportunities for expanded youth involvement, engagement, development and leadership within the community.

PRACTICE APPROACH TO CHANGE

Lessons learned from innovative youth permanency and preparation for adulthood initiatives have shown that the use of collaborative team planning and decision-making provides a powerful practice tool to integrate outcomes in permanency and preparation for adulthood. There are several critical dimensions of such an inclusive process.¹⁰

1. Partner with youth as the central player in their own integrated planning process, engaging them in identifying essential team members that include:

- parent(s), family members and other adults significant in a youth's life, both past and present (including birth, foster, respite and adoptive parents; siblings; grandparents and other relatives; godparents; family friends; teachers; coaches; mentors; neighbors; former social workers or child care staff, etc.);

- adults in the process of being recruited and prepared as potential permanent parent(s), if any;
- child welfare staff and other professionals in a position of decision-making power (social workers, attorneys, residential staff, therapists, etc.);
- professionals or individuals from the local community able to assist in or provide expanded opportunities or resources.

2. Include parents, family members, caregivers, significant adults, professionals and community members in the team process for what they can contribute, rather than excluding them for what they *cannot* contribute.

- Even when such individuals are not interested in or appropriate for placement of the youth, their participation in *planning* is important.

3. Explore each adult's level of commitment to a youth over time:

- as a permanent parent, permanent extended family member or "lifelong connection"; or
- as a time-limited resource and support.

4. Engage youth in a collaborative casework process that prepares them to actively and meaningfully participate in team planning:

- by providing full information about permanency options, engaging in strategic "permanency conversations" and thoroughly processing the pros and cons of permanency decisions;
- by providing full information about the dimensions of comprehensive preparation for adulthood and a realistic understanding of the resources, relationships, supports and skills that will maximize success;
- by empowering them to build and sustain mutually satisfying relationships with the adults on their planning team (parent[s], family members, other significant adults and/or professional connections).

5. Develop a youth-centered, family-focused integrated plan that addresses the following critical dimensions:

- **Safety:** how physical safety and psychological safety will be achieved and sustained over



time, and how and when a safety plan will be developed and implemented;

- **Permanence:** how the most secure and lasting commitment by a permanent parent will be achieved and sustained over time; how enduring connections to birth parents, siblings, extended family members, other significant adults, race, ethnicity, culture, religion and language will be achieved and sustained over time;
- **Well-being:** how optimal outcomes related to health, mental health, education, vocation, employment/career, housing, identity, life skills and community engagement will be achieved and sustained over time.

6. Facilitate an ongoing collaborative team planning process to:

- insure a safe and secure family permanency outcome and monitor progress toward comprehensive preparation for adulthood;
- enhance the network of formal and informal post-permanency supports and services necessary beyond exit from the system; and
- strengthen relationships among team members functioning as the “safety net” of adults committed to supporting a youth into adulthood.

Annie, age 20

Four years ago, Annie was referred to a youth permanency initiative and matched with two families that were willing to make a commitment to be “connected for life.” Beth and her husband have two daughters older than Annie; Savannah and her partner have two daughters younger than Annie. Annie proudly says she’s the middle child in her family. Over time, Annie has come to identify Beth more as “mom” and Savannah more as a “special friend.” She will officially join Beth’s family in an upcoming commitment ceremony, including a legal name change. Savannah and her family will celebrate with them. Annie lives in an adult group home, where she works part-time as a receptionist. Her passion is Shakespeare, whom she quoted when asked her feelings about permanent families for older teens: “. . . tis the stuff that dreams are made of.”

GETTING ON WITH IT: KNOWING WE’RE MAKING A DIFFERENCE

Indicators of Change

In a child welfare system that prioritizes an integrated approach to achieving family permanency and comprehensive preparation for adulthood for all youth in care, the following results will be visible.

Youth will:

- Have the family-focused and community-based opportunities, resources, skills and supports to sustain lifelong family relationships (that offer a sense of belonging, emotional support, full legal and social status, and connection to race, ethnicity, culture, religion and language) and achieve comprehensive preparation for adulthood;
- Have access to full information regarding personal, family, medical and educational histories and legal documents required to obtain essential benefits and privileges;
- Be actively engaged in individual planning and become increasingly responsible in decision-making;
- Be prepared for and supported in providing leadership for system change;
- Be educated and ready to learn;
- Be employed and ready for career;
- Be embraced by family and ready for relationships;
- Be connected with significant adults, peers, and services;
- Be housed safely;
- Be healthy and well;
- Be hopeful, confident and ready to navigate life.¹¹

Parent(s), family members and other significant adults in a youth’s life will:

- Understand a youth’s comprehensive and individualized needs for “permanency” and “preparation for adulthood,” be actively engaged in meeting those needs and supported in making a lasting or lifelong commitment;
- Be meaningfully included in joint planning and decision-making with youth and professionals, as well as in collective leadership for system change.



The system will:

- Act with urgency to assure a safe, secure and legally permanent family as early in life as possible, as well as comprehensive and continuous preparation for adulthood for each youth in care;
- Engage and support families as the primary vehicle to preparing youth for adulthood;
- Strategically blend funding, policy and practice in achieving optimal integrated outcomes for youth related to safety, family permanency and well-being (health, mental health, education, employment, housing, identity, life skills and community engagement).
- Prioritize consumer participation and empower youth, parent(s) and family members to provide leadership in decision-making, implementation and evaluation;
- Assure *all* youth equal, adequate and accessible family-focused and community-based post-permanency resources and supports (regardless of whether they exit the system to reunification, adoption, legal guardianship, an alternative planned permanent living arrangement or independent living);
- Seek out and support strategic public, private, corporate and community partnerships and resources that enhance opportunities and promote successful outcomes for youth.

Malik, age 16

Malik has lived in an adolescent shelter for the past two years and is participating in an innovative youth permanency initiative. He recently identified a mentor, his friend's father and a shelter care staff person to be part of his youth-centered permanency team. He is considering inviting his adoptive parents to join, even though they went through adoption "dissolution" some time ago. A single parent was recently identified as a possible permanent family for Malik. She could only consider making a commitment if weekend respite were provided. Malik has already been spending alternate weekends with his mentor and his friend's family. They agreed, during the team process, that these weekend "respite" visits would continue no matter where he lived. As a result of the team meetings, the mentor also

agreed to transport and supervise sibling visits with Malik and his brother. The friend's father is also assisting Malik with career exploration and applying for a part-time job.

CONCLUSION

Consider how far we have come. And consider how much further we can go. We can not change the past, but we can shape the future. "Aging out" is preventable; permanency is achievable. "Lack of preparation for adulthood" is avoidable; a comprehensive approach is essential. "Compartmentalization of services to youth" is correctable; an integrated system design, blended funding streams, synchronized policies, strategic case practice, meaningful consumer involvement and collaborative planning are critical.

Consider this the only *call to action* we need. And remember the wisdom of Jim Casey, the founder of United Parcel Service and the Annie E. Casey Foundation: "*Determined people working together can do anything.*"

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- 10 Adapted from *Family Consultation Team* training materials, Massachusetts Families for Kids program at Children's Services of Roxbury (csrox.org).
- 11 Casey Life Skills Tools (caseylifeskills.org) and Casey Family Programs, "It's My Life: Integrated Transition Practice Framework" (casey.org). Casey Family Services. "The Road to Adulthood: A Summary of Life Skills Activities." October 2004. Frey, Lauren. *Merging Permanency and Independent Living: Lifelong Family Relationships and Life Skills for Older Youth*. NRCYD Update. National Resource Center for Youth Development. Summer 2004 (nrcys.ou.edu). Jim Casey Youth Opportunities Initiative, Inc. *Logic Model* (jimcaseyyouth.org). New Ways to Work, *Youth Transition Action Teams Operational Functions Framework*, September 2004 Draft (nww.org). *Framework and Measures for Permanence for Young People*. National Resource Center for Foster Care and Permanency Planning at the Hunter College School of Social Work and Casey Family Services/The Casey Center for Effective Child Welfare Practice. August 2004 (hunter.cuny.edu/socwork/nrcfcp).

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Siblings in Out-of-Home Care Fact Sheet

The literature on siblings in out-of-home care extends back to the early 1980s and tends to repeat a few major themes. This fact sheet presents a very brief summary of some of the information frequently discussed.

Reasons often given for separating siblings:

- one or more of the children have special needs
- sibling conflict/rivalry
- shared acts of disobedience
- siblings reinforce behavioral problems used as coping mechanisms in an abusive home
- can't find homes willing to take groups
- more expensive (e.g., subsidies)
- workers don't know children have siblings, or cannot locate them
- hard to coordinate when children have different workers
- assumption that it's easier to place individual children for adoption
- parentified child loses his/her own childhood
- when one child assumes parental responsibility, development of all the children suffers
- searching for a home to take the whole group delays permanency for each child

Reasons cited for keeping siblings together:

- attachment to and connectedness with family members
- placement together minimizes the trauma of parental separation
- preference of children
- siblings provide emotional support to each other, boost self-esteem
- being with a caring sibling protects against further loss during trauma

- children from dysfunctional homes may have stronger ties to their siblings than to their parents
- visits with birth parents are easier to arrange when the case plan is reunification
- child with special needs may benefit from being part of a family, rather than the sole focus of the caregiver's attention
- removing an abusive sibling does not stop the behavior, it only changes the identity of the victim; all siblings may benefit from therapy and staying together

Negative effects of separation:

- greater risk of emotional disturbance and school problems
- separation teaches children to walk away from problems rather than resolve them
- separation teaches children that family relationships are not important
- loss of caregiving by older sibling negatively affects both children
- removing a sibling from a placement for behavioral problems reduces trust and leads others to believe they may be removed, too

When siblings might/should be placed separately:

- safety
 - unresolved incest
 - sibling violence
 - sibling emotional abuse
- serious medical problems of one sibling
- it would entail removing one or more children from a placement in which they have formed attachments with adults
- already disrupted joint placement
- children request it



- large age difference
- children don't recognize the sibling link

Some of the literature implies that the issue of siblings is not important when placing infants, on the assumption that the infant has no relationship with or memory of the older sibling. However, the child's knowledge that a sibling exists who was never known can lead to a search for that sibling, similar to the search for birth parents who were never known. The individual still feels a need to be connected with the sibling.

Suggested casework practices:

- introduce children into a family in staggered placements
- use life books
- assess resource parents for large groups looking for: administrative skills, coping skills, access to community services, existence of support systems, experience with living in large family, willingness to value sibling ties
- present sibling groups together in photolistings, recruitment campaigns
- sibling communication and visitation when in separate placements

- place children in homes in the same neighborhoods and schools
- when placement is separate, have older children participate in planning for younger ones
- assign one worker to all siblings
- joint therapy sessions
- shared vacations, respite care

Much of the legal literature deals with cases in which siblings have been separated and are seeking to be either reunited in placement or granted visitation rights. The siblings' rights of association are weighed against the competing rights of biological, foster, or adoptive families, and their attachment to one another is only one of several issues considered in determining the "best interest" of the child.

Decision-making in sibling placement:

- consider every case on its own merits
- assess the strength of the siblings' ties
- consider the lifelong nature of the sibling bond
- give the child a say
- seek opinions from caregivers, therapists, teachers, medical professionals

From the National Leadership Symposium on Siblings in Out-of-Home Care. © 2003 Casey Family Programs. Reprinted with permission from Casey Family Programs.



Children's Educational & Psychological Issues

Learning Disabilities

Inability to acquire, retain, or broadly use specific skills or information, resulting from deficiencies in attention, memory, or reasoning, and affecting academic performance.

WHAT CAUSES LEARNING DISABILITIES (LD)?

No single cause accounts for the many types of learning disabilities that exist. However, the basis of all learning disabilities is believed to be abnormal brain function. An estimated three to fifteen percent of school children in the United States may need special educational services to compensate for learning disabilities. Boys with learning disabilities outnumber girls five to one. Children with learning disabilities are typically of average to above-average intelligence; they simply process information differently.

WHAT ARE THE SYMPTOMS OF LEARNING DISABILITIES?

A child suffering from a learning disability may:

- Have problems coordinating vision with movement
- Be clumsy at physical tasks (cutting, coloring, buttoning, tying shoes, running)
- Have problems with visual perception
- Have problems with phonologic processing (recognizing sequences or patterns and distinguishing among sounds)
- Have problems with memory, speech, reasoning, and listening
- Have problems with reading, arithmetic, or writing (most learning disabilities are complex, with deficiencies in more than one area)
- Be slow to learn the names of colors or letters, to assign words to familiar objects, to count, and to progress in other early learning skills

- Exhibit delayed learning to read and write
- Have a short attention span and memory span
- Have difficulty with printing and copying (activities that require fine motor coordination)
- Have difficulty communicating and controlling impulses
- Have discipline problems
- Be easily distracted, hyperactive, withdrawn, shy, or aggressive

EARLY INDICATORS OF LEARNING DISABILITIES

Following is a list of early indicators of learning disabilities. Keep in mind that the earlier a child is diagnosed, the better his/her chances are to enjoy and succeed in school and life!

EARLY WARNING SIGNS

Pre-School

- Late talking
- Slow vocabulary growth
- Inability to find the right word
- Trouble learning numbers, alphabet, days of the week
- Extreme restlessness
- Poor ability to follow directions
- Trouble interacting with peers

Grades K-4

- Slow to learn connections between letters and sounds
- Confusion of basic words (*run, eat, want*)
- Consistent reading and spelling errors, including letter reversal (b/d)
- Transposition of number sequences and confusion of arithmetic signs
- Slow recall of facts
- Slow to learn new skills, relies heavily on memorization
- Impulsiveness, lack of planning
- Unstable pencil grip
- Trouble learning about time



HOW IS A LEARNING DISABILITY DIAGNOSED & TREATED?

A doctor examines the child for any physical disorders. The child then takes a series of intelligence tests, both verbal and nonverbal, including testing for reading, writing, and arithmetic skills. Psychological testing is the final step of evaluation. No drug treatment has much effect on academic achievement, intelligence, and general learning ability. However, certain drugs, such as methylphenidate, may improve attention and concentration. The most useful treatment for a learning disability is an education that is carefully tailored to the individual child.

Reactive Attachment Disorder

Difficulty forming loving, lasting, intimate relationships, due to a failure to attach, to bond, or to trust a primary caregiver during the first two years of life.

Some children with extreme attachment issues develop reactive attachment disorder (RAD). It is thought that only a small percentage of maltreated infants will be diagnosed with this disorder. Many children who have been abused or neglected have less severe attachment issues that may still impair their ability to form healthy relationships.

WHAT CAUSES RAD?

Many factors can contribute to the lack of healthy attachments. Parental problems such as substance abuse, immaturity, or a mental health issue can impede attachment. A young child who has been moved many times in foster care or who does not have frequent, regular visitation may also have attachment problems.

Any of the following factors, especially occurring during the first two years of life, puts a child at high risk of developing an attachment disorder:

- Maternal drug and/or alcohol use during pregnancy
- Premature birth
- Abuse (physical, emotional, sexual)
- Neglect

- Sudden separation from primary caregiver (illness or death of primary caregiver; chronic illness or hospitalization of child; out-of-home placement)
- Undiagnosed and/or painful illness (colic, chronic ear infections)
- Frequent moves or placements
- Inconsistent or inadequate daycare
- Chronic maternal depression
- Immature parents with poor parenting skills
- Drug-addicted infant

WHAT ARE THE WARNING SIGNS OF RAD?

Although the following behaviors may be seen in many children, a child developing difficulties in attachment will display many of them:

- Manipulative, superficially engaging, or charming
- Abnormal eye contact
- Indiscriminately affectionate with strangers or lacking ability to give and receive affection
- Not cuddly with parents or inappropriately demanding or clingy
- Extreme control battles often manifest in covert or “sneaky” ways
- Destructive to self, others, material things
- Cruel to animals, siblings
- Accident prone
- Engages in stealing, lying
- Hoarding or gorging food, abnormal eating patterns
- Preoccupation with fire, blood, gore
- Lack of impulse control and cause-and-effect thinking (frequently acts hyperactive)
- Developmentally behind, even in favorable environments
- Learning lags and speech disorders, abnormal speech patterns
- Lack of conscience
- Crazy, chronic, obvious lying
- Poor peer relationships



- Persistent nonsense questions and incessant chatter

Adapted from “Children at Risk for Reactive Attachment Disorder: Assessment, Diagnosis and Treatment,” Keith Reber, *Progress: Family Systems Research and Therapy*, 1996, Volume 5 (pp. 83–98). Encino, CA: Phillips Graduate Institute.

Attention-Deficit/ Hyperactivity Disorder

Excessive, long-term, and pervasive behaviors, including distractibility (poor sustained attention to tasks), impulsivity (impaired impulse control and delay of gratification), or hyperactivity (excessive activity and physical restlessness).

WHAT CAUSES ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER (AD/HD)?

AD/HD is not caused by poor parenting, family problems, poor teachers or schools, too much TV, food allergies, or excess sugar. AD/HD is very likely caused by biological factors that influence neurotransmitter activity in certain parts of the brain and have a strong genetic basis. Approximately four to six percent of the U.S. population has AD/HD; however, if one person in a family is diagnosed with AD/HD, there is a twenty-five to thirty-five percent probability that another family member also has AD/HD. This disorder is more common in boys than girls.

WHAT ARE THE SIGNS OF AD/HD?

The American Psychiatric Association’s *Diagnostic and Statistical Manual* recently renamed the disorders formerly known as ADD and ADHD to be AD/HD.

AD/HD includes three subtypes:

1. A predominantly inattentive subtype (formerly ADD). Signs include:
 - Easily distracted by irrelevant sights and sounds
 - Failing to pay attention to details and making careless mistakes
 - Rarely following instructions carefully and completely
2. A predominantly hyperactive-impulsive subtype (formerly ADHD). Signs include:
 - Losing or forgetting things like toys, pencils, books, and tools needed for a task
 - Feeling restless
 - Fidgeting and squirming
 - Running, climbing, leaving a seat in situations where sitting or quiet behavior is expected
 - Blurting out answers before hearing the entire question
 - Having difficulty waiting in line or for a turn
3. A combined subtype, which is the most common of the three.

AD/HD refers to all types of attention-deficit disorders, both with and without hyperactivity. To be considered for a diagnosis of AD/HD, these behaviors must appear before age seven and last for at least six months. The level of disturbance must occur more frequently and in a more severely pronounced manner than among other children in the same age group. And above all, these behaviors must create a real handicap in at least two areas of a child’s life, such as school, home, or a social setting.

WHAT TREATMENTS ARE AVAILABLE?

Clinical experience has shown that the most effective treatment for AD/HD is a combination of medication and therapy or counseling to learn coping skills and adaptive behaviors. The most well known treatments of AD/HD are psychostimulants, such as Ritalin and Dexedrine, and some antidepressants that affect the levels of dopamine, noradrenaline, and serotonin in the central nervous system. Taken in normal doses, stimulants can result in decreased appetite, stomachaches, agitation, irritability, and insomnia for some children. The long-term effects of taking these drugs are not yet known.

Medications can result in an improvement in core symptoms, such as impulsive behavior and inattention, as well as improved school and social performances. For that reason, treatment for AD/HD is more effective when regular use of drugs is combined with behavior treatment. Reward systems for appropriate behavior or performance, teaching parents child-management skills, and therapy that instructs parents and teachers in improved



contingency management skills can help most children. Children who regularly take their medication and practice behavior techniques routinely do better than those who rely on stimulants alone.

Currently, there is great controversy about the possible overdiagnosis—and overmedication—of children with AD/HD. Obtaining a second opinion is good practice.

WHEN SHOULD A PERSON SEEK HELP?

Since many children exhibit occasional inappropriate or hyperactive behaviors, widespread confusion has arisen about the diagnosis and treatment of AD/HD. Due to those uncertainties, parents and guardians should not attempt to diagnose their children. Children who are responding to stressful family situations, are bored in the classroom, or are passing through certain stages of development may appear inattentive, hyperactive, or impulsive—yet they do not have AD/HD.

To determine whether a child needs to be examined by a physician, psychologist, or other medical specialist, you should consider several critical questions:

- Are the child's troublesome behaviors excessive, long-term, and pervasive?
- Do they occur more often than in his/her peers?
- Are his/her behaviors a continuous problem and not just a response to a temporary situation?
- Do his/her behaviors occur in several settings, or only in one specific place, such as the playground or school?

You should talk to the child's teacher to get a clearer reading on the child's daily behaviors. You should also seek a consultation with a health professional to rule out other possible psychological problems, such as depression or a learning disorder.

Childhood Depression

A feeling of intense sadness beyond an appropriate length of time.

WHAT CAUSES CHILDHOOD DEPRESSION?

Children who develop major depression are likely to have a family history of the disorder, often a parent who experienced depression at an early age. Depression in children can be triggered by events or problems, such as being removed from their home, the death of a parent, a friend moving away, difficulty in adjusting to school, difficulty making friends, or drug or alcohol abuse. However, some children become depressed without profoundly unhappy experiences.

WHAT ARE THE SYMPTOMS OF CHILDHOOD DEPRESSION?

The defining features of depression in children are the same as they are for adults. However, recognition and diagnosis of the disorder are more difficult in youth because expression of the symptoms varies with youth's developmental stage, and children may have difficulty properly identifying and describing their internal emotional or mood states. Therefore, symptoms of depression may manifest in children as the following:

- Frequent vague, nonspecific physical complaints, such as headaches, muscle aches, stomachaches, or tiredness
- Frequent absences from school or poor performance in school
- Talk of or efforts to run away from home
- Outbursts of shouting, complaining, unexplained irritability, or crying
- Being bored
- Lack of interest in playing with friends
- Change in sleep patterns
- Among older youth, alcohol or substance abuse
- Social isolation, poor communication
- Fear of death
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility



- Reckless behavior
- Aggression, refusal to cooperate, antisocial behavior
- Difficulty with relationships
- Suicidal thoughts

Five or more of these symptoms must persist for two or more weeks before diagnosis of depression is indicated.

WHAT TREATMENTS ARE AVAILABLE?

Treatment often combines short-term psychotherapy, medication, and targeted interventions involving the home or school environment. In order to prevent the recurrence of depression, it is recommended that treatment be continued for at least six months after the remission of symptoms.

WHAT TO DO AS A CASA/GAL VOLUNTEER

If these characteristics are present in a child with whom you are working, request that an assessment be completed by a qualified mental health professional who can diagnose and treat childhood depression. The local child protection agency will need to make the referral for this assessment.

Conduct Disorder

A repetitive and persistent pattern of behavior in which children or adolescents violate the rights of others or violate norms and rules appropriate to their age.

WHAT CAUSES CONDUCT DISORDER?

Researchers have not yet discovered what causes conduct disorders, but they continue to investigate several psychological, sociological, and biological theories. Psychological and psychoanalytical theories suggest that aggressive, antisocial behavior is a defense against anxiety, an attempt to recapture the mother-infant relationship, the result of maternal deprivation, or a failure to internalize controls. Sociological theories suggest that conduct disorders result from a child's attempt to cope with a hostile environment, to get material goods that come with living in an affluent society, or to gain social status among friends. Other sociologists say inconsistent

parenting contributes to the development of the disorders. Finally, biological theories point to a number of studies that indicate children could inherit a vulnerability to the disorders. Children of criminal or antisocial parents tend to develop the same problem. Other biologists believe that male hormones or problems in the central nervous system could contribute to the erratic and antisocial behavior. None of these theories can fully explain why conduct disorders develop. Most likely, an inherited predisposition and environmental and parenting influences all play a part in the illness.

WHAT ARE THE SIGNS OF CONDUCT DISORDER?

Children who have demonstrated at least three of the following behaviors over six months should be evaluated for possible conduct disorder:

- Steals, without confrontation (e.g., forgery) and/or by using physical force (e.g., muggings, armed robbery, purse-snatching, or extortion)
- Consistently lies (other than to avoid physical or sexual abuse)
- Deliberately sets fires
- Is often truant from school or absent from work
- Has broken into someone's home, office, or car
- Deliberately destroys the property of others
- Has been physically cruel to animals and/or to humans
- Has forced someone into sexual activity with him/her
- Has used a weapon in more than one fight
- Often starts fights

WHAT TREATMENTS ARE AVAILABLE?

Treatments, including behavior therapy and psychotherapy (either individual or group sessions), are aimed at helping young people realize and understand the effect their behavior has on others. Some children also suffer from depression or attention-deficit/hyperactivity disorder; use of medications as well as psychotherapy has helped lessen their symptoms of conduct disorder. Moralizing and threatening do not work. Often the most successful



treatment is to separate the child from a damaging environment and to administer strict discipline.

Post-Traumatic Stress Disorder

Re-experiencing a very distressing event that has overwhelmed a child's coping mechanism and has created intense feelings of fear and helplessness.

WHAT CAUSES POST-TRAUMATIC STRESS DISORDER (PTSD)?

A child who experiences a catastrophic event may develop PTSD. A stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred, such as experiencing or witnessing one of the following:

- Physical or sexual assault or abuse
- Family and community violence
- Severe accidents
- Life-threatening illnesses
- Natural disasters (flood, fire, earthquakes)

A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s).

WHAT ARE THE SIGNS OF PTSD?

PTSD affects how a child feels and acts. Signs of stress may include the following:

1. A child may re-experience the trauma by:
 - Talking about the trauma over and over again
 - Including trauma-related events in play
 - Dreaming about the trauma
 - Feeling like the trauma is happening all over again
 - Becoming very distressed when reminded of the trauma

2. A child might withdraw from the trauma experience by:
 - Avoiding thoughts or feelings about the trauma
 - Avoiding activities associated with the trauma
 - Forgetting parts of the trauma
 - Losing skills such as toilet training or language skills
 - Wanting to be alone more than usual
 - Becoming less affectionate toward others
 - Feeling like there is nothing to look forward to in the future
3. A child may experience restlessness and agitation, such as:
 - Having difficulty falling asleep or staying asleep
 - Becoming easily angered, irritable, or jumpy
 - Having concentration problems
 - Expressing fear (fear of being left alone or sleeping alone)
 - Becoming overly watchful and easily startled
 - Reporting physical complaints when reminded of the trauma

WHAT TREATMENTS ARE AVAILABLE?

Treatment of PTSD in children generally involves "talking therapies" (such as cognitive behavioral therapy, family therapy, or brief psychotherapy) and may include the prescription of medication by a psychiatrist.

WHAT TO DO AS A CASA/GAL VOLUNTEER

As with any other childhood disorder, it is critical to have a competent professional assess the child. Post-traumatic stress disorder is sometimes misdiagnosed attention-deficit/hyperactivity disorder. The more relevant information you can gather, the more likely you are to understand the needs of the child and to make appropriate recommendations to the court.



Fetal Alcohol Spectrum Disorder

A combination of particular facial features, growth deficiency, and central nervous system damage resulting from alcohol exposure during pregnancy.

WHAT CAUSES FETAL ALCOHOL SPECTRUM DISORDERS (FASD)?

A fetus exposed to any amount of alcohol may suffer from fetal alcohol spectrum disorder. Alcohol causes structural and functional damage to the central nervous system, which consists of the brain and spinal cord. FASD describes a range of clinical conditions associated with prenatal alcohol exposure, including 1) fetal alcohol syndrome (FAS) with full distinctive facial features, 2) alcohol related neurodevelopmental disorder (ARND) with some distinctive facial features, and 3) ARND with few or no distinctive facial features. The risk of severe birth defects increases with the amount of alcohol consumption. However, even small amounts of alcohol can be harmful; therefore, women are recommended to avoid alcohol during the entire pregnancy.

WHAT ARE THE SYMPTOMS OF FASD?

The effects of prenatal alcohol exposure include but are not limited to the following:

- Poor sucking ability
- Poor sleeping habits
- Unusually small body, head, eyes, or jaw
- Cleft palate
- Heart defects
- Hip dislocation and other joint deformities
- Mental retardation
- Learning disabilities
- Speech and language difficulties
- Hyperactivity
- Inappropriate emotional responses
- Problems with fine and gross motor skills
- Memory deficit or “quirky memory”

- Inability to generalize from one situation to another
- Easily stimulated or distracted
- Difficulty with cause and effect
- Seeming lack of remorse
- Lack of boundaries
- Overly affectionate
- Hyper-/undersensitivity to touch, sound, light, and textures
- Hygiene problems

ALCOHOL RELATED NEURODEVELOPMENTAL DISORDER (ARND)

A child with an alcohol related neurodevelopmental disorder (ARND) other than fetal alcohol syndrome (FAS) does not have the facial deformities of FAS, but the child’s central nervous system damage, resulting from alcohol exposure during pregnancy, may be as severe as that of a child with FAS. Children with ARND who lack the facial deformities of FAS often have their noncompliant, disorganized, or hyperactive behavior misinterpreted as willful misconduct, attention-seeking behavior, or plain laziness. Because these children have no physical indication of neurological damage from alcohol, they are often punished instead of helped to overcome behaviors associated with the disorder. Often these behaviors decrease with the proper support.

WHAT TREATMENTS ARE AVAILABLE?

There is no cure for FASD. However, supports can be put in place to address the many effects of prenatal alcohol exposure. These may include speech/language therapy, occupational therapy, medical and dental care, an Individualized Education Plan (IEP) or 504 plan, and parent and teacher training in strategies for working with children with FASD.



Special Education Services

THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

What Is the Individuals with Disabilities Education Act (IDEA)?

The **Individuals with Disabilities Education Act (IDEA)**, a federal law originally passed in 1975 as PL 94-142 and amended in 1984, 1990, 1997, and 2004, mandates that all eligible children receive a free, appropriate public education regardless of the level or severity of their disability. It provides funds to assist states in the education of students with disabilities and requires that states make sure that these students receive an individualized education program based on their unique needs in the least restrictive environment. IDEA also provides guidelines for determining what related services are necessary and outlines a “due process” and “procedural safeguards” to make sure needed services are provided.

Who Is Eligible for Services Under IDEA?

Children, from birth through age twenty-one, who need early intervention and/or special education and related services because of a disabling condition are eligible. Eligibility for services is determined through “nondiscriminatory evaluation.” This requires that Early Intervention Providers and school districts use testing materials free from racial or cultural discrimination and presented in the child’s native language or means of communicating. Tests must be chosen that assess the child’s actual abilities if sensory, motor, language, or other impairments are present. Evaluations cannot be based solely on one general test, such as an intelligence test, and the child is to be assessed across all areas related to the disability by a “multidisciplinary team” or “IEP team.”

An appropriate education may include an out-of-district or private school placement if the school district cannot provide appropriate services in the district. The courts have also ruled, however, that an “appropriate” education is not always the same as the “best” education as long as the education services adequately meet the child’s needs.

What Is an IEP?

After a child aged three or older is diagnosed with special learning needs, you may hear the term “Individualized Education Program” (IEP). This is a written, legal document that describes the specialized educational plan and related services to be provided to the student. It guides both teachers and parents in the appropriate education of the child for a period of one year (except in states piloting multi-year IEPs). It is developed in a team meeting in which all members of the IEP team decide what an appropriate education is for the child and identify goals, objectives, description of how progress will be measured, and necessary services.

If a child is in the custody of the local child protection agency, the IEP team will likely include teachers, caseworkers, parents, foster parents, and others who interact with the child. The child must be assigned an education surrogate/surrogate parent—a trained community member who advocates for appropriate educational services for the child. The surrogate parent gives permission for testing and for services to meet the needs of the child. Some counties have a list of people who are qualified to assume the role of the surrogate parent, and with training, foster parents or CASA/GAL volunteers may be permitted to assume this role.

What Is an IFSP?

An Individualized Family Service Plan (IFSP) documents and guides the early intervention process for children birth to age three with disabilities and their families. At the discretion of the state education agency (SEA) and the local education agency (LEA), children may utilize an IFSP through age five. The IFSP is the vehicle through which effective early intervention is implemented in accordance with Part C of the Individuals with Disabilities Education Act (IDEA). It contains information about the services necessary to facilitate a child’s development and enhance the family’s capacity to facilitate the child’s development. Through the IFSP process, family



members and service providers work as a team to plan, implement, and evaluate services tailored to the family's unique concerns, priorities, and resources.

What Is the School's Responsibility in Developing an IEP?

The local education agency is responsible for:

- Contacting parents about the need for an IEP
- Setting a date, time, and location to meet that is convenient for everyone on the team, including the parent(s) or family member(s)
- Designating an official from the school district to be involved in and to conduct the meeting and ensure the team decisions are implemented
- Inviting all members of the IEP team
- Ensuring that the meeting is held, the IEP written, and placement decisions made
- Making sure that the IEP is reviewed at least annually and revised if necessary (except in states piloting multi-year IEPs)

What Is the Parent's Role in Developing the IEP/IFSP?

In IDEA, the term "parent" refers to the child's biological parent, a guardian, a person acting as the parent of a child (such as the grandparents), or a surrogate parent appointed if the child is a ward of the state or the parent is unavailable.

IDEA ensures that parents are equal partners in the IEP/IFSP process. School personnel, early intervention agencies, and parents must work toward the common goal of developing an effective IEP that addresses the academic, developmental, and functional needs of the child.

Parents should prepare for an IEP meeting by reviewing their child's past education records. IDEA ensures that parents are permitted to inspect and review records in a timely manner. Parents should also have in mind goals based on what they see as needed, and they may want to talk with their child's teacher before the meeting. The IEP should describe the student's educational goals, related services needed, and the school placement decision. If parents are dissatisfied with any aspect of the IEP and are unable to resolve the problem, they may request mediation and, if necessary, pursue due process hearing options guaranteed by the law. Parents may obtain assistance in preparing for and/or attending IEP meetings from the local chapter of organizations, such as the Arc or LDA, for parents of children who have a disability.

Many communities also have advocacy organizations specifically serving people with disabilities. Every state also has a protection and advocacy (P and A) agency.

Who Should Be Involved in IEP/IFSP Meetings?

The IEP/IFSP team is composed of:

- A person from the school district (for IEPs) or early intervention agency service provider (for IFSPs), other than the student's teacher, who is qualified in special education or special education supervision
- A special education teacher or, where appropriate, a special education provider
- A regular education teacher (if the child is, or may be, participating in the regular education environment)
- One or both of the student's parents, family members, or guardians
- The student, when appropriate
- Someone qualified to interpret the instructional implications of evaluation (this may be one of the school personnel above)
- Other people who are involved in the education of the student as identified by the school, the early intervention agency, or the parent

A meeting may be held without a parent attending if the parent is unable or unwilling to do so. The district must, however, invite the parents and document its attempts to set a time and place where all persons can attend. Other members may be absent or excused with written parental agreement and consent in certain situations.

What Is Included in an IEP?

IDEA requires that the following items be included in the IEP:

- A statement of the student's present levels of educational performance
- A statement of measurable goals including academic and functional goals
- A statement of the special education and related services and supplementary aids and services that will be provided to the student as well as how much the student will participate in regular educational programs
- The dates these services will begin and how long they will last



- For each student age sixteen and over, transition services that will be provided

What Is Included in an IFSP?

According to IDEA, the IFSP shall be in writing and contain statements of:

- The child's present levels of physical development, cognitive development, communication development, social or emotional development, and adaptive development
- The family's resources, priorities, and concerns relating to enhancing the development of the child with a disability
- The major outcomes to be achieved for the child and the family; the criteria, procedures, and timelines used to determine progress; and necessary modifications or revisions of the outcomes or services
- Specific early intervention services necessary to meet the unique needs of the child and the family, including the frequency, intensity, and the method of delivery
- The natural environments in which services will be provided, including justification of the extent, if any, to which the services will not be provided in a natural environment
- The projected dates for initiation of services and their anticipated duration
- The name of the service provider who will be responsible for implementing the plan and coordinating with other agencies and persons
- Steps to support the child's transition to preschool or other appropriate services

How the IFSP Differs from the IEP

The IFSP differs from the IEP in several ways:

1. It revolves around the family, as it is the family that is the constant in a child's life.
2. It includes outcomes targeted for the family, as opposed to focusing only on the eligible child.
3. It includes the notion of natural environments, which encompass home or community settings such as parks, child care, and gym classes. This focus creates opportunities for learning interventions in everyday routines and activities, rather than only in formal, contrived environments.

4. It includes activities undertaken with multiple agencies beyond the scope of Part C. These are included to integrate all services into one plan.
5. It names a service coordinator to help the family during the development, implementation, and evaluation of the IFSP.

When Is It Appropriate for the Student to Participate?

Students need to participate in the IEP process as much as they can. Their opinions, preferences, and choices need to be part of the decision-making process. The chance to choose areas of instruction, based on their preferences, will help them develop skills that lead to independence and self-determination. There may be several factors that limit how much students participate, including their age and their ability to make adequate decisions. However, students can participate in some way in their IEP process.

What Is to Be Reviewed at IEP Meetings?

Each student's progress related to his/her Individualized Education Program must be reviewed yearly to determine current progress and future needs (except in states piloting multi-year IEPs). The review needs to consider the general progress of the student, staff and parental concerns about the student's progress, adherence to the measures described in the IEP, and what changes need to be made to meet the student's needs.

Changes may be made to the IEP after the initial or annual meeting by developing a written document to amend the IEP, if the LEA and the parent are in agreement to do so. IDEA requires that parents receive written notice whenever the district proposes or refuses to initiate or change anything related to the child's identification, evaluation, program, placement, or the provision of a free appropriate public education.

Additionally, parents and educators should ensure that goals are functional and chronologically age appropriate, and that they prepare students for adulthood.

What Is Meant by Placement in the Least Restrictive Educational Environment?

The decision to place a student with a disability in a particular education program must be based on the factors specified during the IEP process. This decision must be reviewed at least annually, and placement may change if the child's education program or needs change.



IDEA requires that students with disabilities be educated with students who do not have disabilities to the greatest extent appropriate. The law states that “unless a child’s individualized education program requires some other arrangement, the child is (to be) educated in the school which he/she would attend if not disabled.” It requires that removal of the child from the regular classroom occur only when education in regular classes “with the use of supplementary aids and services cannot be achieved satisfactorily.”

The Arc and other organizations interpret “least restrictive” as representing instruction in the regular classroom to the greatest extent possible or appropriate. Families need, through the IEP process, to ensure that adequate accommodation and support are provided before alternative placement is considered and that time spent outside of the regular classroom is based upon functional considerations such as community integration and instruction. The Arc is

opposed to student’s placement in segregated facilities, as they do not provide opportunities for learning from nondisabled role models, although the law and many other parents and professional organizations support a full continuum of placements being available.

Adapted from materials created by the Exceptional Children’s Assistance Center, 1998–1999, and the ERIC Clearinghouse on Disabilities and Gifted Education (ERIC EC) and the Council for Exceptional Children, 2000. Updated for the 2007 revision.



Mental Health Assessments for Infants & Toddlers

By Sherri L. Hill and JoAnne Solchany

INFANT MENTAL HEALTH . . . A CONTRADICTION IN TERMS?

It is often difficult to think about infants and young children dealing with mental health issues, so difficult in fact, that it is easily dismissed by some—seen as irrelevant or implausible. Can a four-month-old infant be depressed? How can an eight-month-old have an adjustment disorder? What could possibly suggest that a two-year-old might be dealing with post-traumatic stress?

We like to believe that infants and toddlers are immune from these issues, that parents can protect them, or that when their age is measured in months rather than years they will be inherently insulated and more resilient. Accepting that an infant might have mental health issues might be tolerated for the isolated case, but accepting the concept of *infant mental health* takes us into uncomfortable territory, which tends to challenge our understanding of infants and children in the world.

Infants and toddlers do experience mental health issues. They do experience stress and emotional pain in response to separations, witnessing violence, experiencing neglect, or being denied the stability of a primary caregiver. If we look at what infants see and try to see through their eyes, then the impact of those experiences becomes clearer. For example, infants cannot ask for help when feeling threatened or unsafe. They instead protect themselves by doing the only thing they can do, shut down or withdraw. If this becomes a pattern, it can quickly (within just a few days) develop into depression—often characterized by refusing food, crying incessantly, experiencing sleep disruptions, refusing to make eye contact, and “just giving up.” In fact, although infant depression was first identified over 60 years ago, it is still difficult for many of us to bear the thought that an infant can experience the helplessness, sadness, and emptiness seen in depression.

WHAT IS “INFANT MENTAL HEALTH”?

ZERO TO THREE: National Center for Infants, Toddlers and Families defines “infant mental health” as the *capacity of the child from birth to three to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn. Infant mental health is synonymous with healthy social and emotional development.* It is how the child fits into the world around them—attachment with their primary caregiver, relationships with important others, smooth developmental progress, the increasing ability to control behavior and express emotions, and the ability to explore and play.

Understanding infant mental health means understanding the world as experienced by the baby. For example, in a divorce situation the parents may be extremely stressed as they go through negotiations and court procedures. The young child may be especially vulnerable to the same stressors—the separations, moving, fewer resources—as well as the added stress of not being able to depend on parents in the usual way as one or both are so focused on the divorce. What is it like for a baby whose world has been mom and dad—having shared meals with them, and felt confident knowing they were both available in the safe haven called home—when suddenly it all falls apart? There are also those young children who fall into circumstances that put them at risk very early in life. What of the child of the addicted parent who is trying hard to do the right thing—staying clean and sober, maintaining adequate housing, and working—but is derailed by their addictions? This child does not see addictions or sobriety. This child sees mom or dad becoming unavailable to them.

Infant mental health assessments provide opportunities to see the world through the eyes of the child. They assess how the child is responding to their environment, how they are developing, what kinds of problems they may be experiencing, and how supportive their caregiving relationships are. They



allow us to explore what is going on with that baby and answer questions such as:

- How is this child being impacted?
- What might this mean for the future?
- Will this child be at risk?
- What is the baby's experience of the situation?
- Can that baby seek and find comfort with the available caregivers?
- Are current experiences impacting development and growth?
- What protective factors are in place for this child?

IN WHAT KINDS OF CASES ARE INFANT MENTAL HEALTH ASSESSMENTS USEFUL?

Separation from Primary Caregiver(s)

Any case which involves a young child possibly separating from a primary caregiver should, at minimum, involve a consult and may require both an infant mental health assessment as well as ongoing monitoring. Separations, even if temporary and done with the best of intentions, can bring about grief and mourning that without adequate support can lead to extreme sadness and withdrawal. These could include:

- divorce cases that are initiated in pregnancy or in a child's first three years of life,
- cases involving termination of parental rights,
- cases involving incarceration of a primary caregiver,
- cases wherein a caregiver enters residential rehabilitation.

Traumatic Events

An infant mental health consultation or assessment is recommended with any case involving exposure to domestic or community violence or other traumatic events. Babies can and do develop traumatic stress responses including re-experiencing of traumatic events. Contrary to popular belief, babies do remember—though not in the same ways that we think of remembering as adults. A variety of events, including hospitalization, may be experienced by the very young child as traumatic. However, no two children experience or respond to the same event, even a traumatic one, in the same way. Assessment

allows us to explore how an event has impacted an infant or toddler.

Outside Placements

Any dependency case involving the placement of an infant or toddler (0–3) outside the care of their primary attachment figure warrants an assessment. Removing a child from her home is a traumatic experience for that child, even if it is for excellent reasons. Infants and young children can and do attach to multiple caregivers, but they rely—physically and psychologically—on a primary attachment figure. Removing a child from his primary attachment figure equals plunging him into the unknown; it is scary and overwhelming even if the child already has, or can develop, a trusting and loving relationship with the alternate caregiver. Primary attachment figures are not interchangeable. Losing one during the early years means the young child will experience abandonment, even when it is in the best interests of the child. Assessment helps us consider how the experience of removal, and subsequent placement, impacts the child and what can be done to provide support through these changes.

Red Flag Behaviors

Assessments are also useful in cases where caregivers report seeing “red flags” around the child's development or behavior. For example, babies often show us they are distressed through their eating, sleeping, elimination, and with aggression in their relationships. It is common to see development become delayed or even go backwards with children who are experiencing mental health issues and no intervention. An assessment helps to identify how a child's experiences are impacting his overall developmental progress and well-being.

WHO TYPICALLY CONDUCTS THE ASSESSMENT? WHAT QUALIFICATIONS SHOULD THE EVALUATOR HAVE?

Infant Mental Health Training

The evaluator should have had specific training in *infant mental health, not just child development*. Training in infant mental health should be substantial, including focus on infant development, parent-child relationships, emotional functioning, pathology, diagnostics, assessment, and intervention. An increasing number of states have training programs and infant mental health centers such as our Center on Infant Mental Health and Development at the



University of Washington's School of Nursing. The mission of these programs is to provide education and clinical training on the unique needs and circumstances of the youngest of children. Because they cannot tell us their story, infants and young children can be one of the most challenging and difficult populations to understand and work with.

At a minimum, the person conducting or coordinating the assessment should be able to ensure there is a thorough assessment of the whole child. The assessment should not be limited to an assessment of the parents' skills or to whom the child seems "most attached." It is optimal to look *simultaneously* at what the caregiver(s) bring(s) to the setting AND what the baby brings to the setting, as well as how the child and caregiver work together in both calm and stressful times.

Experience with Infants/Toddlers

Infant mental health evaluators should have a background with substantial experience with infants and toddlers. Experience conducting evaluations on young children or families does not automatically equate to expertise with infants or toddlers. Assessing preverbal children requires training and experience in observing babies and an understanding of what capabilities an infant does and does not have to interpret the world. An infant mental health specialist cultivates his or her ability to see the world through the eyes of the infant. Babies' behaviors do not always mean what an untrained eye might initially guess. For example, babies are often more likely to show their distress and act out when they are in the presence of the caregiver with whom they feel the most secure. This can seem counterintuitive to those who have not worked with this young age group.

Skill in Evaluating and Diagnosing Young Children

Evaluators should also be familiar with the DC 0–3, *the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (1994, 2005)*. This is a diagnostic system specifically designed to evaluate and diagnose children from birth through age three. It frames mental health issues in the context of the development and relationships of the young child. A growing number of localities have accepted this diagnostic criterion to be used with infants and young children in addition to, or in place of, the DSM-IV-TR.

Varied Professional Backgrounds

The evaluator(s) themselves may come from a variety of disciplines—social workers, psychologists, nurses,

nurse practitioners, psychiatrists, occupational therapists, pediatricians, speech-language pathologists, or early intervention specialists. Infant mental health assessments are often conducted by teams. For example, the speech therapist may conduct a speech evaluation, an occupational therapist may evaluate the child's skills and abilities, and the psychiatric nurse practitioner or psychologist may evaluate the child's emotional, social, and family functioning. Collaborative skills are critical for an effective infant mental health assessment, and can be particularly helpful for the courts.

WHAT DOES AN INFANT MENTAL HEALTH ASSESSMENT TYPICALLY INCLUDE?

An infant mental health assessment should include evaluation of the child's:

- **primary attachment relationship**—How is this relationship constructed? How does the child experience this relationship? Can the child depend on this individual to provide for their needs?
- **significant relationships**—specifically those who provide any kind of care or regular interaction. Parent(s), grandparent(s), other relatives, foster parent(s), and child care providers may all fall into this group; as would any partners of caregivers who may regularly have a great deal of influence on that baby's environment and care. For foster children, if reunification remains an option or if the biological parent(s) have visitation, assessments of these relationships are also vital.
- **sensory capacity**—Can they tolerate touch? Do they become overwhelmed by too much noise? etc.
- **self-regulation**—the ability to self-soothe or calm themselves down when upset.
- **attainment of developmental milestones.**
- **ability to engage or connect with caregivers**—this includes eye contact, checking that a caregiver is near, and seeking out caregivers when hurt or frightened.
- **communication**—verbal and nonverbal.
- **demonstration of curiosity, ability to play, and cognitive development.**
- **social-emotional functioning**—Do they smile and show a range of emotion?
- **physical growth and development.**



While these areas should all be screened, some areas may require more in-depth assessment or evaluation.

It is important to recognize that *developmental assessments*, commonly done with young children, are *not the same as* a thorough infant mental health assessment. Routine developmental assessments for children entering foster care may review developmental milestones and general growth, yet not assess social-emotional development or relationships. An infant's fine and gross motor skills might be progressing well, but if they are not relating or connecting with the adults in their lives then their ability to learn is compromised, possibly leading to delays in cognitive or social-emotional development.

WHAT TOOLS ARE TYPICALLY USED WHEN CONDUCTING AN INFANT MENTAL HEALTH ASSESSMENT?

Multiple Observations in Different Contexts

Infants and toddlers cannot be effectively assessed in one meeting. In fact, most infant mental health assessments will involve several sessions (four to six sessions are recommended by ZERO TO THREE: National Center for Infants, Toddlers, and Families). These sessions need to include multiple contexts over time. Assessments should include at least one home visit, and should include visits to child care if applicable. Children need to be seen in their own environments, as this is where they should be the most comfortable. However, clinic or office visits may also be included to look at differences in behaviors and interactions in an unfamiliar setting.

Adult Questionnaires

Measures or questionnaires completed by adults may be included in assessments; however, caution must be used when applying these to the assessment of an infant or young child. They should never be the sole source of information. Parents and other adults see children through their own interactions and experiences which can lead to biased or inaccurate information.

Ongoing Monitoring and Updates

Infants and toddlers develop and change rapidly—a day can be the difference between crawling and walking. Assessments may need to be updated within as few as four to six months. Weekly or monthly monitoring may also be required, depending on the situation. For example, significant changes in the

caregiving environment (divorce finalized, changes to visitation, parent being released from treatment or custody, change in foster home, etc.) often necessitate a more in-depth reassessment. An outline of planned updates and recommendations for future age-specific assessments should be provided.

Screening Tools

Infant mental health assessments may also include certain instruments or screening tools such as a sensory checklist or a developmental assessment. For example, children who have not been touched or held much often develop difficulties tolerating touch. While most babies will grasp your finger when you place it in their palm, babies with such difficulties withdraw from your touch. Sensory checklists also help identify other issues such as lack of eye contact, inability to tolerate water or clothing on skin, or difficulties tolerating being cuddled. A developmental assessment would identify developmental delays in cognitive areas. These may be helpful but, again, should never be the only source of information. Infant mental health assessments rely much more heavily on observations and interactions. It is important to note that these assessments and subsequent treatments may be covered by health insurance.

WHAT INFORMATION SHOULD ASSESSMENTS PROVIDE CHILD ADVOCATES & THE COURT?

Behaviors, Competencies, Problems

Ideally an assessment will tell you how the infant is functioning in the settings in which she is being cared for, how she is growing and developing, and what challenges she faces. The child's behaviors, competencies, and problems are identified as well as how that child can regulate their behavior and emotions with and without their caregiver's support. An infant mental health assessment will help to identify the primary attachment figure and how this child is able to access and use this person to be successful and thrive. Secondary attachment figures and other significant relationships are also evaluated. A diagnostic profile, which provides specific diagnoses on several axes, may or may not be generated by an assessment.

For example, using the DC 0–3 Diagnostics, a child may have an Axis I diagnosis of Traumatic Stress Disorder if the child has witnessed ongoing domestic violence in their family and an Axis II diagnosis of an



Underinvolved Parent-Child Relationship if the father is unavailable and the mother is too overwhelmed or depressed to care for her baby as needed. An Axis III diagnosis would reflect any medical conditions, Axis IV would identify current and chronic stressors, and Axis V looks at a child's social-emotional capacities in interactions with both primary caregivers and with a skilled play partner such as a clinician.

Needed Supports

The purpose of the infant mental health assessment is not to ascribe blame, but to assess what challenges exist for the infant in his current environment. It is also to assess what changes and supports could be provided in that environment to get her back on track. Questions that should be addressed include:

- What have we learned about this infant that will help create an environment that will protect and support his growth through all the changes that he is facing?
- What are the key sources of stability and security for this baby during this time of stress?
- Who is this child's primary attachment figure? Is this person able to provide the structure, nurturance, and care that he needs?
- What have we have learned about this baby's life that we need to address so she can continue to grow and develop in the most optimal way possible?

WHAT ARE SOME PITFALLS OR CHALLENGES OF INFANT MENTAL HEALTH ASSESSMENTS?

Misinterpretation

The main pitfalls with infant mental health assessments lie in the hands of those who review them. Parties who are unfamiliar with, or resistant to, the concept that infants and toddlers "have mental health" may discount the need for these assessments or dismiss the results. This can be damaging to all parties involved and can be devastating for the young child.

Reports can be misinterpreted by individuals who don't understand how infants experience their worlds or how infants develop. For example, a common misinterpretation often occurs around breastfeeding. If an assessment reports that an 18-month-old child has become more dependent on breastfeeding since her

parents' separation, it is often interpreted as a mother trying to manipulate visitation. In truth, children who are experiencing stress and separation often want more regular comfort through breastfeeding.

Another common misinterpretation occurs around tantrum behaviors. When a young child tantrums when returning to the foster dad after visiting birth relatives, it does not necessarily mean he is upset to be with foster dad. Rather, it might be that he feels safe and secure with foster dad and can therefore let his emotions out much more readily when with him.

It is important to remember that babies develop their attachments and relationships based on their daily experiences with their caregivers. Babies don't see who has more resources; they see only who connects them with the world, who soothes their anxiety, and who is physically, emotionally, and psychologically available. Babies don't see legal or blood relationships—they only see interpersonal relationships.

Outdated Assessments

Another danger is accepting an outdated infant mental health assessment. Young children develop and change quickly; a child can demonstrate profound physical, emotional, and cognitive changes in a matter of days. Often, court proceedings involve delays. An assessment done even one month previously without any follow-up may provide an inaccurate picture. This is particularly true with very young infants.

Misused Assessments

An infant mental health assessment should not be considered a parenting evaluation; and likewise, a parenting evaluation cannot replace an infant mental health assessment. They look at things through similar, but different lenses. Furthermore, an infant mental health assessment should never be used to deny or reward one caregiver or another. It should not be about the needs of the adults involved—it must be about the needs of the child. The goal should be discovering or uncovering what is going to be in the best interest of this child and get them on the best trajectory.

IN CLOSING

It is common to think about babies and young children as resilient and immune from the hard things that impact their lives. Any of us working on behalf of children and families wish for every child



to have a safe and nurturing life. We would like for all children to be given the opportunity to grow up to be successful and happy adults who will be able to parent their own children in optimal ways. Sadly, even the youngest children experience loss, separation, trauma, and fear. They get sad, frustrated, and angry. They can feel hopeless and yearn for the safety and security of someone who will love them unconditionally and provide for them emotionally as well as physically. In infant mental health we strive to explore, assess, and intervene in the lives of the youngest children. Seeing the world “through the eyes of the infant” means seeing things from a whole new perspective. Opening our eyes to infant mental health and the insight such assessments can provide will help us truly serve the best interests of all children.

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Professional Assessment of Children

TOOLS FOR ASSESSMENT

The selection of instruments (tests) to be administered to a child must be appropriate for the purpose of the evaluation and must take into consideration the child's age and any special disabilities such as sensory deficits, physical or motor impairments, or speech disorders. Tests should also be culturally appropriate or at least be free of cultural bias.

Other factors of importance in selecting tests for individual examination are determined by the attributes of the tests. Among those to be considered in choosing one test in preference to another are:

- **Validity**
How well does the test measure what it is said to measure?
- **Reliability**
How consistently are the test results reproduced when the same individual is re-tested? When the test is broken up via the split-half method and compared with itself, is it internally consistent?
- **Standardization**
The test norms should be derived from a representative sample of the population to whom the test is to be applied.
- **Objectivity**
An objective test involves specific responses to specific requests or situations. A standard set of directions is followed for administering and scoring the test. Any departures from these prescribed procedures must be reported.

(Note: No single test score is conclusive; professionals look for several sources of data to support conclusions they draw from the tests.)

BRIEF DESCRIPTIONS OF SOME COMMONLY USED ASSESSMENT TOOLS

The following list of assessment tools is in no way intended to be complete. It does, however, give some examples of the types of instruments that may be used. As a CASA/GAL volunteer, you are not expected to have an expert's knowledge of the use of assessment instruments. However, some familiarity with the types of instruments being used may help guide research and further discovery on behalf of the child.

DEVELOPMENTAL SCALES

Denver Developmental Screening Test (1 month–6 years)

Quick assessment of personal, social, fine motor, adaptive, language, and gross motor development.

Gesell Developmental Schedules (2½ years–6 years)

Thirteen tests assessing a wide range of developmental factors in preschoolers. Assesses behavior and emotional and physical development. Used for screening, early intervention, or diagnosis.

Bayley Scales of Infant Development (2 months–30 months)

Two-scale test for infant mental and motor development and a behavior rating. Assesses early mental and psychomotor development. Used in the diagnosis of normal versus retarded development.

Ages and Stages Questionnaire (ASQ) (6 months–5 years)

Test to screen infants and young children for developmental delays during their first five years.

BRIGANCE® Infant & Toddler Screen Infant Assessments

(infant: birth–11 months; toddler: 12–23 months)

Tool to assess infant and toddler developmental skills and observe caregivers' involvement and interactions.



**Battelle Developmental Inventory
Screening Test (BDIST)**
(6 months–8 years old)

Assessment for fine and gross motor, adaptive, personal-social, receptive and expressive language, and cognitive skills.

INTELLIGENCE TESTS

**Wechsler Intelligence Scale for Children—
Revised (WISC-III)**
(5 years–15 years)

Twelve subtests divided into two major divisions yielding a verbal IQ, performance IQ, and full scale IQ for children tested individually. Provides verbal and nonverbal scales.

**Wechsler Preschool & Primary Scale
of Intelligence (WPPSI-II)**
(2 years–6½ years)

Ten standardized subtests divided into verbal and nonverbal scales to assess cognitive and reasoning abilities. Scores converted to deviation quotient comparing subject to age peers.

Stanford-Binet Intelligence Scale (SB-IV)
(2 years–Adult)

Measures overall cognitive abilities. Emphasis at lower ages on sensorimotor performance; at school age and above, highly dependent on verbal skills. Verbal and nonverbal tests assess verbal reasoning, abstract/visual reasoning, quantitative comprehension, and short-term memory. Can be used to substantiate scores from group tests, to provide more comprehensive assessment, and when a subject has physical, language, or personality disorders that prevent group testing. Results can help identify subjects who would benefit from specialized learning environments.

Leiter International Performance Scale
(2 years–18 years)

Multiple-item nonverbal task assessment of intelligence. Individual performance scale. Covers range of functions, non-timed, nonverbal, assumed to be culture-free. Useful for children with speech or language difficulties.

Wechsler Adult Intelligence Scale–Revised (WAIS-R)
(16 years–Adult)

Eleven subtests yielding verbal IQ, performance IQ, and full scale IQ. Verbal and nonverbal scales.

Popular and well-standardized test but considered not useful for exceedingly superior or for retarded.

VOCABULARY

Peabody Picture Vocabulary Test (PPVT)

Point-to-response nonverbal multiple-choice selection of picture associated to word spoken by examiner. Measures receptive vocabulary for Standard American English, estimates verbal ability, and assesses academic aptitude. Also used with English as a Second Language (ESL) students, mentally retarded, and gifted students. Vulnerable to deficit in visual/perceptual functions. Scores converted to mental ages, deviation IQ.

Full Range PVT

Similar to Peabody. Assesses individual intelligence when scores are converted to mental age and tables are available for comparable Wechsler Verbal IQ. May be used in testing special populations such as physically handicapped, uncooperative, aphasic, or very young subjects.

**PERCEPTUAL- OR VISUAL-MOTOR
INTEGRATION TESTS**

Bender Visual-Motor Gestalt Test
(3 years–Adult)

A paper-pencil test, untimed. Assesses visual-motor functions. Evaluates developmental problems in children, learning disabilities, retardation, psychosis, and organic brain disorders. Visual-perception, visual-motor integration, motor skill, and organizational ability are tapped by copying figures. Also used as projective test.

Illinois Test of Psycholinguistic Abilities (ITPA)
(2 years–10 years)

Ten subtests evaluate child's cognitive and perceptual abilities in communication, auditory, psycholinguistic process of visual reception, levels of organization, sequential memory, association of symbols, ordering recall, discrimination and conceptualization of similarity, and closure.

Frostig Developmental Test of Visual Perception
(pre-kindergarten)

Forty-one-item paper-pencil test assessing eye-motor coordination, figure-ground, form constancy, discrimination of position in space, and reproduction



of spatial relationships. Evaluates children referred for learning difficulties or neurological handicaps.

Goodenough-Harris Drawing Test

(3 years–15 years)

Assesses mental ability through nonverbal technique and drawing tasks. Revisualization, ability to reproduce representation of human figures. Developmental age scores. Also used as projective device.

Benton Revised Visual Retention Test

(8 years–Adult)

Measures visual memory. Utilizes ten cards depicting one or more geometric forms exposed ten seconds. Assesses revisualization, spatial perception, and perceptual-motor reproductions. Scored for number correct and number of errors. Used as supplement to visual mental examinations.

Memory for Designs (Graham-Kendall) Test

(8½ years–Adult)

Assesses revisualization and visual-motor coordination. Fifteen cards with simple geometric figures, each exposed five seconds, to be reproduced. Used to differentiate between functional behavior disorders and those associated with brain injury.

AUDITORY PROCESSING TESTS

Illinois Test of Psycholinguistic Abilities (ITPA)

(2 years–10 years)

Assesses specific psycholinguistic abilities and disabilities in children. Facilitates assessment of child's abilities for remediation. Ten subtests of auditory-reception, association, sequential recall, grammatic closure, sound-blending, and verbal expressiveness. Assesses decoding, ordering, memory, and ability to analyze and synthesize parts-to-whole.

Goldman-Friscoe-Woodcock Test of Auditory Discrimination

(4 years–Adult)

Diagnoses an individual's ability to hear clearly under increasingly difficult listening conditions. Twelve subtests measure auditory discrimination, attention, memory, and sound-symbol skills. Intersensory integration is involved in multiple-choice response to pictures associated with recorded words. Used for instructional planning.

KINESTHESIA & TACTILE PERCEPTION

Southern California Sensory Integration Tests

(4 years–10 years)

Measures an individual's ability to see, touch, and move in a coordinated manner. Seventeen-item paper-pencil and task assessment tests measuring visual, tactile, and kinesthetic perception, and different types of motor development. Used to identify the degree and type of disorder often associated with learning and emotional programs, minimal brain dysfunction, and cerebral palsy.

Reitan-Indiana Neuropsychological Battery for Children

(5 years–Adult)

Assesses brain-behavior functioning in children. Includes subtests of sensory perception, intersensory manual form perception, tactile localization, tactile-kinesthetic perception, learning, and recall. Used for clinical evaluations.

MOTOR TESTS

Southern California Sensory Integration Test

(4 years–10 years)

Five of six subtests require imitation of patterned movements, body positions, or response to verbal requests.

Southern California Motor Accuracy Tests

(4 years–8 years)

Measures degree of accuracy in drawing a pencil line over a printed line. Used in diagnosis of perceptual-motor dysfunction in atypical children. Used in clinical evaluations.

Lincoln Oseretsky Motor Development Scale

(6 years–14 years)

Measures motor development. Tests fine and gross motor skills. Used to supplement information obtained from other techniques concerning intellectual, social, emotional, and physical development.

Purdue Perceptual Motor Survey

(6 years–10 years)

Range of postural, motor, body image, and form perception measures.



Frostig Developmental Test of Visual Perception (3 years–10 years)

Eye-motor coordination subtests measure skill of visually guided movements.

Bayley Scales of Infant Development, Motor Scale (2 months–30 months)

Assesses developmental levels of motor patterns, including prehension and locomotion.

ACADEMIC SKILLS & SCHOOL ACHIEVEMENT

Standardized Tests Given by Schools:

All measure reading, math, and writing skills.

- Iowa Test of Basic Skills (ITBS)
- Washington Assessment of Student Learning (WASL)

Tests Given by Specialists:

Woodcock-Johnson Psychoeducational Battery (W-JPEB)

Twenty-seven-test battery. Evaluates individual cognitive ability, scholastic achievement, and interest level. Used to diagnose learning disabilities for instructional planning, vocational rehabilitation, and counseling.

Wide-Range Achievement Test—Revised (WRAT-R)

Three paper-pencil subtests, which measure basic educational skills of word recognition, spelling, and arithmetic. Identifies individual learning difficulties. Used for educational placement, measuring school achievement, vocational assessment, and job placement and training.

Peabody Individual Achievement Test (PIAT)

Four-hundred-item test of mathematics, reading, comprehension, and general information. Provides an overview of individual scholastic attainment. Used to screen for areas of weakness requiring more detailed diagnostic testing.

ADAPTIVE BEHAVIOR SCALES

Ages and Stages—Social Emotional (ASQ-SE) (6 months–5 years)

Eight questionnaires that recognize young children at risk for social or emotional difficulties.

Vineland Social Maturity Scale—Revised

One-hundred-seventeen-item interview covering eight categories of self-help in general, eating, dressing, communication, self-direction, socialization, and locomotion. Measures successive stages of social competence and adaptive behavior. Used to measure individual differences, which may be significant in cases of mental deficiencies and emotional disturbances, in order to plan therapy or individual education.

Woodcock-Johnson Scales of Independent Behavior (SIB) (2 years–Adult)

Assesses functional behavior, self-help skills, and communication skills. Usually used with developmentally delayed individuals.

A.A.M.D. Adaptive Behavior Scale (3 years–6 years)

Assesses social and daily living skills of children whose adaptive behavior indicates possible mental retardation, emotional disturbance, or other learning handicaps. Used for screening and instructional planning.

PERSONALITY & SOCIAL/EMOTIONAL FUNCTIONING

A variety of tests can be used to examine various personality or emotional hypotheses about children. These tests include the following:

The Achenbach Child Behavior Checklist (CBCL) (2 years–16 years)

Assesses behavioral problems and competencies of children and adolescents. Evaluates child behavioral problems from subject's perspective with Youth Self-Report (for ages 8–11 years), from parent's point of view with Child Behavior Checklist, and from teacher's perspective on classroom behavior with Teacher Report Form. Direct Observation Form used by experienced observer to rate on basis of a series of at least six ten-minute observation periods.

Behavioral Assessment Scale for Children (BASC) (2½ years–18 years)

Assesses the range of behavior for typically developing children in order to look for areas of psychological damage.



**Minnesota Multiphasic Personality Inventory–
Adolescent Version (MMPI-A)**

(Adolescents–Adults)

One-hundred-fifty-item true/false test of ten clinical variables or factors. Assesses individual personality. Used for clinical diagnosis and research on psychopathology.

Children’s Depression Inventory

(8 years–13 years)

Twenty-seven-item pencil-paper inventory measuring overt symptoms of child depression such as sadness, anhedonia, suicidal ideation, and sleep and appetite disturbance. Assesses severity of depression in children and adolescents. Also used to measure progress during treatment.

VARIOUS PROJECTIVE TESTS

**TAT, CAT, Robert’s Apperception Test for Children,
Piers-Harris Children’s Self-Concept Scale, Sentence
Completion Test**

Used with caution, as they are not standardized. They can be helpful when used with other sources and by a trained clinician.

Adapted from *Tests: A Comprehensive Reference for Assessments in Psychology, Education and Business*, second edition, Richard C. Sweetland, PhD, and Daniel J. Keyser, PhD, general editors. Kansas City, MO: Test Corporation of America, 1986. Updated for National CASA by Peggy Tribble, PhD, May 2000, and Carol Weisheit, early childhood resource specialist, March 2006.



Resiliency: The 40 Developmental Assets

THE SEARCH INSTITUTE'S FRAMEWORK FOR LOOKING AT PROTECTIVE FACTORS

In an effort to identify the elements of a strengths-based approach to healthy development, Search Institute developed the framework of developmental assets. This framework identifies forty critical factors for young people's growth and development. When drawn together, the assets offer a set of benchmarks for positive child and adolescent development. The assets clearly show important roles that families, schools, congregations, neighborhoods, youth organizations, and others in communities play in shaping young people's lives.

EXTERNAL ASSETS

Support:

1. **Family support:** Family life provides high levels of love and support.
2. **Positive family communication:** Young person and his/her parent(s) communicate positively and young person is willing to seek advice and counsel from parent(s).
3. **Other adult relationships:** Young person receives support from three or more non-parent adults.
4. **Caring neighborhood:** Young person experiences caring neighbors.
5. **Caring school climate:** School provides a caring, encouraging environment.
6. **Parent involvement in schooling:** Parent(s) are actively involved in helping young person succeed in school.

Empowerment:

7. **Community values youth:** Young person perceives that adults in the community value youth.

8. **Youth as resources:** Young people are given useful roles in the community.
9. **Service to others:** Young person serves in the community one hour or more per week.
10. **Safety:** Young person feels safe at home, school, and in the neighborhood.

Boundaries and Expectations:

11. **Family boundaries:** Family has clear rules and consequences, and monitors the young person's whereabouts.
12. **School boundaries:** School provides clear rules and consequences.
13. **Neighborhood boundaries:** Neighbors take responsibility for monitoring young people's behavior.
14. **Adult role models:** Parent(s) and other adults model positive, responsible behavior.
15. **Positive peer influence:** Young person's best friends model responsible behavior.
16. **High expectations:** Both parent(s) and teachers encourage the young person to do well.

Constructive Use of Time:

17. **Creative activities:** Young person spends three or more hours per week in lessons or practice in music, theater, or the arts.
18. **Youth programs:** Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
19. **Religious community:** Young person spends one or more hours per week in activities in a religious institution.
20. **Time at home:** Young person is out with friends, "with nothing special to do," two or fewer nights per week.



INTERNAL ASSETS

Commitment to Learning:

21. **Achievement motivation:** Young person is motivated to do well in school.
22. **School engagement:** Young person is actively engaged in learning.
23. **Homework:** Young person reports doing at least one hour of homework every school day.
24. **Bonding to school:** Young person cares about his/her school.
25. **Reading for pleasure:** Young person reads for pleasure three or more hours per week.

Positive Values:

26. **Caring:** Young person places high value on helping other people.
27. **Equality and social justice:** Young person places high value on promoting equality and reducing hunger and poverty.
28. **Integrity:** Young person acts on convictions and stands up for his/her beliefs.
29. **Honesty:** Young person “tells the truth even when it is not easy.”
30. **Responsibility:** Young person accepts and takes personal responsibility.
31. **Restraint:** Young person believes it is important not to be sexually active or to use alcohol or other drugs.

Social Competencies:

32. **Planning and decision-making:** Young person knows how to plan ahead and make choices.
33. **Interpersonal competence:** Young person has empathy, sensitivity, and friendship skills.
34. **Cultural competence:** Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. **Resistance skills:** Young person can resist negative peer pressure and dangerous situations.
36. **Peaceful conflict resolution:** Young person seeks to resolve conflict nonviolently.

Positive Identity:

37. **Personal power:** Young person feels he/she has control over “things that happen to me.”
38. **Self-esteem:** Young person reports having high self-esteem.
39. **Sense of purpose:** Young person reports that “my life has a purpose.”
40. **Positive view of personal future:** Young person is optimistic about his/her personal future.

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