Understanding Young Children's Mental Health: A Framework for Assessment and Support of Social-Emotional-Behavioral Health

Nebraska Early Childhood Mental Health Work Group

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The Early Childhood Mental Health Assessment subgroup of Nebraska’s Early Childhood Mental Health Work Group was assigned the task of identifying resources which address assessment of infant/toddler mental health, including the social, emotional, and behavioral development of infants, toddlers, and preschoolers. Three goals were identified to accomplish this task.

Provide early childhood and mental health practitioners recent information regarding assessing early childhood mental health. Provide early childhood practitioners information about resources to assist in early identification of potential infant/toddler/preschooler mental health concerns. Provide mental health practitioners current information on early childhood mental health assessment resources.

These tasks were accomplished by completing a comprehensive search of current resources (books or journals) regarding infant mental health assessment, as well as searching for appropriate measurement tools designed specifically for evaluating social, emotional, and behavioral strengths and needs of young children. Resources found in the search were reviewed, and assessments were recommended in two categories: screening (brief effort to determine if future assessment is needed) and diagnostic/assessment (detailed assessment that can be used for diagnostic purposes). The result of this subgroup committee’s work is a draft document of identified resources entitled “A Framework for Assessment and Support of the Social-Emotional-Behavioral Health of Young Children.” This information will be distributed to interested groups and will be amended as new resources become available.

Visit the website at www.esu3.org/ectc/partnerships/ecmh.htm to view this document online along with other information about activity in Nebraska related to addressing the mental health of young children. Some of these materials are available for review through the free loan services at the Media Center at the Early Childhood Training Center (402) 597-4826. For more information about the work of the group, contact Eleanor Kirkland at (402) 471-3501.
Assessment of Early Childhood Social-Emotional-Behavioral Health

Assessing the social, emotional, and behavioral health of infants, toddlers, and preschoolers presents distinct challenges to early childhood teachers and clinicians. Effective assessment presupposes an understanding that is only now beginning to emerge of the characteristics of healthy development and of mechanisms of risk and protection. Most experts agree that best practice early childhood mental health assessment involves sensitivity not only to nuances of a baby’s or young child’s behavior, but also to parent-child interaction patterns, family dynamics, environmental supports, and cultural expectations. At the same time, the rapidly changing nature of early development demands that expectations be anchored with age-appropriate markers that change on a monthly, or more frequent, basis.

Nearly all authorities emphasize the importance of comprehensive, multimodal, and multidisciplinary assessment. Early intervention practitioners are urged to rely on careful observation of child behavior and child-caregiver interaction, sensitive interviewing of caregivers (and those young children who have verbal communication skills), and use of standardized assessment instruments to identify social, emotional, and behavioral strengths, risks, and needs. In addition, they are encouraged to heed the expertise of education, psychology, social work, nursing, medicine, and occupational and physical therapy in designing an assessment plan and in making treatment decisions.
Despite trends toward strengths-based assessment and the importance of building on a foundation of child and family strengths, a primary purpose for screening and assessment is to “ensure that young children experiencing atypical emotional development and their families have access to needed supports” (Knitzer, 2001). Thus, the screening and assessment process must help professionals and family members recognize indications that a young child's developmental trajectory is prematurely narrowing or is off-course.

This Framework was developed by the Early Childhood Mental Health Assessment subgroup of the Nebraska Early Childhood Mental Health Work Group as a resource for early childhood professionals. The Framework is intended to give practitioners tools to help them improve their understanding of early childhood mental health and to increase their knowledge of available social-emotional-behavioral screening and assessment instruments.

**Early Social-Emotional-Behavioral Health**

Some of our most valuable understanding of the importance and characteristics of early childhood social-emotional-behavioral health come from researchers and clinicians who have focused their attention on infant mental health. Thus, this Framework relies on definitions of infant mental health to describe early childhood social-emotional-behavioral health. For example, at the October 2000 Head Start Infant Mental Health Forum, Charles Zeanah and Paula Doyle Zeanah (2001) proposed that infant mental health is the:

state of emotional and social competence in young children who are developing appropriately within the interrelated contexts of biology, relationship, and culture. This definition emphasizes the infant as imbedded both within multiple contexts and as developing and changing (p. 19).

Expanding on the Zeanah and Zeanah definition, the ZERO TO THREE Task Force on Infant Mental Health began its work in 2001 with a draft definition of infant mental health that we have applied to
infants, toddlers, and preschoolers. We believe early childhood social-emotional-behavioral health is:

the developing capacity of the child from birth to six to: experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn, all in the context of family, community, and cultural expectations for young children. [Early Childhood] mental health is synonymous with healthy social and emotional development (see infant mental health definition for birth to three, Zero to Three, in press).

Implicit in these definitions is the idea that child characteristics, parent-child interaction patterns, family structure and routines, and social and cultural environment are interwoven components of early childhood mental health. It is the child's developing social, emotional, and behavioral competence, however, that is the focus of mental health screening and assessment. Effective early childhood mental health assessment targets the infant's, toddler's, or preschooler's skill at expressing and regulating emotions, engaging in positive relationships with primary caregivers (and, eventually, peers), and cooperating with developmentally appropriate behavior management. At the same time, effective screening and assessment identifies risk and protective factors in the environment, as well as in the child's personal and biological characteristics, that may signal concern or uncover strengths before such factors are apparent in the young child's behavior.

Although the focus of assessment is on the child's emerging skills, healthy social-emotional-behavioral development for infants, toddlers, and preschoolers must be viewed in the context of the child's family and culture. Family and culture provide the environment that nurtures healthy development, protecting the child from the adverse effects of temperamental difficulties, traumatic events, poverty, illness, or other stressors. Responsive caregiving (see below) is recognized as a critical contributor to infant, toddler, and preschooler mental health. In addition to warmth and sensitivity, responsive caregiving includes providing young children with routine, structure, adequate nutrition, good well-child health
Risks to Healthy Social-Emotional-Behavioral Development

Risks for healthy social-emotional-behavioral development are best understood by taking into account the family and culture with which the child is constantly interacting and by recognizing the profound effects of those interactions on both the child and the environment (Hinrichs, Davies, & Flood, unpublished description of mental health services at Lincoln Action Program Early Head Start/Head Start). Dante Cicchetti and his colleagues (Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981; Cicchetti & Toth, 2000) have described this approach as an ecological/transactional theory of development. In the ecological/transactional model both risk (“potentiating” or “vulnerability producing”) and protective (“compensatory”) factors within a child’s environment shape developmental outcomes. However, the theory emphasizes that there is no “one-way” influence or causation. Risk and protective factors affect the child, but the child also influences her or his environment in many ways. When considering parent-child interaction, for example, parental behavior is understood to affect the child’s emotions and behavior, and child behavior is seen as influencing the parent’s responses, creating a complex, interactional foundation for parent-child relationships and child mental health.

Risks that ought to be identified in effective screening and assessment may be seen primarily in the infant’s, toddler’s, or preschooler’s characteristics and behavior, or they may be recognized in parent-child interaction patterns, family needs, or in the social and cultural situation. According to the American Academy of Child and Adolescent Psychiatry, mental health concerns commonly identified for infants are dysregulation of physiological function (e.g., fussiness), feeding and sleeping problems, and failure to thrive (Thomas, 1998). For toddlers, most frequently identified concerns are behavioral disturbances, including aggression, defiance, impulsivity, and overactivity. For
preschoolers, “struggles for independence and autonomy” make aggressive, overactive, or defiant behavior primary concerns as well (Schroeder & Gordon, 2000, p. 264). In addition, delayed development of reciprocal interaction and communication in children with symptoms of autism or related concerns is an important concern in the early years. However, when child characteristics are considered in isolation, most of these risks or problems are not very good predictors of future mental health (Zeanah & Zeanah, 2001). It is only when the child’s characteristics are combined with stresses in parent-child interaction, family relationships, or the larger environment (e.g., poverty, unemployment) that most risk factors actually provide a strong indication that there may be future problems for the child. For infants and very young children, the parent-child relationship is central to healthy development. Responsive caregiving protects children, and problematic relationships appear to increase the child’s vulnerability. In fact, young children appear to be affected by serious environmental risks primarily through the effect those risk factors have on the child’s interactions and relationship with a primary caregiver (Zeanah & Zeanah, 2001). It appears that risks such as adolescent parenthood (Wakschlag & Hans, 2000), parental psychopathology (Seifer & Dickstein, 2000), maternal substance abuse (Lester, Boukydis, &Twomey, 2000) and exposure to violence (Kaufman & Henrich, 2000) have a substantial effect on many parents’ abilities to interact with their young children in the sensitive, consistent, and emotionally available way that is critical for the child’s healthy social, emotional, and behavioral development.

When risks to healthy development occur, early identification helps families and professionals to design interventions that can be offered to young children and their families early enough that the child’s behavioral flexibility and brain plasticity is optimal, and a potentially negative developmental trajectory is most likely to be altered. The goals of best practice intervention when concerns about young children’s mental health are identified invariably include strengthening parent (or primary caregiver)-child relationships.
Social/Emotional/Behavioral Screening and Assessment Instruments

Standardized assessment instruments are one component of a comprehensive, multimodal, and multidisciplinary assessment. As noted earlier, these instruments are intended to be used in combination with careful observation, preferably in several contexts, and sensitive interviewing to provide a thorough understanding of a young child's social, emotional, and behavioral strengths, risks, and needs. When they are used as part of a collaborative relationship with a child's family, standardized instruments facilitate comparison between one particular child and other children who have similar characteristics, such as age, gender, or ethnicity.

Screening and assessment differ in scope, length, and cost. Screening is usually briefer and less expensive than assessment or diagnostic evaluation. It can be defined as the “process of measuring infants and children (usually in large numbers) to identify those needing further assessment to determine whether they exhibit a condition or are at risk to do so in the future” (Wolery, 1989, pp. 122-123). Rather than providing a full picture of a child and her or his family's strengths, risks, and needs, screening is focused on answering a single question: Should this child be referred for diagnostic assessment? (p. 123). The screening instruments recommended in the Framework are relatively brief checklists designed to identify temperamental or behavioral signs that an infant, toddler, or preschooler may need to be evaluated to determine if she or he needs intervention to achieve or maintain healthy social, emotional, or behavioral development. Screening should not be used to make a diagnosis.
Assessment, on the other hand, is the “process of gathering information for the purpose of making a decision” (Bailey, p. 2). As described in this Framework, it involves evaluating information from observations, interviews, and standardized instruments, often completed by professionals from several different disciplines, including education, psychology, social work, nursing, medicine, and occupational and physical therapy. The decision to be made is typically more complex than a simple yes or no diagnosis. Assessment decisions generate directions for intervention that help practitioners build on child and family strengths, respond sensitively to cultural issues, and target specific needs. In early childhood mental health assessment, the goal is to describe strengths and needs in a way that leads directly to an intervention plan. Effective early childhood mental health assessment points to interventions that will increase opportunities for the child to regulate and express emotions, experience close and secure relationships with caregivers, begin to demonstrate prosocial skills with peers, and explore and learn within a safe and interesting environment.

The Early and Periodic Screening Diagnosis, and Treatment (ESPDT), a Medicaid child health program, was established to provide a mechanism to identify potential physical, mental, developmental, dental, hearing, and vision problems, and complete diagnostic assessment for follow-up when a risk is identified. A number of services are covered for treatment if problems are identified including: care coordination, child care consultation for individual children, parent-child therapy and therapeutic day treatment, wraparound and community support services and other traditional mental health treatments. Participation in each of these EPSDT components provides a mechanism to promote the well being of young children in low-income families. All children enrolled in Medicaid are entitled to the EPSDT coverage. It is highly recommended that this program be used as a resource for early childhood mental health assessment.
Early childhood social, emotional, and behavioral instruments vary in quality. Some are in early stages of development and have been used with only a relatively small number of children and families in one location, with little representation of differing income levels, ethnicity, or cultures. Others have been tested with thousands of children in different parts of this country, with a good representation from diverse groups. However, no instrument is perfect. In particular, even the best instruments do not predict future problems with a great deal of accuracy. Especially for young children, social-emotional-behavioral instruments are much better at giving valuable information about the child's current strengths and needs than they are at predicting how well the child will function in the future. This Framework provides limited information about the measurement qualities of the recommended instruments for those readers who are familiar with psychometric issues, such as reliability, validity, normative samples, and generalizability of results.


Assessing and treating infants and young children with severe difficulties in relating and communicating. May 1997

Available from: Zero to Three, P.O. Box 79768, Baltimore, MD 21279-0768, (800) 899-4301, www.zerotothree.org.

Center on the Social and Emotional Foundation for Early Learning. www.csefel.uiuc.edu/pies/overview.html

Diagnostic Thinking About Mental Health: Zero to Three

Available from: Zero to Three, P.O. Box 79768, Baltimore, MD 21279-0768, (800) 899-4301, www.zerotothree.org.


Special Section: Assessment of Infant and Toddler mental health.


The DC: 0-3 Casebook: A guide to the use of Zero to Three's Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood in assessment and treatment planning. 1997

Available from: Zero to Three, P.O. Box 79768, Baltimore, MD 21279-0768, (800) 899-4301, www.zerotothree.org.
Summary of Recommended Social-Emotional-Behavioral Health Assessments for Young Children

Key to successful assessment is the adoption of a holistic information gathering approach that includes parent input, observation and administration of an assessment tool. This section contains a review of measures that may be helpful in your practice. When determining which measure to use to evaluate a child consider the following:

- Does this assessment fit the purpose (e.g., program planning, comprehensive assessment or screening)?
- Does the assessment answer the questions you want answered about the child’s mental health (e.g., temperament, self-control, or emotional regulation)?
- Was the tool developed on a population that was demographically similar to the one you are evaluating (e.g., culture, language spoken in the home)?
- Are the psychometric properties adequate?
- Is it easy to administer and score?

Screening Measures

- Ages and Stages Social-Emotional Scale (ASQ-SE) (Bricker, 2001) [3-60 months]
- Brief Infant Toddler Social Emotional Assessment (BITSEA) (Carter, 1998) [12-60 months]
- Early Screening Project (ESP) (Walker, Severson, & Feil, 1995) (3-5 months)
Comprehensive Assessment Measures

- Adaptive Behavior Assessment System - II (ABAS-II) (Harrision & Oakland, 2003) (0 - 89 years)
- Child Behavior Checklist for ages (1 1/2 - 5 (Parent Report) and Caregiver-Teacher Report Form (C_TRF) (Teacher Report) (Achenbach & Rescoria, 2000) (2 - 5 years)
- Infant Toddler Social Emotional Assessment (ITSEA) (Carter, 1998) (12-60 months)
- Eyberg Child Behavior Inventory (ECBI) (2-16 years)
- Devereux Early Childhood Assessment Clinical Form (DECA-C) (LeBuff & Naglieri, 2003) (2-5 years)

Curriculum Linked Assessments

- Creative Curriculum Developmental Continuum (Dodge, Colker & Heroman, 2003) (2-5 years)
- Devereux Early Childhood Clinical Form (DECA-C) (LeBuff & Naglieri, 1998) (2-5 years)
- High/Scope Child Observation Record for Infants & Toddlers (COR) (High/Scope Educational Research Foundation, 2002) (6 weeks - 3 years)
- High/Scope Preschool Child Observation Record (COR) (High/Scope Educational Research Foundation, 2003) (2 1/2 years - 6 years)
- Infant Toddler Developmental Assessment (Erickson & Vater, 1998) (birth-3 years)
- The Work Sampling System: An Overview (Meisels, Jablon, Dichtelmiller, Dorfman & Steele, 1995) (Preschool - Grade 5)
Adaptive Behavior Assessment System-II (ABAS-II) (Harrison & Oakland, 2003) (Comprehensive Assessment)

The ABAS-II includes a parent and teacher rating assessment of adaptive skills for individuals from birth to 89 years. This norm-referenced assessment can be used for diagnostic evaluation, identification of strengths and limitations, and monitoring progress. The ABAS-II evaluates a broad range of skills including communication, pre-functional pre-academics, health and safety, leisure, self-care, self-direction, social, and motor. There is a parent/primary caregiver form for ages birth to five years and a teacher/daycare provider form for ages two to five. The 241 item assessment is rated on a four point Likert scale and also includes a check box if the respondent guessed when responding. The assessment is available in English and Spanish.

Psychometric Properties: This assessment was standardized on 2100 children (0-5) with 750 teachers and 1350 parents completing the survey. The sample included an equal number of males and females. The proportions of racial/ethnic groups were based on the racial/ethnic proportions according to census data and the children were also geographically distributed. The test-retest reliability was .90 for the preschool scales and inter-rater reliability was .83.

Recommended for Use By: Individuals trained in basic principles of psychological and educational assessment and test interpretation.

Cost: $165 for preschool kit
Time: 30-45 minutes
Available from The Psychological Corporation, Harcourt Assessment Company, 19500 Bulverde Road | San Antonio, Texas 78259. harcourtassessment.com, 1-800-872-1726.

The ASQ:SE provides information related to the social and emotional behavior of children ranging in age from 3 to 60 months. This screening tool is designed for use by a child's parents or other primary caregivers. It identifies young children whose social or emotional development requires further evaluation to determine if referral for intervention services is necessary. The tool is a series of eight questionnaires across 8 age groups. Seven behavioral areas are assessed including: self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people. Scoring of the instrument is simple and interpretation is straightforward by providing empirically derived cutoff scores.

Psychometric Properties: Validity, reliability, and utility studies were conducted to determine the psychometric properties of the screening instrument. Normative studies included 3,014 children. This tool was based on a normative group that closely paralleled the 2000 United States census data for income, level of education and ethnicity. Concurrent validity ranged from 81% to 95%. Sensitivity of the tool was 78% and specificity was 95%, suggesting that it is useful in discriminating between children with social-emotional delays for typically developing peers.

Administration: Parent questionnaire.
Targeted Professionals: Early Childhood Teachers
Cost: $125.00
Time: 10-15 minutes

Available from: Brookes Publishing Company Co. PO Box 10624, Baltimore, MD 21285, (800)-638-3775
www.brookespublishing.com

The BASC is a multimethod, multidimensional approach to evaluating the behavior and self-perceptions of children. The set of rating scales and self-report forms can be used individually or in combination. The three core components are Teacher Rating Scales (TRS), Parent Rating Scale (PRS) and Self-Report of Personality (SRP). The BASC facilitates differential diagnosis and educational classification of a variety of emotional and behavioral disorders and aids in the design of treatment plans for describing the behaviors and emotions of children and adolescents (2:6 through 25:11). The TRS/PRS composites include externalizing problems, internalizing problems, adaptive skills, and a behavioral symptoms index. The SRP composites include clinical maladjustment, school maladjustment, and emotional symptoms index. This standardized assessment provides T scores and percentiles by sex and age for general and clinical populations. All BASC parent and self-report surveys are available in Spanish as well as English, and there are tape recorded instructions that read each item to parents, available in both Spanish and English.

Psychometric Properties: This assessment was standardized across 375 testing sites with 13,000 children. The distribution of children was controlled for age, gender, race geographic region, and social economic status and included special populations. The scales' internal consistency ranges from low .70 to low .90s. Test retest reliability across the 3 scales ranged from high .60 to low .90s. The BASC TRS and PRS scales correlated highly with the corresponding scales on the Achenbach tests (which are parent/teacher rating scales).

Administration: Parents, teachers or child completes the forms. Recommended for Use By: Clinicians Cost: $359.99 Time: Time varies for each component. TRS/PRS: 10-20 minutes; SDH: 15 minutes
Brief Infant-Toddler Social and Emotional Assessment (BITSEA) (Carter and Briggs-McGowen, 1998) (Screening)

Appropriate for children 12 - 36 months of age. A shortened questionnaire that is based on the Infant-Toddler Social and Emotional Assessment that can be completed by parents or providers, this instrument evaluates both social-emotional problems and competencies. The scale identifies strengths and weaknesses within the following five dimensions of social and emotional development: 1) Externalizing problems (e.g., aggression); 2) Internalizing problems (e.g., depression/withdrawal; 3) Regulatory problems (e.g., sleeping, eating, unusual sensitivities); 4) Maladaptive Behaviors (e.g., head-banging); 5) Seven Scales of Competencies (e.g., attention, prosocial peer interactions, task mastery, empathy, emotional awareness). Completion of the ITSEA is recommended if the child fails the BITSEA. This tool can only be used with the authors’ permission.

Psychometric Properties: These scales were standardized on two groups of children in Connecticut. The community sample consisted of 1280 children aged 12-42 months. There were an equal number of boys and girls. The sample included 66% Caucasian, 8% Hispanic, 17% African-American, 3% Asian, and 1% Other. The Early Intervention sample consisted of 237 participants with a developmental delay in only one area. Of these children 75% were boys. Fifty-three were suspected of having Pervasive Developmental Delay (PDD) or autism. They ranged in age from 12-36 months. This sample included 59% Caucasian, 15% Hispanic, 20% African-American, 3% Multiracial, and 3% Other.

Administration: Parent/caregiver completes the forms.
Recommended for Use By: Early Interventionists, Early Childhood Teachers
Cost: Free-need to request from the author
Time: 30 minutes

The CBCL is a parent rating scale that examines the behavioral problems of young children using a 100-item scale. The C-TRF is a companion teacher/caregiver rating scale using a 99-item scale. The two profiles examine six areas, which are identified as internalizing or externalizing behaviors, and provides a problem score in each of these areas as well as a total problem score. The assessment can be hand or computer scored. It also comes in a Spanish version.

Psychometric Properties: This assessment tool was standardized on a group of 398 children who were referred, not referred, or at-risk. Norms are based on those children in the non-referred category. The inter-interviewer reliability ranged from .927 to .959. Test-retest reliability ranged from .952 to .996. The inter-parent report ranged from .74 to .76.

Administration: Parent/caregiver completes the survey.
Recommended for Use By: Clinicians. Early Interventionists (with specialized training)
Cost: Forms: 25 for $10; Manual-$25
Time: 20 minutes.

Available from: T. M. Achenbach, Center for Children, Youth & Families, University of Vermont, 1 South Prospect St., Room 6433, Burlington, Vermont, 05401-3456 (802) 656-8313
Devereux Early Childhood Assessment (DECA) (LeBuffe and Naglieri), 1998. (Curriculum-Linked)

The DECA is a standardized norm referenced behavior rating scale that measures 27 positive behaviors and a 10 item behavioral screener in preschool children 2 to 5. The DECA includes three scales measuring attachment, self-control and initiative and a behavioral concerns scale. It was normed on a representative, national wide sample of 2,000 children. Questionnaires can be completed. Scoring and interpretation needs to be completed by professionals trained in assessment and familiar with child development.

Psychometric Properties: The assessment was standardized on a sample of 2000 preschoolers in 28 states. Half of the children were rated by parents and the other half were rated by preschool teachers or childcare providers. The sample consisted of 51% boys and 49% girls. The sample included 69.4% Caucasian, 17.2% African-American, 3.5% Asian, 1.0% Native American, and 9% Other. The test-retest reliability for protective factors ranged from .55 to .80 for parents and .87 to .94 for teachers. The inter-rater reliability was .59 to .77 for protective factors. The construct validity was -.65 correlation between protective factors and problem behavior.

Administration: Rating scale based on previous observations
Recommended for Use By: Early Interventionists, Early Childhood Teachers
Cost: $199.95
Time: 10 minutes

Available from: Kaplan, P.O. Box 609, 1310 Lewisville-Clemmons Rd., Lewisville, NC 27023-0609, Phone: 800-334-2014, www.kaplanco.com
Early Screening Project (ESP) (Walker, Severson, & Feil, 1995) (Screening)

The ESP is a three stage social-emotional screening for use with preschool and kindergarten children. In Stage One, the top 3 children who are exhibiting externalizing and internalizing behaviors are identified through teacher rankings. These children are further assessed by teachers regarding several critical areas, including aggressive behavior, social interactions, and adaptive and maladaptive behavior (Stage 2 screening). Students who meet or exceed the normative criteria on Stage 2 checklists are observed in social activities during Stage Three. Specifically, two 10-minute observations are conducted of the children’s antisocial behaviors (e.g. fighting or arguing and disobeying established rules), nonsocial behaviors (e.g. tantrums and solitary play), and prosocial behaviors (e.g. parallel play and following established rules). An optional parent questionnaire was added to Stage 3, and includes three four-item scales assessing peer play, interactions with caregivers, playing with materials, and self-care. An important outcome of the ESP screening procedures is a list of students whose behavioral disturbances are severe enough to require careful behavioral assessment and planning.

The screening procedure has the potential to identify significant behavior problems earlier in their trajectory, and could allow a program to be proactive in its behavioral interventions.

Psychometric Properties: The ESP was standardized with 2,853 children enrolled in preschool and kindergarten classrooms in eight states. Demographics of the population included 58% from low-income families and 39% from middle-income families. Ethnic distribution included: 69% White, 16% Hispanic, 12% Black, and 3% Native American or Asian. Empirical studies demonstrate that these screenings provide reliable and valid estimates of those children who are most in need of behavioral support. In one study, accuracy was examined by comparing the preschoolers it selected
against those that teachers identified as possibly having serious behavior problems. Results showed that between 94% and 100% of young children identified as not having a behavior disorder were accurately categorized, and between 62% and 100% of young children selected as having a behavior disorder were correctly identified (Walker, Severson & Feil, 1995). Inter-rater reliability comparing ratings by teachers and assistant teachers fell between .48 and .93 depending upon the scale. These reliabilities are comparable to other measures of preschool behavior problems, such as the Preschool Behavior Questionnaire (Behar & Stringfield, 1974) and Conners Teachers Rating Scale (1989). Test-retest reliabilities across a 6 month interval were at or above .70. This is to be expected given the variable behaviors at this age. Finally, significant correlations were demonstrated between the ESP scales and other measures of behavioral disturbance in preschool children (Feil, Walker, & Severson, 1995).

**Recommended for Use By:** Early childhood teachers.

**Cost:** Unknown

**Time:** Stage One and Two: 1 hour

*Available from Applied Behavior Science Press, 261 E 12th Ave, Suite 210, Eugene, OR 97401, 888-345-8744*

**Devereux Early Childhood Assessment - Clinical (DECA-C) (LeBuffe and Naglieri), 1998. (Comprehensive Assessment)**

The Devereaux Early Childhood Assessment - Clinical (DECA-C) is a standardized norm referenced behavior rating scale that assesses behaviors related to both social and emotional resilience and social and emotional concerns in preschool ages two through five. The primary purpose of the DECA-C may also be used to guide interventions, help identify children needing special services, assess outcomes, help programs meet Head Start, IDEA and similar standards. The DECA-C is a 62-item scale that can be completed by either parents or teachers.
Psychometric Properties: This assessment was standardized on 2,000 children from 92 preschools and child care across the United States. Teachers provided ratings on 1,017 children and parents ratings were obtained on the remaining 983 children. The sample of children closely approximated the proportion in the U. S. population in the areas of regional distribution, gender, race, ethnicity, and socioeconomic status. Internal reliability of the Total Score was .88 for Teachers and .88 for Parent Raters. The inter-rater reliability for teachers across domains ranged from .78 - .94 and for parents ranged from .55 - .88. The authors report results of criterion-related validity studies that demonstrated that the DECA-C was useful in making decisions about children's social and emotional health.

Administration: Rating scale based on previous observations
Recommended for Use By: A professional license or a degree from a four year college or university and graduate level training in assessment
Cost: Manual $54.95; Record form $59.95
Time: 15 minutes

Available from: Kaplan, P.O. Box 609, 1310 Lewisville-Clemmons Rd., Lewisville, NC 27023-0609, Phone: 800-334-2014, www.kaplanco.com
Eyberg Child Behavior Inventory (ECBI)
(Comprehensive Assessment)

The Eyberg Child Behavior Inventory (ECBI) is a rating scale that measures conduct problems in children ages two through sixteen years. The ECBI is designed for completion by parents and assesses the frequency of disruptive behavior occurrences in the home. The 36-item ECBI indicates how often each of the behaviors occurs (7 point intensity scale) and whether or not the behavior is a problem (yes/no problem scale). This tool provides clinicians with information that is useful for the identification and treatment of conduct disorder behavior in children and adolescents.

Psychometric Properties: The ECBI was standardized on parents of children in 1980. The children were drawn from a pediatric outpatient clinic in a large urban medical school in the northwest. Children represented were primarily lower and lower-middle income Caucasian families. The ECBI was restandardized on parents in 1999 in six outpatient pediatric settings in the southwest. This new standardized population is demographically representative of general child/adolescent population in the southwest U.S. It consisted of 798 children between the ages of two and sixteen with all age groups represented equally. There were equal numbers of boys and girls. The sample included 74% Caucasian, 19% African American, 3% Hispanic, 1% Asian, and 1% Native American, adn 2% or other or mixed ethnicity. The ECBI consisted of two scales of intensity and problems with test-retest reliability at .86 and .88 respectively. Inter-rater reliability coefficients were .86 (intensity) and .79 (problem skills). The ECBI scales were found to correlate significantly with the parenting stress index.

Administration: Parent/caregiver completes this survey
Cost: $147.00
Time: 10 minutes

Infant Toddler Developmental Assessment (IDA), (Erikson & Vater, 1998) (Curriculum Linked)

This instrument provides a family-centered, team assessment of children from birth to age 3 and includes five scales: Gross Motor, Fine Motor, Relationship to Inanimate Objects, Language, and Self-Help. Three sub-domains are identified: Relationship to Persons; Emotions & Feeling States, and Coping. The instrument can be used to assess current development and support curriculum planning as well as to monitor ongoing development and child outcomes.

Psychometric Properties: This assessment tool was standardized on a group of 100 children, 52 male, 37 female, and 11 unreported, who were rated according to the Providence Profile to gain information about their developmental level. Content validity was measured by comparing developmental ages on this instrument with the Bayley Scales of Infant Development, the HELP, LAP, and Vineland Scales and ranged from .84 to 1.00. The inter-item consistency within the eight IDA domains ranged from 90 to 96. Finally, inter-rater reliability ranged from .91 to .95, with the exception of Language/Communication, which was .81.

Administration: Observation & Direct Assessment
Recommended for Use By: Early Interventionists
Cost: $483.00
Time: Unknown

Available from: Riverside Publishing 425 Spring Lake Drive, Itaska, IL 60143, 800-323-9540.
Infant-Toddler Social and Emotional Assessment (ITSEA) (Carter and Briggs-McGowen, 1998) (Comprehensive Assessment)

Appropriate for children 12 - 36 months of age. Questionnaire can be completed by parents or providers. Evaluates both social-emotional problems and competencies. Includes strengths and weaknesses within the following five dimensions of social and emotional development; 1) Externalizing problems (e.g., aggression); 2) Internalizing problems (e.g., depression/withdrawal; 3) Regulatory problems (e.g., sleeping, eating, unusual sensitivities); 4) Maladaptive Behaviors (e.g., head-banging); 5) Seven Scales of Competencies (e.g., attention, prosocial peer interactions, task mastery, empathy, emotional awareness). This tool has been normed based on typical young children, an at-risk population and infant/toddlers in the early intervention system in Connecticut. This tool can only be used with the author's permission.

Psychometric Properties: The ITSEA has a good to excellent fit indices across scales. The comparative fit indices range from .921 to .999. The mean r-square is .50, and the mean residual for individual items is .21.

Administration: Parent/caregiver completes the forms.
Recommended for Use By: Clinicians, Early Interventionists
Cost: Free-need to request from author
Time: 30 minutes to complete

Available from: Alice Carter, Ph.D., Assistant Professor, Department of Psychology, Yale University, P.O. Box 208205, New Haven, CT 06520-8205 (203) 234-0700.
Although assessment of parent-child relationships and interaction patterns is beyond the scope of this Framework, the Assessment Committee believes that responsive caregiving is such a critical element of social-emotional-behavioral health for young children that it must be addressed in a review of resources for early childhood mental health. The nurturing, protective, and stable relationships infants, toddlers and preschoolers need with adults are constructed through daily interactions between young children and their parents and other caregivers. Responsive caregiving builds trust and, ultimately, fosters self-worth and good peer relationships. Responsive caregiving encompasses both: 1) the creation of safe, structured environments with predictable routines and interesting materials to explore (discussed in Creating Quality Environments), and 2) sensitive, caring, and dependable interactions with stable adult caregivers. Positive interactions with stable adults help young children organize their emotional responses and behavior, develop secure attachments, and resolve interpersonal conflict in healthy ways.

Young children first learn what to expect from other people and what is expected of them through their relationships with parents and other caregivers (Zero to Three, in press). Caregivers whose interactions with babies and young children include matching a child’s emotional tone, suggesting words that seem to name a child’s emotions accurately, and helping a child recognize emotional cues, such as smiles, angry faces, or tears help the child build emotional competence. Such sensitive interactions help infants and young children learn to regulate their emotions and to use their emotional experience to enrich their lives. As partners in many, repeated exchanges of loving touches, looks, verbalizations,
smiles, and laughter with their caregivers, young children develop the skills they need to form positive relationships with peers and other adults (see Thompson, 2001).

Attachment security is one foundation block of such healthy early parent-child relationships. Secure attachments grow out of dependable, responsive, and sensitive interactions with primary caregivers. When caregivers are sensitive to a baby's signals, whether of hunger, tiredness, interest, fear, or joy, and respond to the signals quickly and dependably, the child learns to trust the adult to provide for her or his needs. Of course, early attachments do not determine a child's later mental health. Secure attachments do not guarantee later social-emotional-behavioral health, and insecure attachments do not ensure later problems (Thompson, 2001). However, healthy attachments with dependable caregivers buffer many stressors for young children, help them venture into their environments to explore and learn, and add important skills to help them enjoy subsequent positive social relationships.

Caregiver-child interactions include conflict as well as warmth and affection (Thompson, 2001). A second foundation block of responsive caregiving is setting consistent rules and limits, enforcing developmentally appropriate expectations, and responding to a child's varying levels of compliance with adult instructions. Especially as children become toddlers and preschoolers, the means of conflict resolution and behavior management that is part of their relationship with their parents and other caregivers becomes increasingly important. Ross Thompson noted, “Nothing focuses a young child's attention on what other people are thinking or feeling more than the realization that a conflict must be resolved” (Thompson, p. 26). Dr. Thompson goes on to explain that conflict-related adult-child interactions create a “laboratory” for young children to recognize that other people have feelings and desires different from those of the child and to explore the consequences of those differences. Learning to follow rules and social conventions helps the child develop the prosocial behaviors that are another hallmark of mental health.
It is important that early childhood providers and clinicians support the interaction of parents and other caregivers and the young children they love. Parent-child interaction assessment tools typically require specific training beyond the scope of many early interventionists and early childhood teachers.

**Resources on Responsive Caregiving**

The following resource list provides a sampling of resources that provide a framework to support families in positive interactions with their children.

**Center for Evidence-Based Practice: Young Children with Challenging Behavior.** http://challengingbehavior.fmhi.usf.edu/index.html

**Clinical practices: Redefining the standards of care for infants, children and families with special needs.** Interdisciplinary Council on Developmental and Learning Disorders (ICDL) (2000).

*Available from: ICDL, 4938 Hamden Lane, Suite 800, Bethesda, MD 20814, www.icdl.com*


*Hazelden Educational Materials, 1-800-328-9000, Pleasant Valley Road, P.O Box 176, Center City, MN 55012-0176, www.hazelden.org*


Available from: NTC Publishing Group.

Available from: Andrews McMeel Publishing Co

Available from: Goddard Press, 380 Madison Avenue, NY, NY 10017

Sleeping Through the Night. J. Mindell (1997)

Available from: High/Scope Press, 600 North River Street, Ypsilanti, Michigan 48198-0704. Press@highscope.org
Home and childcare environments provide the safety, structure, predictable routines, and interesting materials young children need to develop social, emotional, and behavioral health. Quality environments for young children are dependent on the planning and active involvement of sensitive caregivers who create structures, routines, and interactions through which children come to know themselves as competent and likable. Quality environments support young children's active participation in their own learning (Zero to Three, in press), provide opportunities for challenge, foster the growth of coping strategies, and support children's communication and cooperative play. Resources for assessing childcare environments are briefly reviewed in this document. However, the characteristics of childcare environments most specific to social-emotional-behavioral health are those that foster security, stability, and positive adult-child interactions. A written document, such as this, can describe environmental safety and structure in a separate section from that addressing the adult-child interactions that are integral to the shape of environment for the young child. The child's reality, however, is that relationships, physical surroundings, and schedule are an interwoven whole. Thus, quality environments for young children are those that take seriously the need for children to have "continuity of care", a term that emphasizes the importance of day care policies that support the development and maintenance of positive adult-child relationships. According to Post and Homann (2000), such policies assure that each child's day is anchored around a primary caregiver, that groups are small and share stable caregiver teams, and that
children stay together with each other and caregivers from year to year (p. 92). Post and Homann recommend scheduling procedures focused on children's needs, including mechanisms to prepare children and parents for absences and returns of primary caregivers, and they advocate for caregivers to observe children, record behaviors, and share observations with parents daily.


Available from: California Department of Education, P.O. Box 944272, Sacramento, California 94344-2720
Summary of Recommended Environment Rating Scales

Environment Assessment Instruments

- Early Childhood Environment Rating Scale (Harms, Clifford, 1995) [3-5 years]
- Family Day Care Environment Rating Scale (Harms, 1995) [Birth-5 years]
- Infant-Toddler Environment Rating Scale (Harms, 1995) [Birth-2 years]
- High/Scope Program Quality Assessment (PQA) (High/Scope Educational Research Foundation, 1998)
- Indicators of Quality: Guiding the Development and Improvement of Early Childhood Care and Education Programs (Nebraska Department of Education, 1998)

ENVIRONMENT RATING SCALES

Early Childhood Environment Rating Scale-R (ECERS) (Harms, Clifford, & Cryer 1998); Family Day Care Rating Scale (FDCRS) (Harms & Clifford, 1989); Infant-Toddler Environment Rating Scale (ITERS) (Harms, Clifford, & Cryer, 1990)

These Environment rating scales were developed to assess the quality of young children's childcare environments. Items assess such areas as space and furnishings, personal care routines, listening and talking, learning activities, interaction program structure, language and reasoning and adult needs. Each item is based on a 7-point rating. The ECERS is designed to use in preschool, kindergarten and childcare classrooms serving children 2 through 5 years of age. The FDCRS is designed to use in family day care homes. The ITERS is designed to use in infant/toddler care for children up to 30 months of age.
Psychometric Properties: Several studies of psychometric properties were completed for each of the scales based on observations completed in early childhood environments in North Carolina. Content validity studies were completed for all scales. ECERS: Inter-rater reliability was 86%. Total scale internal consistency was .92. ITERS: Inter-rater reliability was .79. Total scale internal consistency was .83. FDCRS: Inter-rater reliability was 90%. Total scale internal consistency was .85.

Administration: Observation and completion of rating scale.

Recommended for Use By: Early Interventionists, Early Childhood Teachers
Cost: $11.95
Time: 3-4 hours.
Available from: Teachers College Press, Columbia University, 1234 Amsterdam Avenue, NY, NY 10027

High/Scope Program Quality Assessment (PQA) (High/Scope Educational Research Foundation, 1998)
The PQA is a comprehensive rating instrument for evaluating early childhood program quality and for identifying staff training needs. Seven areas are assessed including: learning environment, daily routine, adult-child interaction, curriculum planning and assessment, parent involvement and family services, staff qualifications and staff development and program management.

Psychometric Properties: This tool was developed based on national data from 366 classrooms and 201 children in diverse early childhood settings. Inter-rater reliability for exact agreement was 79.4% and for close agreement was 96.7%. The PQA has been significantly correlated with other measures of program quality and with indicators of children's development. The PQA was significantly correlated (.86) with the Early Childhood Rating Scale. Studies have also shown that levels of program quality as measured on the PQA are positively and significantly associated with indicators of children's development. Program quality was significantly related to several subscales on the High/Scope Child Observation Record with
the strongest association between the program's daily routine and adult-child interactions and children's initiative and creative representation.

**Administration:** Observation and completion of rating scale.

**Recommended for Use By:** Early Interventionists, Early Childhood Teachers  
**Cost:** $22.85  
**Time:** 3-4 hours.  
*Available from: High/Scope Press, 800-40-PRESS, Fax: 800-442-4FAX or email press@highscope.org*

**Indicators of Quality: Guiding the Development and Improvement of Early Childhood Care and Education Programs** (Nebraska Department of Education, 1998)  
These guidelines were developed by a task force to provide guidance to early childhood teachers that can benefit children, their families, and their communities. Indicators were developed in the following areas including: administration, staffing, learning environment, health and safety, family involvement and parenting education, use of community resources and evaluation of program and staff.

**Psychometric Properties:** No psychometric assessment was completed on scale.

**Administration:** Observation and completion of rating scale.

**Recommended for Use By:** Early Intervention Providers, Early Childhood Teachers  
**Cost:** none  
**Time:** 3-4 hours.  
*Available from: Nebraska Department of Education, 301 Centennial Mall South, P.O. Box 94987, Lincoln, NE 68509-4987*


Knitzer, J. Unpublished address to the Nebraska Governor's Symposium on Early childhood and Mental Health (May 2-3, 2001).


