STATE OF NEVADA, HEALTH AND HUMAN SERVICES
IDEA PART C OFFICE

Social-Emotional Evidence-Based Practices Module

Nevada

Includes:

- Importance of Improving Social-Emotional Outcomes
- Conducting Meaningful Screening, Evaluation, and Assessment
- Evidence-based Practices (EBPs)
- Professional Development to Support EBPs

Module 6

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Social-Emotional Evidence-Based Practices

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I. How to Use This Guide: Guiding Principles

Learning Objectives
After reviewing this section:

- The practitioner will recognize the purpose of the social-emotional evidence-based practice module.
- The practitioner will identify the key ideas are shared throughout the module.
- The practitioner will use the guiding principle information for applying the content of the module when working with diverse families and children.

The mission and values of The IDEA Part C Office, Nevada Early Intervention Services and the code of ethics and practice guidelines of various professional organizations serve as the foundations for the Evidence-Based Practices Modules available at **http://dhhs.nv.gov/Programs/IDEA/PartC/.** The content in the Evidence-Based Practices Modules are based on these foundations and a review of the literature on current research and recommended practices in early intervention. The identified learning objectives in each section of the Social-Emotional Evidence-Based Practices Module have been aligned with the Division of Early Childhood (DEC) Recommended Practices. In the Appendix is a list of additional resources that the user may access for more information on social-emotional practices.

All sections of the Evidence-Based Practices Modules are built on the concepts included in the foundations and philosophy of Nevada's approach to providing early intervention services. The modules were developed by a stakeholder group of program administrators, service providers, national technical assistance staff, parents and advocates affiliated with Nevada Early Intervention Services. The modules were also reviewed by national experts to ensure consistency with compliance requirements and recommended practices.

The purpose of the Social-Emotional Evidence-Based Practices Module is to provide service coordinators, developmental specialists, and therapists with guidelines for:

- working with families in a sensitive, supportive manner;
- developing a partnership through initial and ongoing assessment processes that will last throughout the family's time in early intervention services; and,
- learning about the interconnectedness between information gathered from families including evaluation/assessment, the development of meaningful and functional services and support plans, and the delivery of high quality services that are individualized for each child and their family.

Each section of the module has identified learning objectives using the premise of adult learning including:

- becoming aware of the information;
- learning and understanding the information; and,
- then putting the information into practice during interactions with the families.

Social-Emotional Evidence-Based Practices

This module supports the statewide focus on improving social-emotional outcomes for infants and toddlers with disabilities and their families using evidence-based practices.

Some of the key ideas that will be shared throughout this module include:

- Social-emotional outcomes within the early intervention context;
- Social-emotional development and its impact on positive child outcomes and child development;
- Working with families;
- Screening, evaluation, and assessment of social-emotional skills and development;
- Evidence-based practices related to supporting social-emotional development; and,
- Professional development and sustainability of social-emotional services in early intervention.

This module supports Nevada's compliance with federal regulations under the Individuals with Disabilities Education Act (IDEA). The IDEA specifies that there must be a comprehensive system of professional development for those who are working with children with a disability. Nevada's IDEA Part C Early Intervention Manual states there must be training "to promote the preparation of Early Intervention Service providers who are fully and appropriately qualified to provide early intervention, including the social-emotional development of young children" (June 2014). This federal requirement includes training personnel in social-emotional development, screening, assessment and evidence-based practices (IDEA § 303.118(b)(2)). In addition to the personnel requirements, IDEA requires each child's Individualized Family Service Plan (IFSP) must include a statement of the child's present levels of physical development (including vision, hearing and health status), cognitive development, communication development, social or emotional development, and adaptive development based on the information from the child's evaluation and assessments conducted under IDEA § 303.321 (§ 303.344(a)).

II. Social-Emotional Outcomes within the Early Intervention Context

Learning Objectives
After reviewing this section:

- The practitioner will recognize the importance and purpose of services that target consistent support and improvement of social-emotional skills in very young children with disabilities and their families. (aligned with DEC RP INT1)
- Practitioners will have knowledge of evidence-based social-emotional development and why it is important to the children and families we serve in early intervention. (DEC RP L9, INT1, INT2, INT4, IT5)
- Practitioners will be able to share the importance of evidence-based social-emotional development with the primary caregiver and give strategies to facilitate positive adult-child interactions with the purpose of promoting the child's social-emotional development. (DEC RP INT13)

What Research Tells Us about Social-Emotional Development

Research has shown social-emotional development is critical in early childhood for future success and is the foundation for learning (Rock & Crow, 2017). Children who learn appropriate social-emotional skills are known to do better in school because of their ability to develop healthy relationships, learn from others, and problem solve, therefore decreasing the likelihood of demonstrating behavioral concerns. Development of appropriate and healthy social-emotional skills has lasting effects beyond childhood, such as increased health, success, and confidence into adulthood. Strong parent-child relationships are extremely critical to healthy social-emotional skills, which early interventionists can help to support in order to ensure better outcomes for the child and family.

The Center on the Developing Child at Harvard University has summarized their research findings on the importance of early intervention in relation to social-emotional skills:

- Neural circuits create the foundation for learning, behavior and health, and are most flexible during the first three years of life. Over time, these neural circuits become increasingly more difficult to change.
- Stable relationships with caring and responsive adults, safe and supportive environments, and appropriate nutrition are key to healthy brain development.
- Early social-emotional development and physical health provide the foundation for cognitive and language skills to develop.

These findings contribute to the critical importance of early intervention and positive early experiences that lead to success in school, the workplace, and the community (Center on the Developing Child at Harvard University, 2010).

Social-Emotional Evidence-Based Practices

The National Scientific Council on the Developing Child recognizes that "young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development - intellectual, social, emotional, physical, behavioral, and moral". Infants rely on their caregivers to help them regulate and this helps them to learn appropriate ways to respond and express emotions. Infant development begins and continues in the context of an emotional relationship with those in their environment. This makes it necessary to understand and support the social-emotional development of the infants and toddlers we serve in early intervention, as well as supporting their relationships with their caregivers (ITCA-IDEA Part C Position Paper, 2005).

Relationships are the base for social-emotional skills; timing of the bonding experiences of infants has an impact on the ability to build healthy attachments. Bruce D. Perry explains during the first three years of life, the human brain develops to 90 percent of adult size. The part of the brain that helps us to form and build relationships develops during infancy and the first years of life based on our experiences during this time period. Social-emotional skills such as empathy, caring, sharing, inhibition of aggression, capacity to love and many other characteristics of a healthy and productive person are related to the individual's ability to form attachments. The critical period for bonding experiences to form attachments is in the first year of life. Attachment issues that occur for children are often due to a parent's lack of knowledge about development, rather than abuse. Many parents have not been educated on the importance of the child/caregiver relationship to social-emotional development during the first three years of life. Several studies have found improvement can take place, especially if early intervention works toward supporting children and families to enhance their social-emotional development (Perry, B.D., 2013).

In children under two-years old with disabilities or at risk for developmental delays, parental responsiveness is key to their child's social-emotional development. When it occurs promptly, in response to child behavior, and matches the developmental level and mood of the child, it is related to positive child social-emotional outcomes which include increased positive affect and social responsivity; and future impact on increased pro-social problem-solving and decreased teacher-rated behavior problems (Powell & Dunlap, 2010).

"Social-emotional development plays several key roles in early childhood, from understanding feelings, to taking turns, to building healthy relationships with others. It is the foundation upon which much other learning takes place.

Children with strong social-emotional skills do better in school because they are more focused, can cooperate with and learn from others, and exhibit fewer behavioral problems.

Healthy social-emotional development in early childhood leads to better outcomes in adulthood, such as improved health, better jobs, and more stable relationships.

Positive parent-child (or caregiver-child) interactions not only lead to better social-emotional development in children but offer benefits to parents and caregivers as well."

(Rock & Crow, 2017)

Social-emotional intervention approaches should be evidence-based and support the child in the context of the child's relationship with the primary caregivers. Supporting the development of strong positive relationships between children who receive early intervention services and their caregivers, improving social-emotional skills such as self-regulation, self-confidence, coping with frustration, and getting along with others are fundamental to achieving early intervention goals and future success (ITCA-IDEA Part C Position Paper, 2005). A family-centered approach has been well accepted in the field of early intervention from a philosophical and values-based perspective. Recent reviews and meta-analyses have provided documentation that when service delivery incorporates family-centered practices, outcomes for family and children are improved including parenting capabilities and positive child behavior and functioning (Powell & Dunlap, 2010).

Collaboration in Early Intervention with Evidence-based Practices on Social-Emotional Outcomes

Early intervention supports and services must always be delivered in ways that promote the primary sensitive, responsive, and nurturing parent-child relationship. Intervention strategies must never interfere with this important relationship. Early intervention practitioners must receive the support needed to recognize and understand how developmental delays and other conditions, that may be present in either the child or the parent, may influence the parent-child relationship and developmental outcomes. Enhancing the knowledge and practices of early intervention practitioners in the areas of social-emotional development, including attachment theory, parent-child interactions, and evidence-based interventions is critical. Early intervention personnel, including those conducting developmental screenings and evaluations/assessments must take into account the full range of influences on each child's early development and have the ability to work in collaboration with the child's family or caregivers to achieve the outcomes written on the IFSP (IMH & IDEA Part C, July 2005).

The Cambridge English Dictionary defines collaboration as two or more people working together to create or achieve the same thing. It is the responsibility of the early intervention practitioner to develop a relationship that links what is valuable to the family and their own professional knowledge and experience to build this collaboration. Using evidence-based practices supports the family/practitioner collaboration as it uses a decision-making process that integrates the best available research evidence with family wisdom and values and professional wisdom and values to find the most effective intervention for each family in achieving their identified outcomes (Buysse & Wesley, 2006). Equal weight is given to evidence-based research, family wisdom and values, and professional wisdom and values to find and use interventions to support success for the child and family.

A child's family is their first teacher and decades of research support the fact that children's earliest experiences play a critical role in brain development (NECTAC, 2011). Starting from birth, babies learn who they are by how they are treated. Loving relationships provide young children with a sense of comfort, safety, and confidence. They learn how to form friendships, communicate emotions, and deal with challenges from these family experiences. With this understanding, practitioners are able to collaborate with parents as they screen, evaluate, write

outcomes, give strategies and assess the need for infant mental health interventions if the parent-child relationship is troubled (ITCA-IDEA Part C Position Paper, 2005). Watch the video below for information about the importance of interactions between parents and their child.

https://vimeo.com/119255263

(https://www.zerotothree.org/espanol/social-and-emotional-development)

Through this collaboration with the family the practitioner can support healthy caregiver-child social-emotional relationships by:

- Screening and assessment of social-emotional development as part of the early identification process;
- Routinely talking about social-emotional milestones as part of developmental anticipatory guidance on home visits;
- Carefully listening to families to help them identify, clarify, and address issues that may be affecting the developing relationship with their child;
- Consulting with parents through relationship-based practice, in order to promote the parent-child relationship;
- Supporting families as they increase their coping skills and build resilience in their children; and,
- Working with community mental health and public health providers, when there is concern about maternal depression, parental substance abuse, and other family mental health challenges (Heffron, 2000).

It is important to acknowledge building a collaborative relationship with some families may be challenging, however relationships are crucial to learning and survival for human beings. We all have different abilities to form and maintain relationships, with some being able to naturally form these bonds, while others have little interest in building relationships. Research has shown a healthy attachment with a primary caregiver appears to be associated with a high probability of the ability to form healthy relationships with others throughout life, while poor attachment with a primary caregiver is associated with many emotional and behavioral problems throughout life (2013, Perry). By collaborating with the family on their desired outcomes and using evidence-based practices, the practitioner is supporting positive and meaningful impacts not only for the child but for the family as a whole.

Social-Emotional Evidence-Based Practices

In the Appendix you will find links to online educational modules for Social-Emotional Development to browse at your convenience.

Check for Understanding:

1. How do social-emotional skills impact overall development?
2. Who are the most influential people in developing a child's social-emotional skills?
3. What can you do to support developing these relationships in working with families?

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Zero to Three, https://www.zerotothree.org/espanol/social-and-emotional-development video link https://vimeo.com/119255263

III. Social-Emotional Development and its Impact on Positive Child Outcomes and Child Development

Learning Objectives:
After reading this section:

- The practitioner will know about typical social-emotional development in infants and toddlers in the natural environment and family context, and about creating activities and environments promote social-emotional development in young children. (aligned with DEC RP E1, E3)
- The practitioner will identify early warning signs of atypical social emotional development and will know how to initiate further screening or assessment. (aligned with DEC RP INS2)
- The practitioner will learn about the impact of trauma on brain development as well as on family function. (aligned with DEC RP E3, INS2)

Typical Social-Emotional Development

Parents' knowledge of child development is one key driver in improving outcomes for their children, yet more than half of parents wish they had more information on how to be a better parent (Rock & Crow, 2017). Practitioners in early intervention have the responsibility to address with families their questions or concerns and provide information regarding social-emotional development. Social-emotional skills are the base for many other skills to build upon; families want to know what to expect to support their child to succeed in the world. A study conducted in 2016 by Zero to Three and the Bezos Family Foundation found, "a majority of parents (59%) think children do not experience these emotions until the age of six months or older. About half of all parents surveyed underestimate how early their infants are able to pick up on the intentions and feelings of others: 47 percent believe one-year-old children are not affected by parents' mood, despite evidence this capacity emerges around three months of age. The survey also demonstrates a large difference between children's actual developmental capabilities and what parents believe they can do. A child's ability to control his or her emotions develops between three and four years of age but nearly one quarter of parents think that this occurs at one year of age or younger. While the ability to share and take turns emerges between three and four years, 43% of parents think children have this capacity before the age of two. This common misconception reinforces the need for practitioners to share the knowledge they have on social-emotional development and skills with families. Watch the video below for parental perspective on how children learn from their parents.

Did You Know?

Research shows that a strong social and emotional foundation in early childhood powerfully impacts children's later positive attitudes and behaviors, their academic performance, career path, and adult health outcomes! (CDC.org, 2017)

https://www.zerotothree.org/resources/1426-how-do-your-children-learn-from-you

Social-Emotional Evidence-Based Practices

Children are born with the need and desire to connect with those around them. When positive relationships are established with children from birth, children will feel safe and secure while laying the foundation for healthy social and emotional development. Social-emotional development involves several interrelated areas of development, including social interaction, emotional awareness, and self-regulation (U.S. Dept. of Ed., 2017).

Below are some important aspects of social-emotional development for young children:

- *Social interaction* focuses on the relationships we share with others, including relationships with adults and peers. As children develop socially, they learn to take turns, help their friends, play together, and cooperate with others.
- *Emotional awareness* includes the ability to recognize and understand our own feelings and actions and those of other people, and how our own feelings and actions affect ourselves and others.
- *Self-regulation* is the ability to express thoughts, feelings, and behaviors in socially appropriate ways (U.S. Dept. of Ed., 2017).

When you review the social-emotional developmental milestones listed below for infants and toddlers you will see how social interaction, emotional awareness, and self-regulation are intertwined with these expected milestones:

- Birth to 2 months — infants may briefly calm themselves (may bring hands to mouth and suck on hand), try to make eye contact with caregiver and begin to smile at people.

- 4-5 months — infants may smile spontaneously (especially at people), like interacting with people and might cry when the interaction stops, and copies some movements and/or facial expressions (smiling or frowning).

- 6-8 months — infants react positively to familiar faces and begin to be wary of strangers. They also like to play with others, especially parents and other caregivers and will respond to their own name.

- 9-11 months — infants may show early signs of separation anxiety and may cry more often when separated from caregiver and be clingy with familiar adults. They may become attached to specific toys or other comfort items. They understand “no” and will copy sounds and gestures of others.

- Between 12-15 months — toddlers may show fear in new situations, repeat sounds or actions to get attention, and begins to follow simple directions. They may show signs of independence and resist a caregiver’s attempt to help.

- Between 18 months and 2 years — toddlers may need help coping with temper tantrums, begin to explore alone but with parent close by. They may also engage in simple pretend or modeling behavior (feeding a doll or talking on the phone), and be able to demonstrate joint attention; for example, the child points to an airplane in the sky and looks at caregiver to make sure the caregiver sees it too.

- 2-year-olds — toddlers may copy other adults and older children, show much more independence and may show defiant behavior. They can follow simple instructions, mainly play alongside other children (parallel play), but begin to include other children in play.

- 3-year-old — toddlers may start to understand the idea of “mine” and “his” or “hers” and become uneasy or anxious with major changes in routine. They also begin to learn how to take turns in games and follows directions with 2-3 steps.

As a practitioner, it is important to have knowledge of the next steps in social-emotional development to support families in helping their child continue along the developmental continuum. When completing home visits with families, it is helpful to use a curriculum-based assessment tool to write appropriate outcomes, plan activities, and build your toolbox of knowledge.

Atypical Social-Emotional Development

As practitioners in early intervention, you are aware of what is expected or typical of children in regard to social-emotional development. This knowledge makes it easier to see when there are things that could be considered warning signs for social-emotional delays. It is important to remember many of the social-emotional issues that occur for children are due to a caregiver’s lack of knowledge about development, rather than abuse. Many parents have not been educated on the importance of the child/caregiver relationship to social-emotional development during the first three years of life. However, issues in the area of social-emotional development can and do develop and may vary widely depending on each family’s specific situation. Some children may display obvious problems, while others may not appear to be affected by their experiences (Perry, 2013). You may have children on your caseload who have been placed in foster care or have had a complicated medical history; both of those situations may impact social-emotional development of a child.

The following are some examples of what is considered atypical in babies at ages:

- 6 months — extreme irritability or unresponsive to caregivers.

- 12 months — does not seek comfort when upset, hard to console, stiffens.

- 18 months — child shows few emotions, no fear of strangers, does not seem to enjoy making caregiver laugh.

- 24 months — kicks, bites, screams for no reason, does not show affection, likes or dislikes.

- 36 months — may show no signs of empathy, does not greet familiar people, and have continued aggression.

Each family/child situation is different and when, as a practitioner, you observe atypical behaviors, your responsibility is to see if there is a need for further social-emotional screening, evaluation, and/or a referral to mental health professionals. The next section will give you information on the impact of trauma and key information in working with families who may be affected.

Impact of Trauma on Social Emotional Development

Trauma is defined as events that threaten the child's safety and/or the safety of their parents/caregivers. This includes physical and sexual abuse, exposure to domestic violence, significant child maltreatment and neglect, natural disasters, accidents, and painful medical procedures. Early childhood trauma experienced in the first three years of life dramatically changes the brain architecture. Persistent fear and chronic anxiety causes changes in brain activity and have been shown to have long-term adverse consequences for learning, behavior, and health. The following areas are specifically affected:

- emotions;
- response to perceived threats;
- short-term memory;
- fear, anxiety, and impulsive responses; and,
- reasoning, planning, and behavioral control.

What does this look like in early childhood? We may see a very heightened "flight or fight" response where a child exhibits significant fear and anxiety at the slightest perceived threat (a frown or raised voice) or a child sees a perceived threat where there is none (meeting a new person or being in an unfamiliar environment). An infant may appear withdrawn or dysregulated and irritable. A toddler may be impulsive and aggressive; much beyond what is typical for their age (Felitti, et al., 1998). The extent of the harmful effects of trauma are impacted by the duration and intensity of the trauma and the presence or absence of a reliable, positive, caring, protective, and nurturing caregiver during or following the traumatic experiences.

If current trauma/abuse is suspected and there is a concern about the child's safety, then as a mandated reporter, you are required to report this. Discuss with your supervisor if you have concerns.

Children with a confirmed trauma history should be referred to a mental health provider experienced in trauma. The early intervention practitioner and other team members would benefit from working closely with this mental health provider and the caregiver to ensure the early intervention outcomes and services are appropriate for the child's needs.

When working with families and caregivers who have experienced trauma or abuse it is important to:

- ask your supervisor or social-emotional services team for assistance in next steps to support the family and child, if needed;
- be aware of the impact on the child and family by relating to the child and family sensitively with a knowledge of trauma; being aware of possible "trauma triggers" for the child and family;

- recognize the role trauma may have on learning, behavior, and overall health while addressing the child's developmental needs with appropriate social-emotional screenings and assessments;
- utilize the information gained from assessments to address the child and family's needs and desired goals in the Individualized Family Service Plan (IFSP), which may mean linking them to needed community resources such as a mental health provider, support groups, etc.; and,

- assist the family to make the connection with the new community resource, with family consent, rather than just giving them a phone number to call.

If the child is demonstrating social-emotional delays, and/or has a history of abuse/neglect, foster care placement, or other possible traumas, then it would be appropriate to have a conversation with the family regarding the child's needs and their concerns in this area. Discuss with the family the approved assessment tools and choose the tool most appropriate for the child and family. The assessment will gauge the child's areas of need in the social-emotional area, work with your IFSP team identify the appropriate services to address the desired outcomes.

Check for Understanding:

1. What are two situations that might affect a child's social-emotional development?
2. Name two behaviors that are considered "undesirable" to a parent but are actually typical for a child under the age of three.
3. Suggest strategies for helping parents cope with specific behaviors named in #1.

In the **Appendix** there is a mental health resource list and multiple resources listed for **online videos of typical and atypical development** for further learning.

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IV. Partnering with Families

Learning Objectives:
After reading this section:

- The practitioner will know how to build trusting and respectful partnerships with families that are responsive to the families' values, priorities and resources. (aligned with DEC RP F1, F3, F5, F6)
- The practitioner will understand how to consider and address families' cultural and linguistic identity and diversity when conducting screening and assessments for planning effective early intervention services. (DEC RP A1, A5, A11, F7)
- The practitioner provides intervention services that strengthen the families' relationship with their children, and assists them to learn how to support their children's social-emotional development. (F5, INS2, INS13, INT 1, INT 2)

Establishing Rapport and Partnering with Families

Research showing how young children learn and develop highlights that infants and toddlers learn through observing and interacting with familiar adults during familiar daily routines (Shonkoff & Phillips, 2002 &2009). These findings identify family members and other regular caregivers as the primary teachers and interventionists for children (McWilliam, 2015). The reauthorization of the IDEA Part C in 1997 acknowledged these findings, and strengthened the role of families and of services in the natural environment by shifting from a clinical child-based intervention approach to a caregiver-mediated intervention model. This means the intervention services would be provided in the child's natural environment such as the family home, babysitter's or daycare (IDEA, 2004; McWilliam, 2015). Therefore, it is the responsibility of the early intervention practitioner to understand how to teach, consult with, and coach families and caregivers on how to support their child's development during their daily routines and in typical settings (Knowles, 2015; McWilliam, 2015; Ziviani, Darlington, Feeney, Rodger, & Watter, 2013).

Strong and trusting relationships between early intervention professionals and family members and other caregivers is a predictor of effective interventions (Askew, Krehbiel, & Alta Mira Specialized Family Services, 1990). As discussed in Section II, collaboration with families and caregivers can help in developing meaningful outcomes that can be implemented between intervention appointments to produce positive results for the child and family. The IFSP outcomes will be more valuable and useful to the family because they reflect their concerns which incorporate their strengths, resources, and priorities. The practitioner also needs to work to establish rapport which includes understanding the family's challenges and hopes for their child from their point of view, to identify and support family's and caregiver's strengths, and to understand and value their personal priorities for their child (Askew et al., 1990; Lynch & Hanson, 2011). Throughout this collaboration, practitioners must be able to adjust their interactions and approach to the needs, preferences, and culture of the individual families they serve. Although they need to be authentic with their own style of interaction and service provision, to some extent, practitioners may need to adjust their style to support a "goodness of fit" with each family.

Addressing Diversity When Addressing Children's Social-Emotional Development

Early intervention professionals who are working to improve a child's social-emotional outcomes must start with establishing trust, with fostering collaborations, and with finding ways to support families' and other caregivers' knowledge and confidence.

Here are a few points to remember:

- Infants and toddlers learn through observations and through hands-on activities during daily routines in their natural environment;
- Families and caregivers are the primary teachers of their infants and toddlers throughout everyday situations;
- The role of the practitioner is to collaborate with families to develop routines-based strategies to address both, the child's developmental needs and the family's needs;
- Practitioners teach and coach the families to implement these strategies between provider appointments; and,
- Intervention is what occurs between appointments.

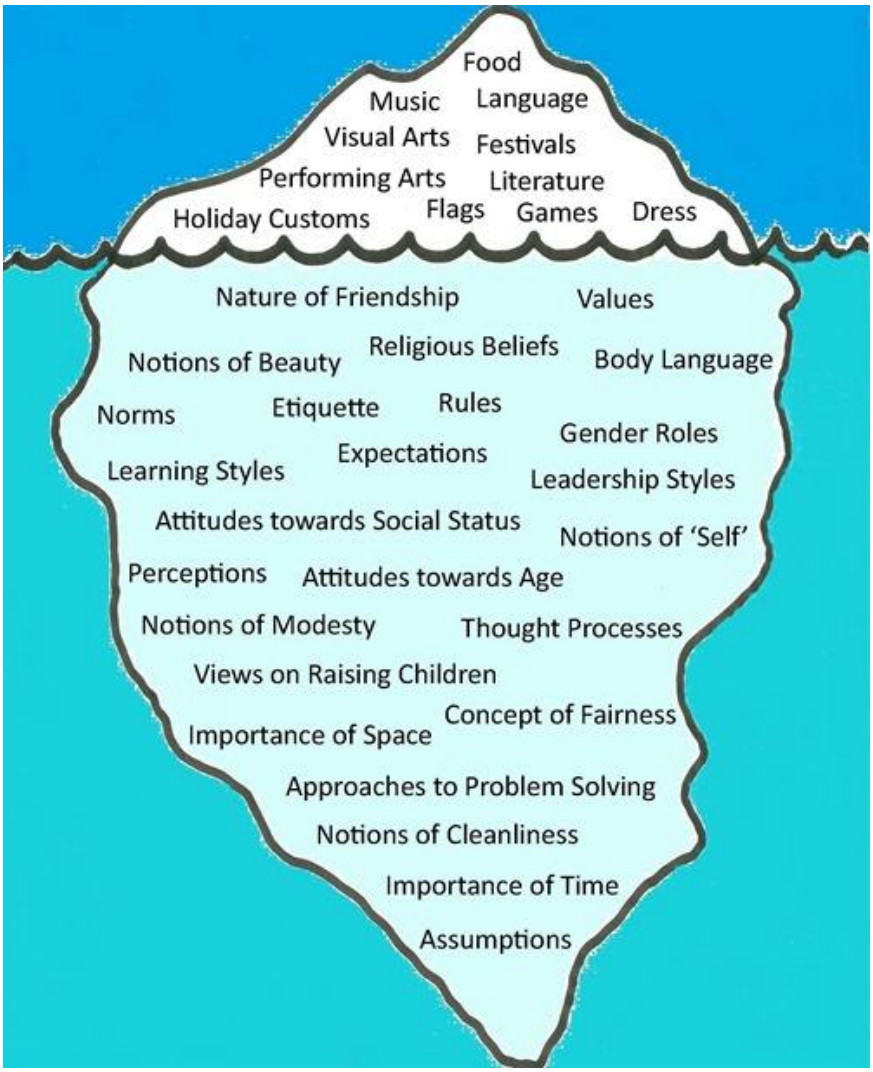
The above points are the same for all families regardless of cultural differences. The family is the child's first and most important teacher. Behavior expectations, display of emotions, mechanisms to cope with stress or change, and the decision about when it may be appropriate to seek an adult's attention, are all examples of social behaviors that children learn through immersion in their family's culture, and by their individual family values (Steed & Banerjee, 2016). Thus, it can be challenging for a practitioner and caregivers alike to distinguish between cultural or individual family differences on the one side, and true social-emotional developmental concerns for a child on the other side.

A person's or family's culture goes far beyond the difference in language, country of origin, or religion. E.T. Hall developed the visual of culture as an "Iceberg-Model" which can help practitioners become aware of cultural factors that can easily be observed, and of factors beneath the surface and that can only be discovered in sensitive and open conversations with families and caregivers (Hall, 1976). When early intervention practitioners are working with families, it is good to note there is so much more to a family's culture than what is apparent on the surface.

Building trusting and respectful partnerships with families means:

- *Practitioners learn about the child's strengths and needs across all developmental domains;*
- *Practitioners learn about the family's strengths and uniqueness;*
- *Practitioners collaborate with the family in a way that demonstrates an understanding of the families' values and cherishes the family as a partner to support the child;*
- *Practitioners must learn about and respect family rules and routines when planning their intervention for the family; and,*
- *The family's strengths and uniqueness are reflected in their Individualized Family Service Plan and incorporate their priorities and concerns in the decision-making about outcomes, strategies, services, and supports.*

As you can see in the picture below, families' have many more cultural values you may need to consider when having discussions and planning strategies with families:



http://interculturalism.blogspot.com/2011/03/iceberg-model-of-culture.html

Food for Thought:

An additional implication of the Iceberg-Model is cultural differences between people from different generations, faiths, family structures, geographical regions, or socioeconomic income groups may be far more significant than the cultural differences between people from different countries!

Visible and obvious cultural aspects – such as clothing, flags, food, performing and visual arts - are often essential to culture and are celebrated with festivals. However, there are also many cultural aspects of any community which may not be so visible. We need to continually reflect on the many beliefs, values, assumptions and expectations which other cultures hold to be able to collaborate effectively with the children and families we serve in early intervention (Hall, 1976).

Do you want to discover more about your own culture, values, and biases? Check out the discussion activities and resources in the Appendix.

The Role of Families and Caregivers in Screenings and Assessments

Once an assessment has been completed, the practitioner needs to sit with the family and review the child's functioning in the area of social-emotional development; the screening, assessment results, and the present levels of development should all be discussed. The practitioner needs to point out to the family the child's strengths, educate families about the next steps for their child in this area, and what is generally typical in their child's age range. To strengthen the practitioner-family collaboration ask the family if they feel you are describing their child, then listen, consider and validate what they have shared with you before discussing any additional screening or assessment. Throughout this conversation, the practitioner needs to keep in mind the family's individual and culturally-influenced expectations (Steed & Banerjee, 2016).

When providing early intervention services, it is important to remember the child's family relationships are the base to build learning upon. Our job is to strengthen the family's relationship with their child and support overall social-emotional development for the entire family. This awareness can assist in continuing to build a trusting relationship with the family. If there are concerns about the child's social-emotional development, discuss how the child and family strengths and positive qualities will be the building blocks utilized to help the child make progress. It is critical the IFSP team members collaborate with the family in identifying progress the family desires for their child. As a team, you will develop outcomes, strategies, services and supports that work for their individual family. The practitioner works with the family to find ways to embed intervention strategies into their everyday activities and routines. If additional screening, evaluation or assessments are warranted, you may need to consult with behavior specialists, your supervisor or social-emotional team that has expertise in social-emotional development to assist you in this process, including Prior Written Notice, if necessary.

Look over the Interactive Activity: Complete the following Engaging Families as Partners in Their Child's Assessment checklist:

http://ectacenter.org/~pdfs/decrp/ASM-2_Engaging_Families_Partners_2017.pdf

Then watch the Engaging Families as Assessment Partners video at:

https://www.youtube.com/watch?v=taZ4D7AJ1Z0&feature=youtu.be

Do you want to learn more about where you are in your work of engaging families? Check out the interventions Informed Family Decision-Making Practices Checklist at http://ectacenter.org/~pdfs/decrp/FAM-2_Inf_Family_Decision_2017.pdf
Then watch the video at:
https://www.youtube.com/watch?v=KOb6nFDroeI&feature=youtu.be

Check for Understanding:

1. What is one way to build an open, trusting relationship with families?
2. Think about a family on your caseload, what have you learned about their cultural values and how did you respect those in your interactions with the family and child?
3. What does the IDEA Early Intervention Parent Handbook require when giving a prior written notice for screening, evaluation, or assessment to a family whose native language is not English?

References:

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V. Screening, Evaluation, and Assessment of Social-Emotional Skills and Development

Learning Objectives
After reviewing this section:

- The practitioner will learn about social-emotional screening and assessment tools, and about family-centered interviews (aligned with DEC RP, A1, A2, and A3).
- The provider will understand specific social-emotional screening and assessment tools, how to determine if formal assessment is necessary, and what to do with results (aligned with DEC RP A3, A9, A10, INS3, INS 10).
- The provider will learn strategies to collaborate with families and other professionals to correctly obtain information about a child's social-emotional skills on the entry and exit Child Outcome Summary Forms (COSF) (aligned with DEC RP A2, A7).

Did you know within early intervention, you must have parent consent in order to complete a screening, evaluation, or assessment? (IDEA, 2004)

General Considerations in Screening, Evaluation, and Assessment of Social-Emotional Skills and Development

Research tells us social-emotional development is critical in early childhood for future success and is the foundation for learning (Rock & Crow, 2017). Children who learn appropriate social-emotional skills are known to do better in school because of their ability to problem solve, develop healthy relationships, learn from others and exhibit fewer behavioral problems. Development of healthy skills has lasting effects beyond childhood, such as increased health, success, and confidence into adulthood. Strong parent-child relationships are extremely critical to healthy social-emotional skills, which early interventionists can help to support to ensure better outcomes for the child and family. A child's experiences throughout daily life at home, child care, outings, family gatherings, and neighborhoods all attribute to social-emotional development.

An infant or toddler who is eligible for early intervention may have a variety of professionals who make up their individual team. Throughout their course of receiving services, it is critical each professional maintains utmost respect for the parent-child relationship and the family's role as leader of their child's team. Each team member has the responsibility of not only sharing information from family members, but also obtaining information. Parents and other caregivers are able to share a wealth of information about a child that professionals cannot obtain during any length of observation or intervention session. Family members give us insights on family routines, roles of each member, culture, history, preferences, norms, and values. Remember, parents know their child best and are invaluable in their child's progress while receiving early intervention services.

Social-Emotional Evidence-Based Practices

The IDEA requires all children eligible for early intervention services should have their developmental levels assessed and updated at least annually. It is recommended all children also be screened routinely to determine if further assessment of social-emotional skills is necessary (IMH-Part C, 2005). Without objective data, interventions to address social-emotional concerns would be impossible to measure effectiveness. Universal screening of all infants and toddlers help us detect early risk factors for social-emotional delays; a child's earliest emotional development is linked to later social behavior (CA Dept. of Education, 2017). Infants can exhibit behaviors at a very early age that can signal the need for social-emotional intervention, such as insecure attachment to a caregiver or inability to soothe themselves independently. Children with autism spectrum disorder, severe cognitive disabilities, abuse/neglect, children of teen or depressed mothers are at an even higher risk of social-emotional delays. Baseline screening can help to determine if further assessment is necessary to support the child and family.

Purpose of social and emotional screening, evaluation, and assessment:

a. To determine identify potential developmental delays, determine eligibility, and identify individual child's strengths
b. To individualize s child intervention strategies and services to identify children who may need more comprehensive evaluations to inform intervention strategies
c. To monitor progress and
d. To evaluate program effectiveness

Appropriate Tools

There are various social-emotional screening and assessment tools available, it is recommended to check the IDEA Part C website, at http://dhhs.nv.gov/Programs/IDEA/PartC/, for approved tools prior to screening or assessing a child. Programs may also have specific requirements regarding the screening and tools, check with your supervisor to be sure. Screening can help to identify need for further assessment or observation. One screening tool is The Ages and Stages Questionnaire. It has a unique sub-test focused specifically on social-emotional development called the ASQ:SE-2. The ASQ:SE-2 is a parent questionnaire for children ages 1-72 months. It includes 30 questions per questionnaire that are quick to complete, even quicker to score, and are reliable and valid. There are other screeners that look at family needs and not just the child's social-emotional development. The Environmental Screening Questionnaire (ESQ) is a brief parent questionnaire identifying family risk factors for social-emotional challenges, identifies opportunities for professional to focus interventions, such as immediate survival needs (housing, income, food). A copy of the Environmental Screening Questionnaire is in the Appendix for your convenience.

If you have questions regarding which screening tool to use for the family you are working with, check with your supervisor or social-emotional team. Prior to completing a screener or an assessment you may want to consider parent interview/discussions that can also give perspective into the family dynamics, build the relationship with the family and understand

where there might be areas of concern or stress. Below are some different types of parent interviews/discussions:

- The ECO Map is a visual diagram of a family's relationships, resources, and supports. It can open the door for more in-depth conversation about strengths and needs, can be used to monitor progress over time; it requires parental involvement, and demonstrates interest in family's life.
- Routine-Based Interviews (RBI) are structured discussions with the family about daily routines and family life. This is completed at the initial evaluation for early intervention eligibility; it could provide the practitioner with insight to the child and family interactions. It encourages discussions between practitioner and family members about what is important to the family as a whole.

Once the screening is completed, you will need to share the results with the family. This is a very stressful time for families so it is important to avoid words like 'pass', 'fail,' or 'test'. Try to emphasize family strengths, provide specific examples of concerns, and ask parents if they feel like it is an accurate representation of their child. Follow up with areas they may have felt were not accurate and make note of their input. Some children may not behave the same with people other than family and in new or different settings; parent input is essential for a complete picture of the child's skills. If you have professional concerns, you need to address those with the family, and have a referral plan and community resources available, if appropriate. If a formal assessment is recommended, be sure to schedule for a time and place when the family is most comfortable and include a Prior Written Notice (PWN).

Assessment tools can be effective methods to gather measurable data and develop social-emotional interventions. After a child has been referred for assessment following concerns from a screening, the practitioner needs to be familiar with age-appropriate social-emotional milestones. It is also critical for professionals to recognize typical as well as atypical skills in order to notice red flags and focus for potential IFSP outcomes. Major categories of social-emotional milestones include: social interaction (trust/attachment), self-regulation (identity), and independence (autonomy) (TACSEI, 2017).

In order for a formal assessment of a child's social-emotional skills or relationships to be effective, there must be a positive relationship between family and professionals as well as a foundation of trust. Social-emotional skills and relationships can be a sensitive topic for all involved and professionals have an ethical responsibility to treat it delicately and prepare for the assessment. Having an open and supportive relationship with the family may also provide insight on what are culturally relevant values and/or behaviors. Without this sort of information, practitioners may inaccurately identify skills as typical or atypical and risk suggesting strategies that could be harmful or offensive to the family. Practitioners must also be aware of the role of the family members in the assessment, to provide information before receiving information. Information from several sources can also be effective in formal assessments, including previous therapy reports, family interview, observation notes, results of previous screenings and even medical records. This increased preparation will likely lead to the selection of the most appropriate assessment tool.

Social-Emotional Evidence-Based Practices

When sharing results of any social-emotional assessment, the practitioner should focus on strengths first before deficits or concerns are presented. For example, if there was a low parent involvement score on an observational assessment tool, best practice would be to share skills the parent was observed to have before discussing the skills that were not observed. When it comes time for concerns to be presented, there should be specific examples so the family can understand or have opportunity to discuss if they do not feel it accurately depicts their child or relationship. Be mindful of the delicate topic while providing the most objective observations and results will be most effective in maintaining a trusting relationship with the family.

Here are a few of the IDEA Part C Office approved tools for consideration when completing a social-emotional screener or assessment:

- The Ages & Stages Questionnaires: Social Emotional, 2nd edition (ASQ:SE-2) is a parent-completed tool with a focus on children's social and emotional development, practitioners can quickly pinpoint behaviors of concern and identify any need for further assessment or ongoing monitoring.
- The Devereux Early Childhood Assessment for Infant and Toddlers (DECA I/T) measures social-emotional resiliency from birth to age 5, consists of a formal assessment as well as parent/family questionnaire, and behavior rating scale. It primarily measures protective factors in infants from ages birth to 18mos and toddlers ages 18-36 months. It is recommended for professionals who have known the child and family for at least four weeks and helps to create a profile for each child based on identified strengths and needs.
- The Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) is parent/child interaction checklist, for children ages 10-47 months and measures developmental parenting (wide range of parenting behaviors that help children develop over time). It comes from a strengths-based measure of parenting interactions to predict children's early social, cognitive, and language development and can be scored from a 10 minute live or video observation of parent-child interaction.
- The Social Emotional Assessment Measure (SEAM) is a curriculum-based assessment to help foster a stronger parent-child relationship as well as encourage prevention, early identification, develop goals and intervention for optimal caregiver-child interactions. This assessment is normed for children 3-63 months.

If you feel you may need assistance in working with a family, you may want to contact your supervisor and/or social emotional team. While each social-emotional assessment has its own procedures for administration, it is important for providers to be mindful to observe various characteristics in children and families in order to capture accurate information as well as develop more meaningful goals.

Some considerations to be mindful of are:

- parents own social-emotional state (signs of depression, abuse, etc.);
- environmental spaces (child care, home, clutter, lack of materials, etc.);
- responsiveness of child's caregivers to the child;
- the individual's child's developmental level;

- the parents' emotional status (ability to recognize, label, and understands feelings within one's self and in others, develops within context of relationships); and,
- regardless of what assessment tool is used, professionals should involve parents or other primary caregivers in the assessment, unless it is not possible to do so.

Child Outcomes Summary Form Rating for Social-Emotional Development

Information from developmental evaluations, screenings, assessments, parent report and observation will be useful in completing the Child Outcome Summary Form (COSF). Part C of the Individuals with Disabilities Education Act (IDEA) requires that every child entering early intervention services have completed Child Outcomes reporting. In addition to providing valuable information about the child's global levels of functioning, the information is needed to make improvements in statewide services and to justify federal and state money spent on early intervention. This is part of the national system of accountability; therefore, the State of Nevada must show the money spent on early intervention makes a difference for children.

Developmental assessment information about every child is needed to determine if progress has been made. The areas required to be reported include the child's skill level in social relationships; acquisition and use of knowledge and skills; and taking appropriate actions to meet his/her needs (NV IDEA Part C Office, 2016).

The COSF is completed by gathering developmental information through the screening/evaluation/assessment process, including both formal and informal assessment procedures (i.e. observations, input from the family, clinical opinion from IFSP team members, and the child's health history). You will be addressing the following areas of development when completing the COSF. *Italicization indicates a social-emotional skill.*

- **Positive social-emotional skills (including social relationships).** Consider the following in your description and scoring: *attachment/separation/autonomy; expression of emotions and feelings; learning rules and expectations; social interactions and play; self-regulations; communicating with others (gestural/verbal).*

- **Acquisition and use of knowledge and skills (including early language/ communication).** Consider the following in your description and scoring: *development of symbolic play; gestural imitation*; problem solving; matching and sorting; *understanding the meaning of words (pointing to pictures, body parts, etc.); following directions; communicating with others (gestural/verbal)*; development of sounds and intelligibility; *visual responses and tracking*; eye-hand coordination; *appropriate use of objects/toys; development of self (recognizes name, distinguishes self from others; developing independence).*

- **Use of appropriate behaviors to meet their needs.** Consider the following in your description and scoring: problem solving; *communicating needs to others (verbal/gestural);* mobility and transitional movement (rolling, sitting, crawling, standing, walking/running; climbing, stairs, etc.): grasping, reaching and releasing;

distinguishing self from others; self–regulation; self-help skills (feeding, drinking, dressing, toileting, grooming/hygiene, etc.).

When rating the child in the three areas of development, you are being asked to compare the child's skills and behaviors to those of his/her same age peers. Remember to utilize all relevant information received from all team members, including the parents or other caregivers, and the evaluation/assessment results to determine the child's rating. The evidence that supports the rating and the source of the evidence must be documented on the Child Outcome Summary (COS) form as well. See appendix for example and decision tree for rating scores (NV adapted COSF from ECO Center, 2009).

Including Families in the Rating Discussion

The family plays several important roles in the child outcomes measurement process, including the family as 1) team member, 2) child information provider, 3) rating participant, and 4) consumer.

1. Just as families are members of IFSP and IEP teams, they are critical to the assessment team (Bagnato & Neisworth, 1991), tell us: "Early childhood assessment is a flexible, collaborative decision-making process in which teams of parents and professionals repeatedly revise their judgments and reach consensus....".

2. COS ratings rely on information about a child's functioning across situations and settings. Parental input is crucial: family members see the child in situations that professionals do not. The rest of the team will need to learn what family members know about the child — what the child does at home, at grandma's house, in the grocery store, etc.

3. As members of the IFSP or IEP team**,** families are natural participants in the COS rating discussion. Their role in the rating is as an expert of their child, while other members of the team will know child development and the skills and behaviors expected at various age levels. Programs and individual teams not including the family in the rating process will need to maximize the role of family as information-provider in order to make the COS rating.

4. Whether or not families participate in the rating discussion, professionals will need to be able to explain to families why the rating is being done and what it means.

Several states and programs have developed brochures and letters that describe the outcomes measurement system for families.

Social-Emotional Evidence-Based Practices

Check for Understanding

1. Why is it important to involve families/caregivers in screening/assessment/COSF procedures?

2. What sources of information would you review before meeting with a family to discuss a concern in the social-emotional development of their child or family?

3. What is the Child Outcome Summary information used for?

References:

DEC Recommended Practices (2005). Quote from Bagnato and Neisworth (1991) Retrieved from: The Early Childhood Outcomes Center, www.the-eco-center.org

ECTA, Early Childhood Technical Assistance Center (2018). *Outcomes Measurement: Self-Directed Learning*: http://ectacenter.org/eco/pages/selflearning.asp

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NV IDEA Part C Office (2016). *Early Childhood Outcome Reporting Guidelines for Parents,* Technical Assistance Center on Social Emotional Intervention for Young Children (TACSEI) Handout 2.5 (2017).

NV adapted COSF from ECO Center, Dec. 2009.

VI. Evidence-Based Practices related to Supporting Social-Emotional Development

Learning Objectives
After reading this section:

- Practitioners will understand how to use evaluation and assessment information to help the family develop functional outcomes and implement strategies to address the family's priorities and concerns and are built in the family's individualized routines. (aligned with DEC RP E1, E2, F4, INS5, INS6, INS7, INT1).
- The practitioner will collaborate with the family to develop functional outcomes and strategies to build upon the child and family's strengths to promote the child's social-emotional development and support family/child relationships. (aligned with DEC RP E1, F5, F6, INS5, INS13, TC2).
- Practitioners will collaborate with families to develop strategies to support them during challenging transition situations and periods (aligned with DEC RP TR1, TR2).
- Practitioners will support families in accessing appropriate community-based services related to social-emotional development and functioning. (aligned with DEC RP TC4).

Developing Functional Social-Emotional Outcomes for Families in the IFSP

Following the results of a formal social-emotional assessment, it is critical to analyze data collected, as well as family concerns, in order to identify and develop appropriate outcomes. A warm, mutual reciprocal collaboration between the IFSP team and family is critical for the family to feel comfortable discussing social-emotional concerns. A child's IFSP outcomes should be the link between information gathered from evaluation and assessment across all domains, observation and parent input, and the family's concerns, resources and priorities. These outcomes should include the child's degree of participation, how behaviors will develop across multiple settings, and the family's priorities for what they would like to see their child achieve in the next six months.

Practitioners should be aware when developing outcomes that they are functional (able to be used in everyday situations and environments, not rote skills to pass a test), general (not too specific that the child is unable to generalize across situations), and measurable (can be determined successful with objective data). Children and families must be given options to apply their new skills in various opportunities and situations. It is important to note social-emotional development is not limited to behavioral issues — a communication outcome can also address a social-emotional developmental concern.

The following is Robin McWilliams's Outcome Functionality Checklist which can be used when writing functional outcomes:

- Is the outcome related to a child's needs in a routine (i.e. time of day, event or activity)?
- Is the outcome clear about what the child or family will do?
- Is the purpose either self-evident or stated ("Maria will ___ to ___.")
- Is the outcome specific enough so everyone knows what is being worked on?
- Is the outcome general enough so the child or family has options for how, when, or where he or she carries out the action?
- Is the outcome necessary for successful functioning in routines or otherwise to meet the family's desires?
- Can one logically answer, "Why are we working on this?" (2002)

Another guide to use for assistance in writing functional outcomes is the Early Childhood Technical Assistance Center (ECTAC) guidelines to develop functional outcomes. High-quality, functional IFSP outcomes are defined as:

- Necessary and functional for the child's and family's life;
- Reflect real-life contextualized settings;
- Crosses developmental domains and is discipline-free;
- Jargon-free, clear and simple;
- Emphasize the positive, not the negative; and,
- Use active words rather than passive words.

In developing the outcome, ECTAC uses the Third Word Rule. In this model, the third word of the IFSP outcome should be a contextualized action that is functional and understandable to the family. For example, "Sarah will **play** with her brother while her mom is fixing dinner." This outcome would be based on information from the evaluation and assessment of the child and information from the family. It should be a reflection of something the parent might want, such as "I just want to be able to fix dinner without having Sarah having a tantrum."

The outcome should emphasize the positive instead of the negative, so instead of the outcome being "Sarah will stop having tantrums every evening when I'm in the kitchen" the example above is positive, and states what the child **will** do that is desired by the parent and not what the child **will stop doing**. It also describes the child and family's participation, includes typical routines and is based on what is important to the family.

Other examples could be:

- Chris will crawl across the room to play with his toys.
- Sarah will say or sign drink when she is thirsty.
- Jose will feed himself part of the meal using a spoon or other utensil.
- Isaac will take turns with his friends when they are on the playground.

A growing body of evidence shows caregiving practices improve when knowledge about child development improves. This includes more positive parent-child interactions,

increased involvement with early learning, and better behavior management. Helping parents and caregivers feel successful and capable in their roles — known as self-efficacy — improves not only parenting practices, but child outcomes as well. Caregivers' feelings of self-efficacy have been linked to an increase in parent responsiveness and sensitivity, as well as children's self-regulation and social skills (Rock & Crow, 2017).

Strategies to Support Children and Families in Developing Social-Emotional Skills

Once assessment is completed and outcomes have been developed, practitioners must then develop instructional strategies for the families to use during daily routines. These strategies should be used within a coaching framework, in other words, the practitioner should be modeling the skill for the parents so the parents can teach the child in between visits for maximum intervention. Strategies should be written as a step-by-step detail of the activities proposed that will lead to the achievement of the outcomes.

To develop appropriate outcomes for infants, practitioners should consider the infant's emerging awareness of self and others. Infants demonstrate this foundation in a number of ways. For example, they can respond to their names, point to their body parts when asked, or name members of their families. Through an emerging understanding of other people in their social environment, children gain an understanding of their roles within their families and communities. They also become aware of their own preferences and characteristics and those of others (CA Dept. of Ed, 2017).

Infants will develop close relationships with children they know over a period of time, such as other children, in the family childcare setting or neighborhood. Relationships with peers provide young children with the opportunity to develop strong social connections. Infants often show a preference for playing and being with friends, as compared with peers with whom they do not have a relationship. Howes' (1983) research suggests there are distinctive patterns of friendship for the infant, toddler, and preschooler age groups. The three groups vary in the number of friendships, the stability of friendships, and the nature of interaction between friends; for example, the extent to which they involve object exchange or verbal communication (CA Dept. of Ed., 2017).

As practitioners, you work on building social-emotional skills for the children and families you work with while thinking about a wide set of developmental skills. Researchers and experts in child development have identified a range of attributes that constitute the social-emotional development from zero to five years of age listed below:

- **Emotional development** is the ability to recognize and understand our own feelings and actions, as well as those of other people; also, how our own thoughts, feelings, and actions affect ourselves and others.
- **Social interaction** focuses on the relationships we share with others and is greatly shaped by our emotional development. As children develop socially, they learn to take turns, empathize with and help their friends, play together, and cooperate with others.

- **Self-regulation** is the ability to express thoughts, feelings and behaviors in socially appropriate ways. Learning to calm down when angry and to use words instead of hitting is an example of self-regulation; other examples include keeping one's attention focused on a task, and working toward goals with persistence.
- **Co-regulation** is the interactive process in which two people, such as an infant and a parent, respond to and shape each other's thoughts, feelings, and actions. Co-regulation helps both parents and children recognize and understand the other's reactions. Co-regulation also develops a crucial cycle of stimulation and rest that contributes to children's healthy social-emotional development (Butler & Randall, 2012).

Developing these characteristics listed above could be a starting place for IFSP outcomes if there are concerns in social-emotional development.

Here are some suggestions for writing effective strategies in the IFSP, strategies should:

- Be directly related to the desired behavior;
- Worded in a way most ordinary people would understand (no jargon);
- Be the simplest, most direct approach to attaining the outcome (versus "exercises" or "stimulation");
- Be developmentally appropriate;
- Be something caregivers can carry out (versus just applicable to professionals);
- Will specify what each person (child or adult) will do; and,
- Be able to answer, "Why are we doing this?" (Robin McWilliam, 2002)

There are more resources and developmental levels with next steps for a range of ages in the Appendix.

Strategies to Support Children and Families during Periods of Transition

During any transition and definitely between programs, it is important to help the new program to get to know the child and family. This includes supporting the family to communicate with the new program about the following:

- the child and family's likes and dislikes;
- the child's strengths and needs;
- what they enjoy doing as a family; and,
- the family culture as it relates to the care of their child, (food preferences, holidays celebrated, social interaction and boundaries).

Here are suggested topics you may want to think about when assisting a family in transition. Discuss:

- The rituals and routines the family has around transitions and separating what works well and help the child;

- Considering other rituals and routines the new program has and include these in the transition planning if the family feels these would be helpful to their child.
- Making plans with the family and new staff to visit the new program before the child's start date to provide some time for the caregiver and staff at the new program to develop their relationships and give the caregiver the opportunity to observe and ask questions.
- As part of the transition plan, ask how separation anxiety is typically handled at the new program. Help the program and caregiver to have a conversation about this process, given the unique needs of the child and the family's preferences. Discuss with the family and new program the possibility of allowing extra time at drop off and pick up times for the caregiver to interact with staff and help the child feel they are being left with people their caregiver likes and trusts. This may ease any separation anxiety the child may have. Encourage the new program to check in with the parents, in the beginning especially, to see how they think the transition is going for themselves and their child.
- Working with the new program to have one point of contact with which the caregiver can discuss concerns and questions. This may be the lead teacher, or it may be an aide who the child likes, and the caregiver feels comfortable talking with.
- The role of the service coordinator of the transitioning program as the primary person who will support and guide the family through the transition process.

Attachment and separation are intertwined. Firm ties to another person help children develop autonomy, and gain the belief we are lovable. These family bonds promote resilience, self-regulation, and a positive sense of self in children. Infants and toddlers who build trusting attachments to teachers help ease the stress of separation from their family (Balaban, 2006). It is part of the child's developmental process to be both attached to the parent yet separate, and this journey is seen as a "developmental necessity" (Resch, 1977). By the time the child is a toddler they can hold an image of their primary caregiver in their mind, but this is fragile and so we see the stress of separation or "separation anxiety" as a result. Factors that influence attachment and separation for families are family stress, parenting style and temperament, the caregiver's own experiences as a child, and their cultural values. Influences for the child are the child's temperament, personality, the nature of their attachment to their primary caregiver and any prior experiences the child has with separation. The teacher's temperament, experiences and cultural values around separation and attachment, will also influence the child's ability to separate and adjust to the new program.

The following are some examples of strategies to assist families with the transition process. The service coordinator can discuss these and other strategies with parents and other caregivers, depending on the needs and preferences of the family.

Strategies that families can use to help with transitions:

- Prepare your child for transition: explain to your child they are going to be in school while Mommy or Daddy gets work done. Talk about the fun things to play with and do in the classroom and how much you like the school and the teachers. There are books about separation you can read to your child to help

them process what will be happening. Encourage the family to visit the new program and include this in the transition plan.

- Try not to make it harder on the child by asking if he/she will miss you and how hard it will be to separate from Mommy. When your child loves school and the teacher that means you have made a good choice!
- If you get emotional when you drop off your child try not to show this to him/her. If you look concerned or worried, your child will follow your lead and the separation will be more difficult for both of you. Try to smile and be confident, assuring your child you will return.

Here are some strategies Practitioners can use to help families with transitions:

- Discuss with families that separation is a part of life and with support and nurturing through this process your child will do well and have fun. It is understandable for it to be difficult at first, but if you are positive and excited about the new experiences your child will have it will be easier than you thought it would be. This first transition will set the stage for future successful transitions, such as to kindergarten.
- Reaffirm for the family that children with special needs are as attached to their caregivers as other children. Help the family to understand how a child with special needs or disabilities may experience a delay in their expression of their separation reactions and their cues may be more subtle or difficult to read. Help the family to communicate to the new program how their child typically behaves when separated from them and what they might expect.
- Encourage and help the family to include in the transition plan information the family agrees to share with the new program about the child, such as the child's likes/dislikes, strengths, needs and family culture.

Most of all, remember it is a difficult time for families as they have built a relationship with their child's IFSP team and they are entering new and uncharted territory. Help them to know their IDEA Parent Rights so they are able to advocate for their child and their family. Let them know about parent advocacy groups, support groups, and other resources to help them get support as their child ages, if needed (http://dhhs.nv.gov/Programs/IDEA/PartC/).

Referral to Specialized Supports and Services

Families may need additional information on supports both during their time with early intervention and after their child ages out of early intervention. This may be especially true when there are social-emotional concerns within the dynamics of the family. There are many supportive agencies that can be reviewed with the family and are listed in the State of Nevada Parent Handbook. The parent handbook link is below:

http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/IDEA/EnglishParentHandbookApril2015UpdateFINAL.pdf

As always, if you have concerns or are uncomfortable in offering a referral or recommendation to other supports or services to the family, talk with your social-emotional

team or supervisor for advice and suggestions. There are many regional resources with phone numbers also listed in the **Appendix,** section VI.

References:

Balaban, N. (2006). *Easing the Separation Process for Infants, Toddlers, and Families.* Beyond the Journal, Young Children on the Web, Nov 2006.

Butler, E. & Randall, A. (2012). *Emotional Co-regulation in Close Relationships.* Emotion Review 0(0) (2012): 1-9.

CA Dept. of Ed., California Infant/Toddler Learning & Development Foundations, Retrieved from: https://www.cde.ca.gov/sp/cd/re/itf09socemodev.asp.

Merrill, S. (2010). *Starting Child Care It's a Transition for Parents Too!* Young Children, Sept 2010.

McWilliam, R. A. (2012). *Implementing and Preparing for Home Visits*. Topics in Early Childhood Special Education, 31(4), 224-231.

Rock, L. & Crow, S. (2015). *"Not Just "Soft Skills" How Young Children's Learning and Health Benefit from Strong Social-Emotional Development,"* TSTF-SED White Paper.

VII. Professional Development and Sustainability of Social-Emotional Services in Early Intervention

Learning Objectives
After reading this section:

- Practitioners will implement evidence-based practices related to social-emotional development in the intervention services provided to infants, toddlers, and their families. (DEC Recommended Practices INT2).

- Practitioners will be aware of resources to support their ongoing professional learning about social-emotional development. (ECTA System Framework, Personnel/Workforce Component (PN), In-service Personnel Development Subcomponent PN7).

- Practitioners will learn about strategies to support their continued use of their knowledge gained from training content and integration into their early intervention practices with infants, toddlers, and families. (ECTA System Framework, Personnel/Workforce Component (PN), In-service Personnel Development Subcomponent PN7).

The training content covered in Sections I-VI of this training module provides a basis of foundational knowledge for addressing social-emotional development in early intervention practices. Each practitioner who completes the Social-Emotional Practices Module has individualized strengths as well as areas that may warrant additional support. Professional learning and development does not end with the completion of the module. Training by itself is much more powerful when ongoing mentoring/coaching is also in place to support the evidence-based research to practice for the practitioner (NCSI, 2014). In order to implement the evidence-based practices covered in the module content, a practitioner should engage in ongoing professional learning activities tosupport the integration of the new knowledge into their work with infants, toddlers, and families. “Training and coaching are two forms of professional development that are linked to build and sustain the competence and confidence of practitioners to implement evidence-based practices as intended” (Snyder, et al, 2015). This section provides information on what evidence-based practices are and how to determine if a practice is evidence-based as well as a pathway for supporting learning experiences and practice through what is referred to as a “practice-based coaching” model (National Professional Development Center on Inclusion, 2008).

Evidence-Based Practices

Evidence –based practices are defined as: “Practices that are informed by research, in which the characteristics and consequences of environmental variables are empirically established and the relationship directly informs what a practitioner can do to produce a desired outcome" (Dunst, et al., 2007).

Social-Emotional Evidence-Based Practices

Please watch the following video:

https://ncsi-library.wested.org/resources/228 (NCSI, 2018)

You can see from the video Evidenced-Based Practices are not just practices that have been researched but practices that are acceptable to the family and have been shown to have positive outcomes in achieving the goals of the professional, family and child. The National Center for Systemic Improvement (NCSI) has developed the following steps to integrate multiple perspectives and sources of evidence to find evidence-based practices:

1. Define the question while considering characteristics of the child and family. Type of intervention, and desired child or family outcome.
2. Consider the evidence from the three circles of evidence:
   Best Available Research Evidence:
   - Search websites that provide intervention effectiveness summaries to identify potential interventions (see NCSI resource list in the appendix).
   - Judge the research evidence for these interventions in terms of impacts on desired outcome and relevance for the child and family.

   Family Wisdom and Values:
   - Consider consensus documents such as position documents and practice guides to tap into families' collective wisdom and values.
   - Consider the individual experiences, beliefs, values, priorities, and perspectives of the family with whom you will be working with related to a specific intervention.

   Professional Wisdom and Values
   - Consider consensus documents such as position statements, program and professional standards, and practice guides to tap into field's collective wisdom and values.
   - Consider your own values, experiences, and priorities to tap into your professional wisdom and values.
3. Determine if the intervention meets the FAIR test: Is it
   - **F**easible to implement,
   - **A**cceptable to families/professionals,
   - Effective in producing a positive **I**mpact, and
   - **R**elevant for the situation.

   If it does not meet **FAIR** criteria, you may need to reconsider practices, strategies or programs you may have had in mind for the particular child/family. If it does meet the criteria, then you have made an evidence-based decision (2018).

Using Evidence-Based strategies is important in making a difference for families' but to sustain and build strong programs also includes individual mentoring or coaching. One option for supporting early intervention practitioners to continue gaining professional knowledge is through the use of a coaching model such as the Practice-Based Coaching Model discussed below.

Practice-Based Coaching Model

The practice-based coaching model consists of three cyclical elements:

1. Planning goals and action steps to support ongoing learning;
2. Engaging in focused observation by a coach, mentor, or other colleague; and,
3. Reflecting on and receiving feedback from others.

Watch the following video on practice-based coaching:

https://eclkc.ohs.acf.hhs.gov/professional-development/article/practice-based-coaching-pbc

Planning Goals and Action Steps

To promote ongoing learning, the practitioner should develop a professional development plan that includes goals for integrating the new content into practice. This plan may address those areas that need practice and/or additional resources that the provider needs to feel confident about and able to use the evidence-based practices related to social-emotional development. The goals of the plan should be specific, measurable, action-oriented, relevant to the work, and time-bound.

Depending on the organizational structure of the practitioner's agency, the plan may be developed by the individual or with a coach or supervisor. The important thing is to identify areas that need further support and plan activities to strengthen the skills of the practitioner.

Engaging in Focused Observation

Implementing the evidence-based practices that the practitioner gained in the training may take time to fully integrate into

Additional Resources

Zero to Three website: https://www.zerotothree.org/

The Puckett Institute: http://www.puckett.org/

DEC recommended Practices: https://divisionearlychildhood.egnyte.com/dl/tgv6GUXhVo

See Appendix for more

intervention and how one engages with the child and family. Having a coach, supervisor, or fellow colleague observe an assessment or a home-visit may identify things that are going well and areas that need additional work. A practitioner may also use video of their interactions during home visits (with parental permission) to gather information to share with others or for personal self-reflection.

The DEC has developed Recommended Practices Checklists that may be useful tools during observation or in reviewing a video tape. Several relate to the training content of the Social-Emotional Module are available at http://ectacenter.org/decrp/type-checklists.asp.

Reflecting on and Receiving Feedback

Part of ongoing professional development is taking time to reflect on how to increase knowledge and skills to provide high quality services. This evaluative activity may be done with a coach, supervisor, other colleagues, or through self-reflection. It is important to periodically identify what is going well, what improvements are needed, and resources to address the individual's learning needs. The DEC Recommended Practices checklists noted above may be useful to use over time to identify areas of growth and areas where improvement is needed.

Technical Assistance Center on Social Emotional Interventions (TACSEI) also provides a self-reflection template the practitioner may wish to use to gauge his or her professional growth. The Center on the Social and Emotional Foundation for Early Learning (2008) has Infant/Toddler Training Modules for self-learning. These can be retrieved at: http://csefel.vanderbilt.edu/resources/training_infant.html.

References:

Division of Early Childhood of the Council for Exceptional Children (2014). *DEC Recommended Practices*. Retrieved at: https://divisionearlychildhood.egnyte.com/dl/tgv6GUXhVo

Dunst, C. J., Trivette, C. M., & Cutspec, P. A. (2007). *Toward an operational definition of evidence-based practice*. (Winterberry Research Perspectives, v.1, n.1). Morganton, NC: Winterberry Press. http://www.wbpress.com/shop/toward-an-operational-definition-of-evidence-based-practice/

National Center for Systemic Improvement (2018). *Three Circles of Evidence-Based Decision-Making in Early Childhood*. San Francisco, CA: WestEd.

National Center for Systemic Improvement (2014), *Effective Coaching: Improving Teacher Practice and Outcomes for All Learners.* Retrieved August 27, 2018 from: http://www.air.org/sites/default/files/NCSI_Effective-Coaching-Brief-508.pdf

National Professional Development Center on Inclusion (2008). *What do we mean by professional development in the early childhood field?* Retrieved August 10, 2008, from http://npdci.fpg.unc.edu/resources/articles/NPDCI-Professi onalDevelopment-03-04-08.pdf

Social-Emotional Evidence-Based Practices

The Puckett Institute (2017). Retrieved at: http://www.puckett.org/

Snyder, P. A., Hemmeter, M. L., & Fox, L. (2015). *Supporting Implementation of Evidence-Based Practices Through Practice-Based Coaching.* Topics in Early Childhood Special Education. Retrieved August 27, 2018 from https://files.eric.ed.gov/fulltext/ED577101.pdf.

Social-Emotional Evidence-Based Practices

Appendix

Section II.

Websites for online educational modules for Social-Emotional Development

CA Dept. of Education (2017). *Social-Emotional Development Domain,* Retrieved from: https://www.cde.ca.gov/sp/cd/re/itf09socemodev.asp Parent handouts related to social-emotional development.

Center for Social and Emotional Foundations for Early Learning
http://csefel.vanderbilt.edu/resources/training_infant.html

Early Intervention Training Program Illinois College of Education
https://blogs.illinois.edu/view/6039/114591

New York State Department of Health Early Intervention Program, *Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals* https://www.health.ny.gov/publications/4226.pdf

Pennsylvania Department of Education
This online course provides a foundation for early intervention and early childhood staff for the understanding of social and emotional development in infants and toddlers. The first module provides an overview of social and emotional development within the context of relationships. Attachment, temperament, self-regulation and the context of family, community and culture are emphasized. The second module provides an overview of responsive routines, environments, and strategies to support social emotional development in infants and toddlers. Observation, responsive caregiving, emotional literacy and development of social skills are explored. The third module looks at individualized interventions for infants and toddlers through determining the meaning of behavior and developing appropriate responses. Behavior as communication and responding to challenging behaviors are highlighted.
http://www.pattan.net/category/Training/Calendar/event/event.html?id=3cdfe38d-95d2-456e-8d96-d8bbee3edc47

Technical Assistance Center on Social Emotional Intervention for Young Children, 2011. Handout for families, http://challengingbehavior.fmhi.usf.edu/do/resources/backpack.html

Virginia Early Intervention Professional Development Center
Encouraging healthy social-emotional development of all children is a major goal of early intervention. Here you will find resources to help you as you interact with families and share strategies for positive social-emotional development. Visit the resource landing pad for information about evidence-based practices and topics; online, print, and video resources, and Virginia-specific guidance. http://www.veipd.org/main/sub_socio_emot_dev.html

Zero to Three Early Development and Well-Being video, https://vimeo.com/119255263, https://www.zerotothree.org/early-development

Social-Emotional Evidence-Based Practices

Section III.

Resources for online learning:

U.S. Dept. of Ed., *Data & Research, Early Learning: Talk, Read, And Sing!* Retrieved at: www2.ed.gov/about/inits/ed/earlylearning/talk-read-sing/index.html contains various English and Spanish tip sheets to assist families, caregivers and early learning educators in fostering health social and emotional development in young children. 6/2017

CA Dept. of Education, (2017). *Social-Emotional Development Domain,* Retrieved from: https://www.cde.ca.gov/sp/cd/re/itf09socemodev.asp Parent handouts related to social-emotional development.

www.zerotothree.org

The CDC website has a free library of photos and videos called *Milestones in action* with developmental milestones at each age (2016). Retrieved from: https://www.cdc.gov/ncbddd/actearly/milestones/milestones-in-action.html

https://www.cdc.gov/ncbddd/actearly/index.html, milestones, free materials, training videos, tracking developmental milestones for parents and professionals.

Section IV.

Environmental Screening Questionnaire (ESQ™)

Caregivers Name: _____

Date: _____

Please check "Yes" or "No" to answer the following questions. Caregivers may choose to omit questions they think are too personal.

Category	Yes	No
Education		
1. Are you a high school or GED graduate?	☐ z	☐ x
2. Are you taking classes or job training?	☐ z	☐ x
3. Do you have trouble communicating on the telephone?	☐ x	☐ z
4. Can you read English or another language?	☐ z	☐ x
5. Were you a teenager when you had your first child?	☐ x	☐ z
Total: _____		
Housing		
1. Have you moved three times or more in the last year?	☐ x	☐ z
2. Do you own or rent a home or apartment?	☐ z	☐ x
3. Do you rely on relatives or friends for housing?	☐ x	☐ z
4. Does your child have a safe outside play area?	☐ z	☐ x
5. Does your living arrangement satisfy your family's basic needs (e.g., heat, water)?	☐ z	☐ x
Total: _____		
Health/Behavior		
1. Do you have a child with a learning, behavioral, or emotional problem?	☐ x	☐ z
2. Do you, your partner, or children have a long-term health problem?	☐ x	☐ z
3. Are there mental health problems such as depression in your home?	☐ x	☐ z
4. Have you had contact with a child protection agency?	☐ x	☐ z
5. Does your child or children get along with other children?	☐ z	☐ x
Total: _____		
Economic		
1. Do you have health insurance?	☐ z	☐ x
2. Do you receive or need public assistance?	☐ x	☐ z
3. Are you currently employed?	☐ z	☐ x
4. Have you experienced credit problems?	☐ x	☐ z
5. Do you have regular telephone service?	☐ z	☐ x
Total: _____		

The development of relationships with certain peers through interactions over time

8 months	18 months	36 months
At around eight months of age, children show interest in familiar and unfamiliar children. (8 mos.; Meisels and others 2003, 17)	At around 18 months of age, children prefer to interact with one or two familiar children in the group and usually engage in the same kind of back-and-forth play when interacting with those children. (12–18 mos.; Mueller and Lucas 1975)	At around 36 months of age, children have developed friendships with a small number of children in the group and engage in more complex play with those friends than with other peers.
For example, the child may: Watch other children with interest. (8 mos.; Meisels and others 2003) Touch the eyes or hair of a peer. (8 mos.; Meisels and others 2003) Attend to a crying peer with a serious expression. (7 mos.; American Academy of Pediatrics 2004, 212) Laugh when an older sibling or peer makes a funny face. (8mos.; Meisels and others 2003) Try to get the attention of another child by smiling at him or babbling to him (6–9 mos.; Hay, Pederson, and Nash 1982)	**For example, the child may:** Play the same kind of game, such as run-and-chase, with the same peer almost every day. (Howes 1987, 259) Choose to play in the same area as a friend. (Howes 1987, 259)	**For example, the child may:** Choose to play with a sibling instead of a less familiar child. (24–36 mos.; Dunn 1983, 795) Exhibit sadness when the favorite friend is not at school one day. (24–36 mos.; Melson and Cohen 1981) Seek one friend for running games and another for building with blocks. (Howes 1987) Play “train” with one or two friends for an extended period of time by pretending that one is driving the train and the rest are riding.
Behaviors leading up to the foundation (4 to 7 months) During this period, the child may: Look at another child who is lying on the blanket nearby. (4mos.; Meisels and others 2003, 10) Turn toward the voice of a parent or older sibling. (4mos.; Meisels and others 2003, 10)	**Behaviors leading up to the foundation (9 to 17 months)** During this period, the child may: Watch an older sibling play nearby. (12 mos.; Meisels and others 2003, 26) Bang blocks together next to a child who is doing the same thing. (12 mos.; Meisels and others 2003, 26) Imitate the simple actions of a peer. (9–12 mos.; Ryalls, Gul, and Ryalls 2000)	**Behaviors leading up to the foundation (19 to 35 months)** During this period, the child may: Engage in social pretend play with one or two friends; for example, pretend to be a dog while a friend pretends to be the owner. (24–30 mos.; Howes 1987, 261) Express an interest in playing with a particular child. (13–24 mos.; Howes 1988, 3)

(Social-Emotional Development Domain, CA Dept. of Ed., https://www.cde.ca.gov/sp/cd/re/itf09socemodev.asp). Foundation: Relationships with Peers, California Infant/Toddler Learning & Development Foundations.

The developing concept that the child is an individual operating within social relationships

8 months	18 months	36 months
At around eight months of age, children show clear awareness of being a separate person and of being connected with other people. Children identify others as both distinct from and connected to themselves. (Fogel 2001, 347)	At around 18 months of age, children demonstrate awareness of their characteristics and express themselves as distinct persons with thoughts and feelings. Children also demonstrate expectations of others' behaviors, responses, and characteristics on the basis of previous experiences with them.	At around 36 months of age, children identify their feelings, needs, and interests, and identify themselves and others as members of one or more groups by referring to categories. (24–36 mos.; Fogel 2001, 415; 18–30 mos.)
For example, the child may: Respond to someone who calls her name. (5–7 mos.; Parks 2004, 94; 9 mo.; Coplan 1993, 2) Turn toward a familiar person upon hearing his name. (6–8 mos.; Parks 2004, 94; 8 mos.; Meisels and others 2003, 18) Look at an unfamiliar adult with interest but show wariness or become anxious when that adult comes too close. (5–8 mos.; Parks 2004; Johnstone and Scherer 2000, 222) Wave arms and kick legs when a parent enters the room. Cry when the favorite infant care teacher leaves the room. (6–10 mos.; Parks 2004)	**For example, the child may:** Point to or indicate parts of the body when asked. (15–19 mos.; Parks 2004) Express thoughts and feelings by saying "no!" (18 mos.; Meisels and others 2003) Move excitedly when approached by an infant care teacher who usually engages in active play.	**For example, the child may:** Use pronouns such as I, me, you, we, he, and she. (By 36mo.; American Academy of Pediatrics 2004, p. 307) Say own name. (30–33 mos.; Parks 2004, 115) Begin to make comparisons between self and others; for example, communicate, "_____ is a boy/girl like me." Name people in the family. Point to pictures of friends and say their names. Communicate, "Do it myself!" when the infant care teacher tries to help.
Behaviors leading up to the foundation (4 to 7 months) During this period, the child may: Use hands to explore different parts of the body. (4mos.; Kravitz, Goldenberg, and Neyhus 1978) Examine her own hands and a parent's hands. (Scaled score of 9 for 4:06–4:15 mos.;* Bayley 2006, 53) Watch or listen for the infant care teacher to come to meet the child's needs. (Birth–8 mos.; Lerner and Dombro 2000, 42)	**Behaviors leading up to the foundation (9 to 17 months)** During this period, the child may: Play games such as peek-a-boo or run-and-chase with the infant care teacher. (Stern 1985, 102; 7–11 mos.; Frankenburg and others 1990) Recognize familiar people, such as a neighbor or infant care teacher from another room, in addition to immediate family members. (12–18 mo.; Parks 2004) Use names to refer to significant people; for example, "Mama" to refer to the mother and "Papa" to refer to the father. (11–14 mos.; Parks 2004, 109)	**Behaviors leading up to the foundation (19 to 35 months)** During this period, the child may: Recognize his own image in the mirror and understand that it is himself. (Siegel 1999, 35; Lewis and Brooks-Gunn 1979, 56) Know the names of familiar people, such as a neighbor. (by end of second year; American Academy of Pediatrics 2004, 270) Show understanding of or use words such as you, me, mine, he, she, it, and I. (20–24 mos.; Parks 2004, 96; 20 mos.; Bayley 2006; 18–24 mos.; Lerner and Ciervo 2003; 19 mos.; Hart and Risley 1999, 61; 24–20 mos.; Parks 2004, 113) Use name or other family label (e.g., nickname, birth

		order, “little sister”) when referring to self. (18–24 mo.; Parks 2004; 24 mo.; Lewis and Brooks-Gunn 1979) Claim everything as “mine.” (24 mos.; Levine 1983) Point to or indicate self in a photograph. (24 mos.; Lewis and Brooks-Gunn 1979) Proudly show the infant care teacher a new possession. (24–30 mos.; Parks 2004)

*Four months, six days, to four months, 15 days. (Social-Emotional Development Domain, CA Dept. of Ed., https://www.cde.ca.gov/sp/cd/re/itf09socemodev.asp)

Web Resources:

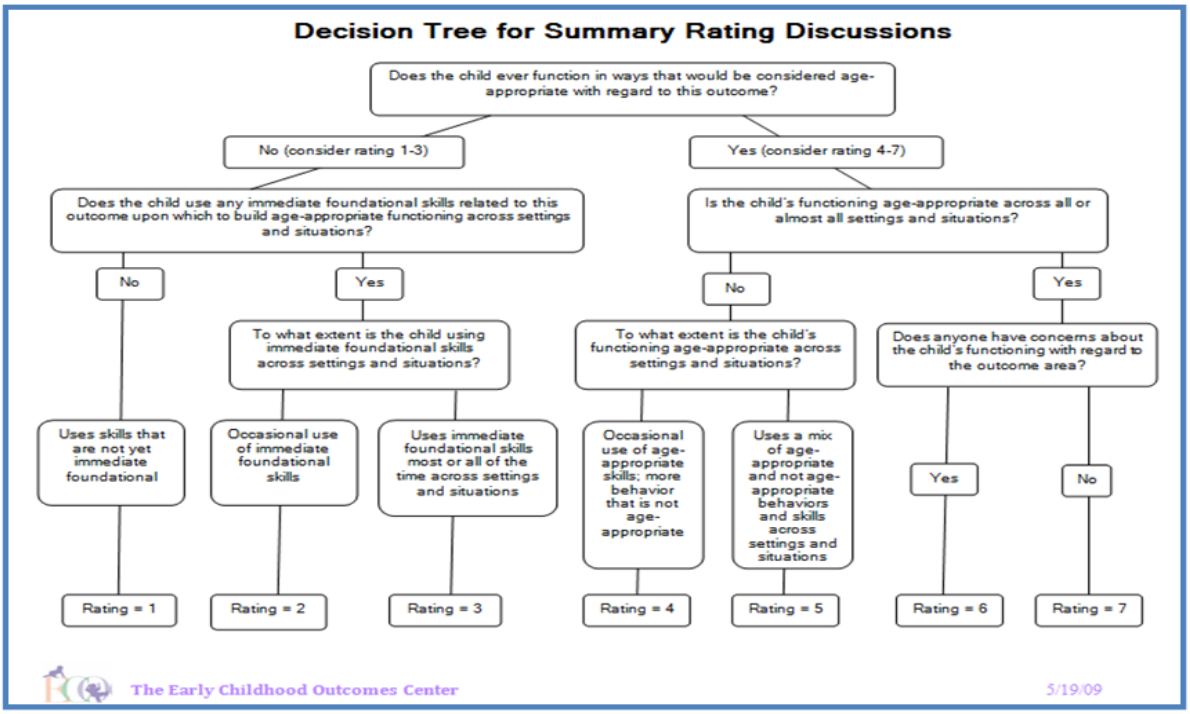
Information about the reliability, validity, and practical utility of assessment instruments: Retrieved at: http://www.jgcp.ku.edu/Grants/ecrimgd.htm

Comparable sets of measures being developed for preschool children by the ECRI-MGD at the University of Minnesota: http://ici2.umn.edu/ecri

Guidelines for selecting materials on child assessment: Retrieved at: http://clas.uiuc.edu/review/ChildAssessment.pdf

Information about screening and assessment of young English language learners from NAEYC: Retrieved at: http://www.naeyc.org/about/positions/pdf/ELL_Supplement.pdf

COSF:



COSF Entry form (Copied from TRAC IV)

Strategies to teach social skills:

The Technical Assistance Center for Social-Emotional Intervention (TACSEI) provides excellent, free resources for providers and families in providing tangible, functional, and meaningful strategies to achieve social-emotional outcomes. The following are strategies from the TACSEI Pyramid model to build social skills:

- Time-delay: The provider or caregiver will delay their response after a prompt to allow the child to respond
- Mand-model: the practitioner or caregiver will model how a child asks for or comments about things in everyday life
- Most-to-Least Prompting: The provider or caregiver provides maximum prompts to child (hand-over-hand, verbal prompt, demonstration, etc.) and slowly removes an assistance over time as child learns targeted skill
- Least-to-Most Prompting: This is used when the child has a targeted skill but does not use it in the appropriate context or at all; the provider or caregiver increases the hierarchy of prompts until child uses the skill appropriately
- Peer Mediated Instruction: Is the use of typical peers to prompt, model and reinforce targeted skill
- Activity-Based Intervention: Is the child-directed approach where intervention occurs within routine, in planned or child activities, with an emphasis on child interaction with others. This includes incidental teaching through activities children have to do (toileting, diapering, eating) or want to do (playing) providing frequent and meaningful learning opportunities
- Prevention Strategies: Include praise, positive statements, responses, anticipating when problems occur, redirection, logical consequences and neutral time
- Environmental arrangement: Is the done for the prevention of challenging behavior and the promotion of interaction with others
- Task analysis: Is the breakdown of a routine into smaller tasks (toileting: pulling pants down, eliminating, wash hands, etc.)
- Social stories: Are scripts and/or pictures to describe an upcoming or frequent activity (grocery shopping, going to school) to help prepare child for transition
- Choice boards: Are used to encourage autonomy through selection of controlled choices, and the use of first/then prompts

When addressing concerns in any area of development, IFSP goals and strategies should be developed within a multidisciplinary team-based model, this means parents are full participants to ensure most meaningful and effective IFSP outcomes for the child and family (TACSEI Module2).

Section V.

Cultural Awareness activity:

Developing an awareness of our own culture, belief system, and the effect that they have in the work with diverse families (Wittmer & Petersen, 2018) could be the first step of the journey. Examples of questions service providers can ask themselves are:

- "What is important to me in my life?"
- "What my parenting style is?"
- "What my personal belief system about the "good" and the "bad" in this world?"
- "What is my worst-case-scenario?"
- "What were my experiences when I grew up?"
- "What do I want for my children?"
- "How does a successful life look for me?"
- "What makes me proud?"

Service providers are encouraged to learn about how their co-workers or loved ones will answer these questions. Without a doubt, there will be significant differences even between people with asimilar work, with similar education-histories, in similar geographic locations, with similar cultural and linguistic background, and in similar socio-economic groups. Discussions like these can make it clearer how differently many families on a provider's caseload may see the world, and everything within it.

Developing an awareness of biases and their effect on working with diverse families could be a next step. This includes a) becoming aware of biases common in the U.S. society as a whole, and b) becoming aware of our individual and personal biases.

a) Examples of common social biases and target groups of societal and structural oppressions in the U.S.:

Type of Oppression	Target Group	Non-Target Group
Racial	People of color	White people
Class	Poor; working class	Middle, owning class
Gender	Women	Men
Sexual orientation	Lesbian, gay, transgender, bisexual	Heterosexual people
Ability	People with disabilities	People without disabilites
Religion	Non-Christian	Christian
Age	People over 40	Young people
Youth	Children and young adults	Older adults
Rank/status	People without college degree	People with college degree
Military service	Vietnam veterans	Veterans of other wars
Immigrant status	Immigrant	U.S.-born
Language	Non-English	English

(Goldbach, 2017)

Service providers may think about and discuss how many traditionally repressed groups they belong, and they may think about how many of these groups a typical or specific family on their caseload belongs. These classifications may help service providers to develop a first understanding of potential challenges or families on their caseload may face in their daily lives, apart from having a child with a disability or a developmental delay. However, no book, no theory, and no research can replace

conversations with families and caregivers about their personal situation, concerns, strengths, about their uniqueness and values that must be considered and/or addressed in the individual family service plans of their children.

b) Personal biases

Biases are rooted in a psychological functionality framework, and are deeply connected with fears, personal experiences, and social learning (Katz, 1960). Biases developed because they fulfil functions that, at one point, may have been helpful to the individual (e.g. adjusting better to a situation, ego-defense, expressing personal values successfully, and others). Humans experience the development of bias and prejudice during their socialization. And socialization starts immediately after birth (Harro, 2000), and children as young as 3 or 4 years old already are aware of and developed biases (Augoustinos & Rosewarne, 2001).

These findings are indictors for the fact that everyone has biases, regardless of if they are wanted or not. The important step is not to deny them, but to identify, recognize, and reframe them in order to secure the provision of equitable high-quality services to all families. Service providers are encouraged to take a personal bias-test, developed by Harvard University: https://implicit.harvard.edu/implicit/demo/, and to discuss their (very likely surprising) results with fellow co-workers, before discussing the potential impact these biases may have on their work with families. Service providers who are aware of their own cultural identity as well as of their own biases will be best equipped to recognize, understand, and accept the variety of social-emotional needs, values, and priorities the families on their caseload may have for the adults, and the children of the family.

Section VI.

Referral to Specialized Supports and Services

Regional resources listed at the IDEA Part C website:

Northeast region:
http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/IDEA/NortheastResourcesDirectory2016.pdf

Northwest Region:
http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/IDEA/NorthwestResourcesRev2013.pdf

Southern Region:
http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/IDEA/LasVegasCommunityResourcesRevFeb2015.pdf

Early Childhood Mental Health Services-Division of Child and Family Services, State of Nevada:

- Northern Nevada Child and Adolescent Services (NNCAS)
  Main Campus- 2655 Enterprise Road, Reno, NV 89512
  (775) 688-1600
- Southern Nevada Child and Adolescent Services (SNCAS)
  6171 W. Charleston Blvd, Building 7
  Las Vegas, NV 89146
  Phone: (702) 486-0000

Rural Clinics and Community Health Services-Division of Public and Behavioral Health, State of Nevada:

- Battle Mountain
  10 East 6th St., Battle Mountain, NV 89820
- Carson City
  1665 Old Hot Springs Road, Suite 150, Carson City, NV 89706
  Phone: (775) 687-0870

- Dayton

5 Pinecone Road, #103, Dayton, NV 89403
Phone: (7750) 461-3769

- Elko
  1825 Pinion Road, Suite A, Elko, NV 89801
  Phone: (775) 738-8021
- Ely
  1675 Avenue F, Ely, NV 89301
  PO Box 151107, Ely, NV 89315
  Phone: (775) 289-1671
- Fallon
  141 Keddie St., Fallon, NV 89706
  Phone: 775-423-7141
- Fernley
  415 Highway 95A, Building 1, Fernley, NV 89408
  Phone: (775) 575-7744
- Gardnerville/Minden
  1528 U.S. Highway 395, Suite 100, Gardnerville, NV 89410
  PO Box 1509 Minden, NV 89423
  Phone: (775) 782-3671
- Hawthorne
  1000 C Street, Hawthorne, NV 89415
  Phone: (775) 945-3387
- Lovelock
  775 Cornell Avenue, Suite A-1, Lovelock, NV 89419
  PO Box 1046 Lovelock, NV 89419
  Phone: (775) 273-1036
- Pahrump
  240 South Humahuaca, Pahrump, NV 89048
  Phone: 775) 751-7406
- Panaca
  1005 Main St., Panaca, NV 89042
  PO Box 738, Panaca, NV 89042
  Phone: (775)962-8089
- Silver Springs
  3595 Highway 50 West, Suite 3, Silver Springs, NV 89429
  Phone: (775)577-0319
- Tonopah
  1 Frankie St., Tonopah, NV 89049
  PO Box 1451, Tonopah, NV 89049
  Phone: (775) 482-6742
- Winnemucca
  475 W. Haskell St., Winnemucca, NV 89445
  Phone: (775) 623-5753
- Yerington
  215 W. Bridge St., Suite 5, Yerington, NV 89447
  Phone: (775) 463-3191

Children's Mobile Crisis Response Team-Division of Public and Behavioral Health

- Rural Nevada- (702) 486-7865
- Northern Nevada- (775) 688-1670
- Southern Nevada- (702) 486-7865

Section VII.

NCSI Resources

Positive Behavioral Interventions and Supports www.pbis.org/community/early-childhood

Promoting Communication with Infants and Toddlers - Tools for Advancing Language in Kids www.talk.ku.edu/promoting-communication-withinfants-and-toddlers-project/

Recognition and Response randr.fpg.unc.edu/

Response to Intervention www.rti4success.org/

Technical Assistance Center on Social Emotional Intervention for Young Children challengingbehavior.fmhi.usf.edu/do/resources.htm

California Evidence-Based Clearinghouse for Child Welfare www.cebc4cw.org

Campbell Collaboration Systematic Reviews www.campbellcollaboration.org/library.html

Cochrane www.cochranelibrary.com/home/topic-and-review-group-list.html

Home Visiting Evidence of Effectiveness homvee.acf.hhs.gov/models.aspx

National Registry of Evidence-based Programs and Practices nrepp.samhsa.gov/AdvancedSearch.aspx

Social Programs That Work, Coalition for Evidence-Based Policy evidencebasedprograms.org/policy_area/prenatalearlychildhood/

What Works Clearinghouse ies.ed.gov/ncee/wwc/FWW/Index

Other Aggregating Sites

Child Welfare Information Gateway www.childwelfare.gov/

Compendium of Parenting Interventions eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/ compendium-of-parenting.pdf

ERIC eric.ed.gov

National Child Traumatic Stress Network on Empirically Supported Treatments and Promising Practices
www.nctsn.org/resources/topics/ treatments-that-work/promising-practices

Promising Practices Network www.promisingpractices.net/programs_evidence.asp

Self-Regulation and Toxic Stress Report 3: A Comprehensive Review of Self-Regulation Interventions from
Birth through Young Adulthood. www.acf.hhs.gov/opre/resource/selfregulation-and-toxic-stress-report-3

Self-Regulation and Toxic Stress Report 4: Implications for Programs and Practice
www.acf.hhs.gov/opre/resource/selfregulation- and-toxic-stress-implications-forprograms-and-practice

Interventions with Emerging Research Evidence

Bridging the Word Gap National Research Network www.bwgresnet.res.ku.edu/

Hanen Programs for Educators www.hanen.org/Helpful-Info/Research.aspx

Igniting Young Children's Communication Skills fpg.unc.edu/news/fpgs-free-guide-ignitingyoung-childrens-communication-skills-reachesyet-another-milestone

1Make the Connection psychologyfoundation.org/Public/Programs/First_Three_YearsMake_the_Connection/Public/Programs/Make_the_Connection/Make_The_Connection.aspx

*NCSI Resource on Best Available Research Evidence Sites Coming Soon! National center for systemic improvement

Family Wisdom and Values Websites

Family Voices org2.salsalabs.com/o/6739/t/11331/shop/shop.jsp?storefront_KEY=347

Hands and Voices www.handsandvoices.org/resources/docs.htm

Parent Technical Assistance Centers www.parentcenterhub.org/ptacs/www.parentcenterhub.org/parentparticipation-ei/www.parentcenterhub.org/resourcelibrary/

Professional Wisdom and Values Websites

American Academy of Pediatrics pediatrics.aappublications.org/collection/council-children-disabilities

American Occupational Therapy Association www.aota.org/Practice/Children-Youth/Evidence-based.aspx

American Physical Therapy Association www.apta.org/EvidenceResearch/

American Psychological Association www.apa.org/practice/guidelines/evidence-based-statement.aspx

American Speech-Language-Hearing Association www.asha.org/Research/EBP/

Division for Early Childhood (DEC) www.dec-sped.org/divisionearlychildhood.egnyte.com/dl/tgv6GUXhVo

Head Start Early Childhood Learning Center (ECLKC) eclkc.ohs.acf.hhs.gov/

National Association for the Education of Young Children (NAEYC) www.naeyc.org/resources/position-statements

National Association of Social Workers www.socialworkers.org/News/Research-Data/Social-Work-Policy-Research/Evidence-Based-Practice

Centers for Disease Control and Prevention (CDC) www.cdc.gov/DiseasesConditions/

National Head Start Association (NHSA) www.nhsa.org/center/effective-practice

Zero to Three (ZTT) www.zerotothree.org/resources

NCSI Reference Documents

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