SERVING CHILDREN WITH DISABILITIES

A Video Series for Child Welfare Workers

Developmental Disabilities

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Overview of the Video Series

Serving Children with Disabilities, ***A Video Series for Child Welfare Workers,*** was developed by the Georgetown University Child Development Center, through a grant from the U.S. Department of Education's Office of Special Education Programs (OSEP). This program is designed to help child welfare workers and other professionals who provide support to families with young children (ages birth–8 years) served by the social service system. The videos and training will help staff to:

- Identify various disabilities found in young children and the characteristics associated with them;
- Develop skills needed to identify young children who may have disabilities;
- Recognize the extra stress families face as they raise a child who has special needs;
- Identify strategies for assisting families in the care of their child with a disability;
- Identify the components of IDEA and the services available through it;
- Assist families to obtain the services their children need; and
- Assist families to recognize and use their own resources and supports as well as those in their communities.

Audience

This video series is designed for use by child welfare personnel working in child protective services, family preservation programs, foster care, and adoption services. Other service providers who work with children in the social service system, such as legal advocates, health professionals, and childcare providers will also find this video series helpful. Professionals may find it helpful to use one or more of the videos with parents of children who have special needs.

Description of the Videos

Developmental Disabilities (21 minutes). This video provides child welfare personnel with information about various developmental disabilities and helps them recognize signs of disabilities in the young children they serve. It illustrates key developmental milestones children achieve as they grow and develop. It also describes atypical behaviors that may indicate the possibility of a developmental disability. In addition, biological and social factors that may increase a child's risk for developmental disability are described.

Supporting Families with Children with Disabilities (22 minutes). This video focuses on the impact raising a child with disabilities can have on family life. It highlights the issues families find important in obtaining and coordinating care for their child and suggests strategies child welfare workers can use to work with families to reduce stress and build on families' strengths.

Accessing Services Through IDEA (23 minutes). This video describes the services and supports available to children from birth through 21 years through the Individuals with Disabilities Education Act (IDEA). By understanding this legislation, child welfare workers can help families obtain needed services for their children, understand available supports, and transition smoothly from one service system to another as their child grows.

Children with Disabilities in the Social Service System

It is estimated that one out of 10 children nationwide has some kind of physical, mental, emotional, or developmental disability and that half of the children within our country's social service system (child protection, family preservation, juvenile justice, foster care, and adoption) have some problem that affects their development (U.S. Department of Education, 1998). Estimates indicate that approximately 50 percent of the 50,000 children available for adoption in the U.S. and 50 percent of all foster children have developmental delays (Jaudes & Shapiro, 1999; Takayama, Wolf, & Coulter, 1998). In addition, an estimated 30 to70 percent of children in out-of-home placements such as foster care have emotional problems.

> *Child welfare workers have regular and frequent contact with a population of children at high risk of developmental disabilities. Many of these children do not receive regular or adequate medical care and assessment. Until they reach the age of mandatory public school attendance, the child welfare worker may be the only social service professional to have contact with them* (Hughes & Rycus, 1998).

Child welfare workers are in key positions to recognize the warning signs of developmental delays, to refer children for evaluation, and to help families access services to which their children are entitled. In order to fulfill their role child welfare workers need knowledge of a variety of areas including child development, developmental disabilities, indications of possible disabilities, referral mechanisms, and the impact of disabilities on family interaction. They also need to develop working relationships with agencies that provide early intervention and special education services. The National Symposium on Abuse and Neglect of Children with Disabilities (1995) recommended that child welfare personnel have training that focuses on issues surrounding disabilities.

This video series will provide information about:

- The developmental milestones children achieve as they grow and develop;
- The characteristics of a variety of developmental disabilities;
- Red flags that signal the need for a developmental assessment;
- The services available to children and families through the Individuals for Disabilities Education Act (IDEA);
- The impact of various disabilities on families;
- Strategies for working in partnership with families; and
- The key role child welfare workers play in helping families access services and supports.

Underlying Philosophy of the Series

The underlying philosophy of this video series is the belief that children should be viewed within the context of the family rather than in isolation. Based on this guiding philosophy the following principles are reflected throughout this video series.

- **Support should be offered within the context of the family and the community in which they live,** rather than to the child in isolation. Family constellations differ, and their racial, ethnic, cultural, and socioeconomic diversity deserves to be honored. Families are the constants in the lives of children and, as such, they should be seen as the experts regarding their children. The most successful support results from the collaboration of service providers and families throughout planning and service delivery.

- **The child's development influences family interactions.** Like all professionals, child welfare workers need to recognize the signs of developmental problems since these problems can have a strong impact on family interactions.

- **Services should be provided in the community.** Services for children identified as needing early intervention or special education services, should be located in the community, whenever possible. Services should be provided in a culturally competent, family-centered, and coordinated manner.

- **A strength-based approach is pivotal.** This approach focuses on the strengths of children and families and moves away from a problem-focused service delivery approach. A strength-based approach focuses on identifying and maximizing the resources of families and includes mobilizing the community, as well as other service sectors.

Use of the Video Series

The three videos in this series are designed to be used in training programs for social workers, child welfare personnel, and other professionals working with young children. They can be used:

- For inservice training for child welfare and social service personnel;
- During orientation for newly hired social service personnel;
- Within training programs for foster and adoptive families;
- As a component of a university-based social work curriculum;
- For continuing education purposes; and
- As a self-study course.

A program of staff education that focuses on child development and disabilities can be created with continuing education units (CEUs) awarded at the end of the course. To facilitate awarding of CEUs, the program objectives and a pre/post test for each video are included in the handbooks. Discussion questions also are included. Related activities are included to help further the learning experience.

Acknowledgements

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Introduction

Objectives for the Video, Developmental Disabilities

As a result of viewing this video, individuals will be able to:

- Recognize warning signs of possible disabilities in young children birth through age eight;
- Identify typical developmental milestones for young children; and
- Identify specific developmental disabilities and their characteristics.

This guide provides information to supplement the material presented in the video. Specific tools to apply the information when working with families are also included. A brief description of the national legislation that gives families the right to early intervention services (for eligible children from birth through 2 years) and special education services and supports (for eligible children from 3 to 21 years) is also included.

DEVELOPMENTAL DISABILITIES

Part One

Noticing Signs of Possible Disabilities

It is important for service providers to recognize signs of possible disabilities when working with families. When children behave in a way that makes one think that they are not developing as they should, this can be an indicator or red flag that something needs to be done. Red flags can include atypical behaviors and failure to attain expected developmental milestones.

Two methods can help you notice red flags.

1. **Observation**—Careful observation can provide useful information to help child welfare personnel and the family decide if a developmental assessment would be helpful. The Observation Guide that follows gives suggestions for observing a child and family.
2. **Interviewing**—Family members are the experts on their children. Getting their views about their child's development is key. It's important to hear about what a child is doing or not doing that causes families to ask questions, be pleased, or be concerned. Pertinent, respectful questions about their child, their hopes for their child's future, and their hopes for their whole family can tell a lot about factors that may help their children grow or put them at risk. A sample of a family-focused interview is included in this text.

If observation and interviews raise concerns about a child's development, child welfare personnel can *encourage* the family to get a developmental assessment, *explaining* to them the service options, including available services under the federal legislation, the Individuals for Disabilities Education Act (IDEA), and *showing* them the steps to take to obtain the services. These steps are described later in this guide.

OBSERVATION GUIDE

1. **Overall appearance**—Does the child appear healthy and well cared for? Are weight/height appropriate for the child's age?
2. **Activity level and attention span**—Does the child appear either lethargic or overly active? Is the child able to follow directions and move from one task to another? Given the child's age, does he/she stay interested in one activity for a reasonable amount of time?
3. **Sociability**—Does the child react appropriately to you and to others outside the family? Does the child appear friendly, fearful, hostile?
4. **Movements**—Does the child perform the physical activities expected for his/her age? Are the child's movements performed in an uncoordinated manner? Do physical activities appear particularly difficult for the child?
5. **Play**—Does the child use toys appropriately for his or her chronological age? Is the child curious about how objects work? Can the child play by him/herself or does the child require continuous assistance? Does the child play with a variety of toys or does he/she prefer one specific toy or one type of toy?
6. **Independence**—Has the child developed self-help skills expected for his/her age or does the child rely on a family member to do things that he/she should be able to do alone?

If you are concerned about what you observe, ask the child's family about their observations (see Family-Focused Interview Guide). All families will not share your concerns. Be sensitive to the family's culture as this may influence their expectations for their children. If your concerns persist, encourage the family to have the child's development evaluated. See Part Three for the referral process to link families to services.

A family's values, beliefs, behaviors, and attitudes about disability, causes of disability, and interactions with professionals are influenced by many factors. Some things to consider in talking with families:

- What have been their experiences with other helping professionals?
- What are their beliefs about disability and its causes?
- How do their religious beliefs shape their ideas of healing?
- What are their practices and attitudes about privacy and asking for help?

FAMILY-FOCUSED INTERVIEW GUIDE

Try to gather this information in a relaxed, conversational manner. Use open-ended questions, encouraging the family to give their opinion and examples of how they view their child and family. Make sure the questions reflect an attitude that the child and family have strengths. Although difficult during times of crisis, a strength based approach will yield a clearer understanding of the needs of the child and family.

Questions about the child

- What is special about your child?
- What are his or her strengths?
- What are his or her needs?
- Tell me how your child lets you know what he/she wants.
- Does your child follow directions as well as you expect?
- Tell me about the kinds of activities your child finds interesting. Does he/she prefer one activity over another?
- Does your child seem lethargic? Overly active? Does he/she move (sit, walk, run, jump) as you expect for his or her age?
- What does your child like to play with? What does he/she not like to play with? Can he/she play alone? Does he/she like to be around other children his/her age?

Questions about birth history

- Does anyone in the birth family have a history of developmental disabilities or delays?
- Are you aware of any problems during pregnancy?
- How old was the child's birth mother at the time of birth?
- Was the child full-term? If not, how many weeks early was the child born?
- Were there any complications during delivery?
- Were there difficulties in the weeks after birth?
- Was prenatal care provided?
- Did the birth mother take any medications, drugs, or alcohol when she was pregnant?
- Did the birth mother smoke while pregnant?

Questions about social issues

- Has anything happened in the family since the child's birth that may have affected him or her?
- Has the family moved?
- Has there been a change in employment or work routine for the caregivers?
- Has anyone moved in or out of the home?
- Has anyone in the family had a major crisis or life event?
- What do you think are your family's strengths?
- What do you think your family's needs are at this time?
- Do you have any concerns or thoughts about your child's development?
- What kinds of things would make life less stressful for you and your family?

Developmental Milestones

Young children generally develop motor, communication and cognitive or problem solving skills in an orderly progression. Later skills build on earlier ones. The chart that follows lists developmental milestones at the approximate age that typically developing children master as they grow and develop. The milestones are arranged in three overlapping areas: motor, communication/language, and cognitive or problem solving. Child welfare personnel can use this chart as an informal guide while observing the development of young children. If a child appears to be significantly behind in the development of these milestones, the family should be encouraged to obtain a developmental evaluation so that intervention, if warranted, can begin as early as possible.

A concern exists if a child does not develop motor, communication, and cognitive skills in this general pattern. Of course, children don't develop skills at exactly the same age. These are general guidelines and the approximate age they typically develop. It is also important to take into consideration extenuating circumstances such as the influence of English as a second language will have on language development.

MOTOR SKILLS	COMMUNICATION AND LANGUAGE SKILLS	COGNITIVE SKILLS
By approximately 6 months a child: Reaches for and picks up toys Rolls over (both ways) Plays with toes Sits with minimum support	Babbles Recognizes familiar faces Makes a variety of sounds Responds to voices	Plays with rattles and other simple toys and objects Looks for fallen objects Looks at and reaches for self in mirror
12 months a child: Crawls on hands and knees Pulls self to stand Walks holding onto furniture Drinks from a cup Begins to walk without help	Waves bye-bye Says Mama, Dada Repeats sounds made by others Responds to verbal and gestural request Responds to name	Plays simple games such as pat-a-cake Looks at pictures in book Shows interest in the things in the environment Enjoys playing with cause and affect toys
2 years a child: Walks a few steps backwards Runs but can't slow down Feeds self with a spoon Carries large object while walking Scribbles when given a crayon Walks without help	Uses 2–3 word combinations Makes needs known with words and gestures Says names of familiar objects Begins to identify body parts such as hair, eyes, ears, and nose by pointing	Plays alone independently Builds a tower of 6 blocks Turns 1 page at a time Joins in nursery rhymes & songs Matches familiar objects Participates in story telling
3 years a child: Walks on a straight line Stands on one foot Rides a tricycle Copies a straight line or a circle from a model	Says own name Repeats simple rhymes Uses 3–5-word sentences Understood by most listeners	Points to tongue, neck, arm Has a concept of two, three Names at least 1 color
4 years a child: Hops on 1 foot Catches a large ball Brushes teeth independently Copies a large square from a model Cuts with scissors	Asks many questions Uses 4+ word sentences Begins to engage in imaginative play Follows directions Answers "who" and "what" questions	Understands size (big/little) Understands opposites (hot/cold) Understands functions of common objects (cup, car, spoon) Knows day and night Matches primary colors

Continued

MOTOR SKILLS	COMMUNICATION AND LANGUAGE SKILLS	COGNITIVE SKILLS
5 years a child: Skips and jumps Holds pencil with an adult grasp Colors within lines Feeds/dresses self Draws face with eyes, nose, mouth	Asks the meaning of words Says home address, names and age of siblings Follows directions with modifiers (i.e., slowly) Relates events and experiences	Matches 10–12 colors Acts out stories Knows left from right Knows difference between a dime and a penny Names four colors Counts up to 20
6 years a child: Jumps rope Plays independently Establishes right/left handedness Prints first and last names	Uses a large vocabulary of nouns, action words, descriptive words Easily makes needs known Likes to be read to Begins to recognize words	Sorts colors, shapes, and sizes Counts to 30 or more Adds and subtracts one digit numbers
7 years a child: Runs swiftly on balls of feet Rides a bicycle with training wheels Taps floor with alternating feet Prints or writes words in capitals & small letters	Uses a large, imaginative vocabulary to describe the environment Shares ideas and opinions	Organizes and classifies information Knows days of the week Tells time Counts to 100 by 1's, 5's, and 10's Shows interest in books Reads sentences
8 years a child: Moves with coordination Exercises large and small muscles Draws figures in good proportion Writes sentences Participates in group sporting activities	Likes humor in stories Prefers silent reading Discusses reading material	Projects beyond immediate needs Knows some addition and subtraction combinations Reading, writing

Atypical Behavior

How children move, interact with others, and solve problems signals how well they are developing. The failure to reach important developmental milestones may indicate a problem. Similarly, the presence of atypical behaviors such as prolonged inattentiveness to activities, echoing or repeating the words of others, or obvious difficulty in moving may signal a possible disability.

EXAMPLES OF ATYPICAL BEHAVIORS	
Motor Skills	Poor muscle control; lack of coordination; continued flapping of hands or snapping of fingers; frequent arching of the back; stiffness of arms and legs; excessive jumping and other repetitive movements
Communication and Language Skills	Intense or prolonged crying; pronounced lack of facial expression; unwillingness to look at, respond to, or engage others; stuttering; unusually poor articulation; absent or limited speech
Cognitive Skills	Pronounced lack of curiosity; inability to figure out logical steps or follow simple directions; slowness in organizing thoughts or following sequences; difficulty in performing typical school tasks

Biological Factors That Result in Disabilities

Many factors may contribute to the occurrence of developmental disabilities. Some disabilities are inherited. Others result from difficulties encountered during pregnancy and birth.

Genetic conditions—Disabilities can result from an inherited gene (such as sickle cell anemia) or from a chromosomal abnormality (such as Down syndrome or Fragile X).

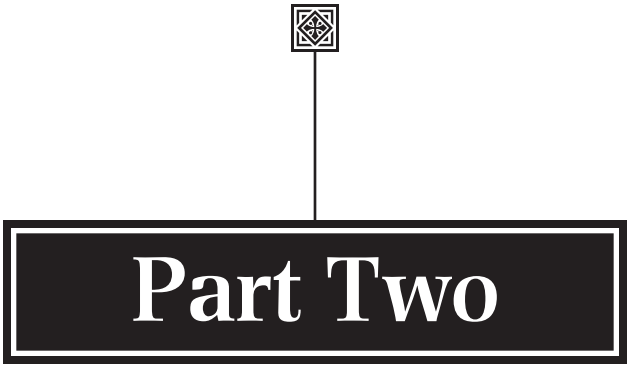
Difficulties during pregnancy and birth—Diabetes, high blood pressure, extreme obesity, and other maternal conditions can have adverse effects on the fetus. Also, maternal exposure to viral and bacterial infections such as rubella or German measles (particularly during the first trimester of pregnancy) may result in disabilities. Maternal use of alcohol or drugs during pregnancy can interfere with normal fetal growth and development. Exposure to toxic fumes from paint, glue, or varnish as well as the use of alcohol, tobacco, or street drugs can lead to low birth weight, premature delivery, and other neonatal problems. Children who are born with low birth weight or who are premature are at increased risk for developmental problems. Medical problems such as seizures also increase the risk of developmental problems.

Social Factors That May Contribute to Disabilities

Poverty and homelessness can contribute to the risk of children having developmental delays. Family members may not be aware of healthy practices during pregnancy or of the critical importance of prenatal care. Families may not have the resources to spend on prenatal care or vitamin-enriched foods that will support a healthy pregnancy.

Children are also at risk when social, economic, and other strains on a family result in child abuse or neglect. Children who are abused or neglected are at increased risk for experiencing developmental delay or disabilities. Neglect leading to inadequate supervision, nutrition, nurturing, and enrichment during the early years can affect a child's development. Additionally, increased care giving or other demands can create stress for the entire family, increasing the risk for abuse and neglect.

DEVELOPMENTAL DISABILITIES



Part Two

Frequently Occurring Developmental Disabilities

Child welfare agencies regularly serve a large number of children with developmental disabilities. Most of these children enter the child welfare system as a result of abuse or neglect or because they need temporary or permanent care (Hughes & Rycus, 1998). Because of the urgency to attend to the presenting family problem, the individual child's developmental disability or delay may not be recognized. By being aware of the signs of some common developmental problems, child welfare workers will be better able to identify children in need of a developmental evaluation because of a possible disability or delay. The following list describes some of the more prevalent disabilities and conditions found in children (NICHCY, 2001, Batshaw, 1997).

ATTENTION DEFECIT/HYPERACTIVITY DISORDER (ADHD) is one of the most common developmental disorders of childhood, affecting about 3–5 percent of all school age children. Boys are more frequently identified as displaying ADHD than girls. Characteristics of ADHD include a short attention span, (especially for activities that require sustained attention and concentration); impulsivity, distractibility, overactivity, a low frustration tolerance, and disorganization. Children with attention problems who are hyperactive are often identified in the preschool years, but children who are primarily inattentive may not be identified until they begin school when sustained attention to school work is expected. Children may have difficulty following classroom rules and teacher instructions or completing assignments. Often they will be disorganized and tend to misplace or lose things. Adolescents may also have difficulty with managing time, completing long-term assignments, and planning. Some children will have difficulty in social situations because they are not able read subtle social cues. As a result maintaining friends may be difficult. ADHD frequently occurs with other disabilities, such as learning disabilities, emotional disorders, such as depression, and behavior problems (conduct disorder, oppositional behavior).

Managing ADHD requires the collaborative efforts of teachers, physicians, and family members. In addition to taking carefully monitored medication, most children with ADHD respond positively when instructions are clear and simple. They often need written instructions and reminders of what is expected. Breaking tasks into smaller pieces is also helpful. Behavior management techniques that are used consistently by all adults help prevent disruptive behavior. Classroom accommodations such as limited homework assignments, alternative or untimed tests can also be beneficial. Some children may benefit from on-going counseling to help them understand and control their frustration, and to improve their social skills. Counseling also provides emotional support.

AUTISM—See Pervasive Developmental Disorder below.

PERVASIVE DEVELOPMENTAL DISORDERS (PDD) are a group of neurological disorders, evident by age three, that affect a child's ability to communicate, understand language, play, and relate to others. The disorders are on a spectrum of severity and include autism, Asperger disorder, pervasive developmental disorder–not otherwise specified (PDD-NOS), Rett syndrome and childhood disintegrative disorder. The incidence of all of the disorders on the PDD spectrum is approximately .1 percent (about 10 per 10,000) and are four times more common in boys than girls.

Autism: A diagnosis of autism is made when an individual displays significant problems across three major developmental areas: social interaction, communication, and behavior. When

children display similar yet less severe characteristics and do not meet the criteria for autism, they may receive a diagnosis of pervasive developmental disorder–not otherwise specified (PDD-NOS). It is estimated that as many as 1 in every 500 children have autism (Centers for Disease Control, 2001). Autism and PDD-NOS adversely affect a child's development and educational performance.

Characteristics often associated with autism are: engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.

Some or all of the following characteristics may be observed in children diagnosed with autism:

- Severe communication problems;
- Difficulty relating to people, objects, and events;
- Unusual play with toys and other objects;
- Difficulty with changes in routines or familiar surroundings; and
- Repetitive body movements or behavior patterns.

Children with autism or PDD-NOS vary widely in their abilities, intelligence, and behaviors. Some children do not speak; others have language that includes repetitive phrases or conversations. Persons with language skills tend to use a small range of topics and have difficulty with abstract concepts. Repetitive play skills, a limited range of interests, and impaired social skills are often apparent. Unusual responses to sensory information, for example, loud noises, lights, certain textures of food or fabrics, are also common. Most children with autism or PDD-NOS also have mental retardation. Because autism and PDD-NOS are spectrum disorders outcome varies for individuals. Some children with severe autism will require constant support and supervision throughout their lives, others may live and work in supported environments, and still others may be able live and work independently.

Asperger Disorder: Individuals with Asperger disorder have average to above average intelligence and language skills. However, they have poor social skills and a restricted range of interests. Infants and toddlers may show mild gross motor delays but children are usually not diagnosed with Asperger disorder until after age 3 when their social difficulties become apparent.

Childhood Disintegrative Disorder (CDD): CDD is very rare. Children with this disorder usually develop normally until they are at least two years of age. Between the ages of two and ten, children begin to lose skills in at least two developmental areas (language, motor, social skills, bowel/bladder control, and play). The children continue to lose skills and eventually function at the level of severe mental retardation with few independent adaptive skills.

Rett Syndrome: Rett syndrome occurs only in girls and is believed to be caused by a genetic disorder. Girls with Rett syndrome develop typically until about 5 months of age. At that time their head growth slows, and they lose purposeful hand skills followed by the development of stereotyped hand movements (hand wringing). The child with Rett syndrome eventually looses social interaction skills, motor, and language skills.

CEREBRAL PALSY (CP) is a condition caused by injury to the brain, usually occurring before, during, or shortly after birth. The damage leads to problems with a way a child moves. Depending on the extent of the brain damage children with CP can have a host of other problems including poor vision, hearing impairment, mental retardation, learning disabilities, speech and language disorders. CP can be mild, moderate, or severe and can affect a child's legs or the whole body. Mild CP may mean that a child is clumsy; moderate CP may mean the child has difficulty walking, and severe CP may mean that a child will use a wheelchair or other special equipment. Usually the more extensive the injury to the brain is, the more severe the CP. The damage to the brain doesn't change over time, but, as the child grows, movements may become more difficult. Each year about 5, 000 children are diagnosed with CP.

There are three main types of cerebral palsy:

- ***Spastic*** CP is the most common form of CP. In this form there is too much muscle tone or tightness. Movements are stiff, especially in the legs, arms, and back.
- ***Athetoid*** CP affects movements of the entire body. This form involves slow, uncontrolled body movements especially when sitting, walking, and using hands. The individual usually has low muscle tone.
- ***Ataxic*** CP affects how coordinated a child moves. Children with ataxia are unsteady and tend to lose their balance easily.

CP is also described by how many body parts are affected:

- ***Diplegia*** primarily involves the legs. Children with diplegia may need to use a walker, especially when they are beginning to walk, and orthotics (braces) on their legs.
- ***Hemiplegia*** means that half of the body is affected.
- ***Quadriplegia*** is the most severe form and involves all extremities, sometimes including facial muscles. Often children with quadriplegia use a wheelchair.

With early and on-going treatment the effects of cerebral palsy can be reduced. Children with CP will learn to compensate for the difficulty in moving their bodies. Although children with CP receive treatment from a variety of professionals, their primary interventionists are physical therapists and occupational therapists. Children with CP often need support in school and may receive services from a special educator or resource room teacher. Often, they benefit from assistive technology and adapted equipment.

DEVELOPMENTAL DELAY (DD) occurs when there is a difference between a child's chronological age and his/her performance in any of the five core developmental areas: motor, cognition, language, social, or adaptive. The diagnosis of developmental delay is usually used with children from birth to age eight when there is no other diagnosis that characterizes the child's delays. Many children identified as having a developmental delay as infants or toddlers are given a more definitive diagnosis such as mental retardation or learning disability by school age.

Young children with DD benefit from early intervention that promotes the acquisition and functional use of developmental skills. With specific remedial activities and enrichment, many children with DD catch up with their peers and attend regular classroom programs with little

need for special services. Other children originally identified with DD eventually need more extensive supports for their specific areas of weakness. These children may continue to need classroom accommodations.

DOWN SYNDROME is the most common and readily identifiable condition associated with mental retardation. It is caused by a chromosomal abnormality resulting in an individual having 47 chromosomes instead of the usual 46. This extra chromosome changes the development of the body and brain. In most cases, the diagnosis of Down syndrome is made according to results from a chromosome test administrated shortly after birth. Approximately 4,000 children with Down syndrome are born in the United States each year. Although parents of any age may have a child with Down syndrome, the incidence is higher for women over 35. Most common forms of the syndrome do not usually occur more than once in a family.

There are many clinical signs associated with Down syndrome. The most common characteristics include:

- Poor muscle tone and hyperflexible joints;
- Epicanthal folds (slanting eyes, with a fold of skin at the inner corners);
- Short broad hands and feet;
- Short, low set ears; and
- Short neck.

Individuals with Down syndrome are usually smaller than their nondisabled peers, and their physical as well as intellectual development is slower. Most children have moderate mental retardation, although they range from mild to severe or profound. Children with Down syndrome benefit positively from early intervention and special education services. Most adults with Down syndrome require support and supervision but can be employed and can live on their own, usually in a group situation.

EPILEPSY is a physical condition that occurs when there is a sudden, brief change in how the brain works. When brain cells are not working properly, a person's consciousness, movement, or actions may be altered for a short time. These changes are called epileptic seizures. About two million Americans have epilepsy; about 50% of new cases each year are children and adolescents. Children with other types of neurological conditions such as cerebral palsy may also experience seizures.

Some people can experience a seizure and not have epilepsy. For example, many infants and toddlers have a seizure from high fevers, called a febrile seizure. Other types of seizures not classified as epilepsy include those caused by an imbalance of body fluids or chemicals or by alcohol or drug withdrawal. A single seizure does not mean that the person has epilepsy.

Seizures can be generalized, meaning that all brain cells are involved. One type of generalized seizure consists of a convulsion with a complete loss of consciousness. Another type looks like a brief period of fixed staring. Seizures are considered partial when the brain cells not working properly are limited to one part of the brain. Such partial seizures may cause periods of altered consciousness and automatic behavior. An example of automatic behavior is buttoning or unbuttoning a shirt repeatedly.

Some children with epilepsy may need special education services or classroom accommodations. Most children take medications so their seizures occur infrequently.

FETAL ALCOHOL SYNDROME (FAS) and FETAL ALCOHOL EFFECTS (FAE) are conditions caused by a mother's use of alcohol during pregnancy resulting in damage to the child's central nervous system. There is a range of symptoms associated with these conditions. Severe forms of FAS include physical malformations and mental retardation. Children with FAS have physical characteristics and significant learning difficulties. Children with FAE do not have all the characteristics of children with FAS.

A child diagnosed with FAS has growth retardation before and after birth, central nervous system dysfunction and characteristic facial features. Children with FAS are often born at low birth weight and continue to have feeding difficulties throughout infancy, sometimes leading to failure to thrive. The children tend to be small throughout their lives. Problems related to central nervous system may include irritability, mental retardation, ADHD, developmental delay, microcephaly, or seizures. Finally, children with FAS will have characteristic facial features such as widely spaced eyes, narrow eyelids, a short, upturned nose, thin upper lips, large, low set ears and under developed jaws. Often these facial features become less apparent as the child grows older.

Children with FAS usually need early intervention and special education services and supports. The cognitive impairments and behavioral difficulties impact significantly on the degree of independence they can achieve as adults.

Children with FAE have less severe symptomatology than children with FAS but also may need and benefit from early intervention and special education services. Because they have less cognitive and behavior problems their prognosis is considered better than that of children with FAS.

FRAGILE X SYNDROME is the most common form of inherited mental retardation. The majority of children affected have mild to moderate mental retardation, but it can result in severe retardation. It is an abnormality of a sex chromosome passed on from the mother. Boys are more often affected than girls. Girls are primarily carriers.

Boys who have fragile X syndrome have many physical characteristics: elongated faces, prominent jaws and foreheads, large protruding ears, a high arched palate, hyperextensable joints, and flat feet. In addition to having mental retardation, they may also have ADHD, motor delays and incoordination, and hypotonia. Significant communication difficulties are also evident. As boys grow older their behavior problems tend to increase.

Girls with fragile X syndrome are less affected physically than their male counterparts. They may only have a narrow face and large ears. Most girls will have learning disabilities rather than retardation. Although they may be impulsive, they tend to be shy and withdrawn rather than hyperactive.

Early intervention, special education, behavior management, social skills training, and medications are beneficial for children with fragile X. Adults with fragile X syndrome need ongoing support.

LEARNING DISABILITIES (LD) include a spectrum of disorders that affect a child's ability to learn through conventional teaching methods. Learning disabilities can involve understanding or using spoken or written language. Learning disabilities can also involve perception. As a result of learning disabilities, it may be difficult for a child to listen, speak, read, write, spell or do math. Learning disabilities can be seen in conjunction with other problems, such as cerebral palsy. However, learning disabilities do not include school related problems that are primarily the result of visual, hearing, or motor disabilities, mental retardation, environmental, cultural, or economic disadvantage. Learning disabilities can mildly, moderately, or significantly impact the learning process. The most common type of learning disability is a reading disability. Often children with a reading disability also have underlying problems in language processing, perception, and visual motor skills.

It is estimated that 5–10 percent of school age children have a learning disability. According to the U.S. Department of Education, over half the children in the country receiving special education services are identified as having a learning disability.

Learning disabilities are characterized by a significant difference in the child's achievement in some areas, as compared to his or her overall intelligence.

Students who have learning disabilities may exhibit a wide range of problems with reading comprehension, spoken language, writing, or reasoning ability. Hyperactivity and inattention may also be associated with learning disabilities. Other traits may include uneven and unpredictable test performance, perceptual impairments, motor disorders, and behaviors such as impulsiveness, low tolerance for frustration, and problems in handling day-to-day social interactions and situations.

Learning disabilities may occur in the following academic areas:

- Spoken language: Delays, disorders, or discrepancies in listening and speaking;
- Written language: Difficulties with reading, writing, and spelling;
- Arithmetic: Difficulty in performing arithmetic functions or in comprehending basic concepts;
- Reasoning: Difficulty in organizing and integrating thoughts; and
- Organization skills: Difficulty in organizing all facets of learning including completing homework assignments, or maintaining a record of responsibilities.

Children with learning disabilities may need very specific special education services from a teacher trained in providing services to children with learning disabilities. They may need small group instruction in a resource room, speech and language services, occupational therapy, or classroom accommodations such as untimed tests, use of calculators, spell checks and other assistive devices.

Depending on the extent of the learning disability, most children can achieve academic success, attend college, and live independently as adults. Compensation strategies will be used and alternative learning formats may be employed, such as books on tapes, tape recording lectures, untimed or oral tests and computer readers.

MENTAL RETARDATION (MR) is an impairment causing a person to develop at or below an average rate and to experience difficulties in learning and social adjustment. Mental retardation results in significantly below average general intellectual functioning as well as deficits in adaptive behavior. These problems occur during the developmental period and adversely affect a child's educational performance. The impairment can be mild, moderate, severe, or profound.

General intellectual functioning is typically measured by an intelligence test. Persons with mental retardation usually score 70 or below on such tests. Adaptive behavior refers to a person's adjustment to everyday life. Difficulties may occur in learning, communication, social development, academic performance, vocational skills, and independent living skills.

Mental retardation is not a disease, nor is it the same as mental illness. Children with mental retardation learn, but slowly, and with difficulty. Probably the greatest number of children with mental retardation have chromosomal abnormalities. Other biological factors resulting in mental retardation include (but are not limited to): asphyxia (lack of oxygen); blood incompatibilities between the mother and fetus; and maternal infections, such as rubella or herpes. Certain drugs have also been linked to problems in fetal development that result in retardation.

Some studies suggest that approximately one percent of the general population has mental retardation. Many authorities agree that people with mental retardation develop in the same way as people without mental retardation, but at a slower rate. Others suggest that persons with mental retardation have difficulties in particular areas of basic thinking and learning such as attention, perception, or memory. Depending on the extent of the impairment, individuals with mental retardation will develop differently in academic, social, and vocational skills. Children with other disabilities such as cerebral palsy or sensory impairments may also have mental retardation.

Individuals with mental retardation benefit from early intervention and special education services and supports. Modifying instruction to meet individual needs increases successful learning opportunities. Goals of educational programming include enhancing adaptive abilities, survival or functional academics, and vocational skills. Many individuals with mental retardation learn to perform basic math computations and achieve basic reading skills.

Individuals with mental retardation will need special education services throughout their school years. Some individuals with mental retardation will be able to live in the community and maintain employment but all will need some level of support and supervision to maintain independence. The extent of that support depends on the level of retardation and other problems the individual experiences.

SPEECH AND LANGUAGE DISORDERS refers to problems in communication and related areas such as oral motor function. Delays and disorders can range from simple sound substitutions (stuttering) to the inability to understand or use language. Some children have such significant oral motor problems they have difficulty in both speaking and feeding. A child may have a specific language disorder affecting their understanding of either oral and written language or verbal expression. Many children have problems in both areas. Many children with overall developmental delay or mental retardation also have language delays. There are some children whose general intellectual functioning is greater than their language abilities. These children are

considered to have a specific language impairment (SLI). Some causes of speech and language disorders include hearing loss, neurological disorders, brain injury, mental retardation, and physical impairments such as cleft lip or palate and vocal abuse or misuse.

Children with a specific language disorder may require services from a host of professionals although the primary resource will be the speech language pathologist. Depending on the extent of the disorder or delay, the child may also need special education services and supports and/or alternative and augmentative communication systems. These systems include sign language, picture boards, computerized communication boards, and voice synthesizers. In young children with limited expressive language skills, these alternative systems have helped them to communicate and also to speak more.

Most children with a speech impairment or language delay will learn expressive communication if they receive supportive services. For those children whose language disorder co-exists with other disabilities, language skill development may depend on the severity of the other disability. Individuals with autism may always have difficulty in expressing themselves while children with severe motor impairments such as cerebral palsy may need an alternative communication system such as computer or voice synthesizer to communicate effectively.

DEVELOPMENTAL DISABILITIES

Part Three

Research indicates that both early intervention provided to infants and toddlers with disabilities and delays and special education provided to school age children can positively affect their development, skill acquisition and the ability to function independently. Each state and local jurisdiction has established an early intervention and special education program to provide services to eligible children. These systems are mandated by federal legislation, specifically, the Individuals with Disabilities Education Act (IDEA).

Legislation Guaranteeing Appropriate Developmental Services

Over the past 25 years, the U.S. Congress passed a series of laws giving children the right to appropriate and needed developmental and educational services from birth through the age of 21. The most important of these is the Individuals with Disabilities Education Act or IDEA.

OVERVIEW OF FEDERAL LEGISLATION RELATED TO YOUNG CHILDREN WITH DISABILITIES

YEAR	LAW	CONTENT
1975	Public Law 94-142 Education of the Handicapped Act (EHA)	Provided the framework for special education for children with disabilities ages 6–21. Guaranteed: free, appropriate, public education; special education and related services; a written Individualized Education Program (IEP); due process rights for parents to identification, evaluation, and placement procedures; and placement of each child in the least restrictive environment for learning.
1986	Public Law 99-457 Education of the Handicapped Act Amendments	Extended the above guarantees (Part B) to 3–5 year olds. Established an early intervention discretionary program (Part H) for infants and toddlers (birth through 2 years) and their families. States design and implement services and supports emphasizing natural settings. Mandated an Individualized Family Service Plan (IFSP) for all eligible young children and their families.
1991	Public Law 102-119 Individuals with Disabilities Education Act (IDEA)	Changed the term "handicapped children" to "children with disabilities." Expanded the definitions of children served and of services included.
1997	Public Law 105-17 Amendments to IDEA	Reauthorized IDEA. Requires states to establish performance goals and indicators for all children, including children with disabilities. Children with disabilities must be included in state assessments of education achievement. The IEP must explain the extent to which a child is not participating in regular education activities with children without disabilities. Mediation must be made available to families when they are in disagreement with the school. Reinforces natural environments as service settings for early intervention.

IDEA sets forth guidelines and requirements for states and jurisdictions to follow in establishing a program for infants, toddlers, children, and youth with disabilities. However, states have the flexibility to develop specific criteria for eligibility for services for infants and toddlers. Child welfare workers need to be familiar with their individual state's specific eligibility criteria and available services. Criteria for eligibility for services for school age children are more uniform and are specifically delineated in IDEA.

Rights and Responsibilities under IDEA

Through IDEA, an infant and toddler with a disability has the *right* to:

- A no-cost developmental evaluation and re evaluations as appropriate;
- Testing in their native language;
- Evaluation by trained professionals who use more than one testing approach;
- Testing using procedures and evaluation materials that are neither racially nor culturally biased;
- An individualized family service plan (IFSP); and
- Services received in an environment that typically developing infants and toddlers would be found, such as the home or child care center.

Through IDEA, a school age child with a disability has the *right* to:

- A free and appropriate public education (FAPE) from age three through 21;
- A no-cost developmental evaluation and re evaluations as appropriate;
- Testing in their native language;
- Evaluation by trained professionals who use more than one testing approach;
- Testing using materials and procedures that are neither racially nor culturally biased;
- An individualized education program (IEP); and
- Placement in a "least restrictive environment" (LRE): each child will be served, educated, and supported in—or close to—his or her own neighborhood, with typically developing children whenever possible.

Through IDEA a family has the *right* to:

- See all of their child's records;
- Review the IEP or IFSP with experts at least once a year;
- Be fully informed of all the rights families have under law;
- Appeal decisions made about the services provided to their child;
- Be informed of and consent to changes made to any of the services provided to the child including school placement before the change occurs;
- Participate on the team that determines their child's eligibility for services; and
- Work in partnership with professionals from relevant disciplines to develop the individualized education program (IEP) or individualized family service plan (IFSP) for their child.

The family has the *responsibility* to:

- Share information about their child with the members of the professional team;
- Be an active team member; and
- Communicate effectively with their child's school.

The cultural background of family members will greatly influence the way they exercise these responsibilities. Families may have difficulty discussing disabilities and seeking help from certain professionals.

Individualized Family Service Plan (IFSP) for Children Ages 0–3

If services are needed for an infant or toddler (ages birth through 2 years), an IFSP team, which includes the family, develops a plan for the child in the context of his or her family. The IFSP identifies what the child and family need in order to support the child's development. Each state has developed its own IFSP guidelines that describe:

- The child's developmental level;
- Basic family information (with parents' concurrence);
- The major outcomes expected to be achieved for the child and family;
- The services the family feels it needs to support the child;
- The services the family needs to support the family as a whole to meet the IFSP outcomes;
- Specific early intervention services, including where and when they will be received;
- A description of the child's natural environments (i.e., the home and community) where services will be provided; and
- Beginning when the child is at 2 ½ years a transition plan to prepare the child and family as the child moves from early intervention services to other services including IDEA's school age services.

Individualized Education Program (IEP) for Children Ages 3–21

The IEP is an individualized program that includes the services and supports needed to meet the educational needs of the school-age child with a disability. The Individualized Education Program (IEP) includes:

- A description of the child's present educational performance level;
- A selection of annual goals, including short-term instructional objectives;
- A listing of the specific special education and related services that the child will receive (and the dates these services will begin and end);
- Specification of the extent to which the child will participate in regular education programs and the supports needed to make it possible for that child to be integrated; and
- Objective ways of determining at least annually whether instructional objectives are being achieved.

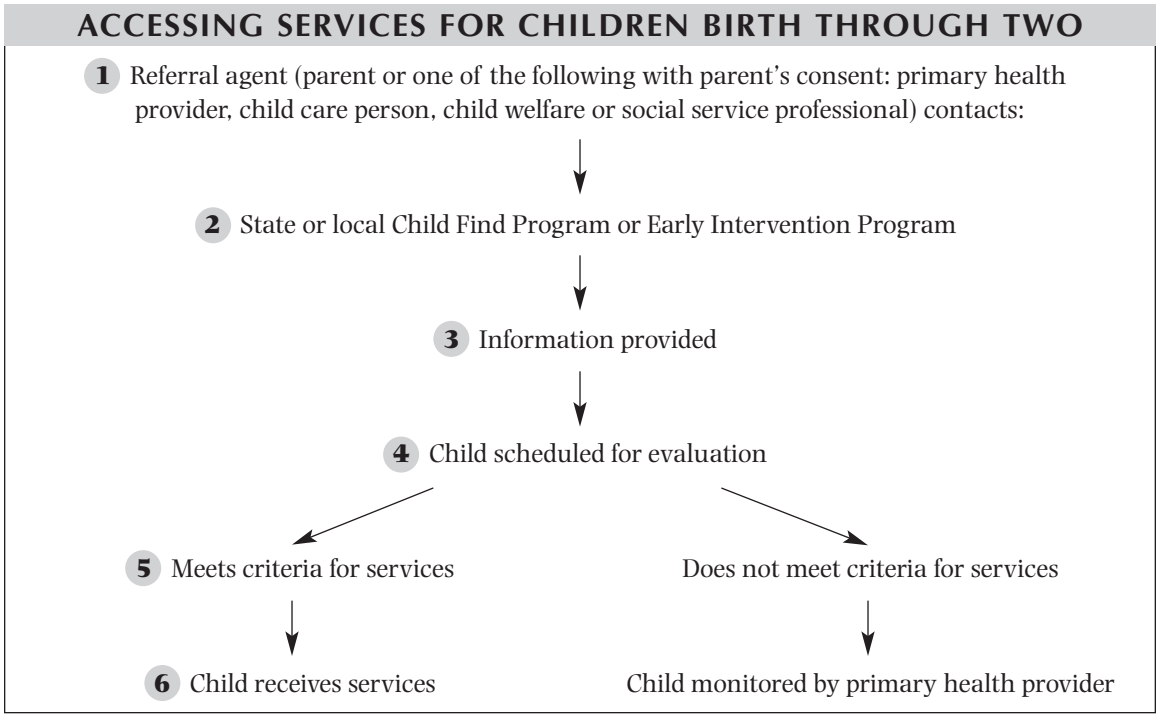
Accessing Services for Children with a Disability or Delay

Children from Birth through Two

The first step in obtaining community-based services for infants and toddlers with disabilities or delays is to contact the local Early Intervention Program or Part C Office, a program established with Part C funds to assist families in *accessing* appropriate services. The Early Intervention or Part C office may have a program called Child Find. Child Find Programs are established to screen or evaluate children suspected of having a disability or delay.

The next step in the process of obtaining services will be to obtain a multidisciplinary evaluation. An evaluation is performed to determine if the child has the specific degree of developmental delay established by each state, a diagnosed disability, or a condition that is highly likely to result in a developmental delay or disability. Multidisciplinary evaluations are conducted in a variety of places. In some jurisdictions the Child Find Program may do an evaluation, in other localities

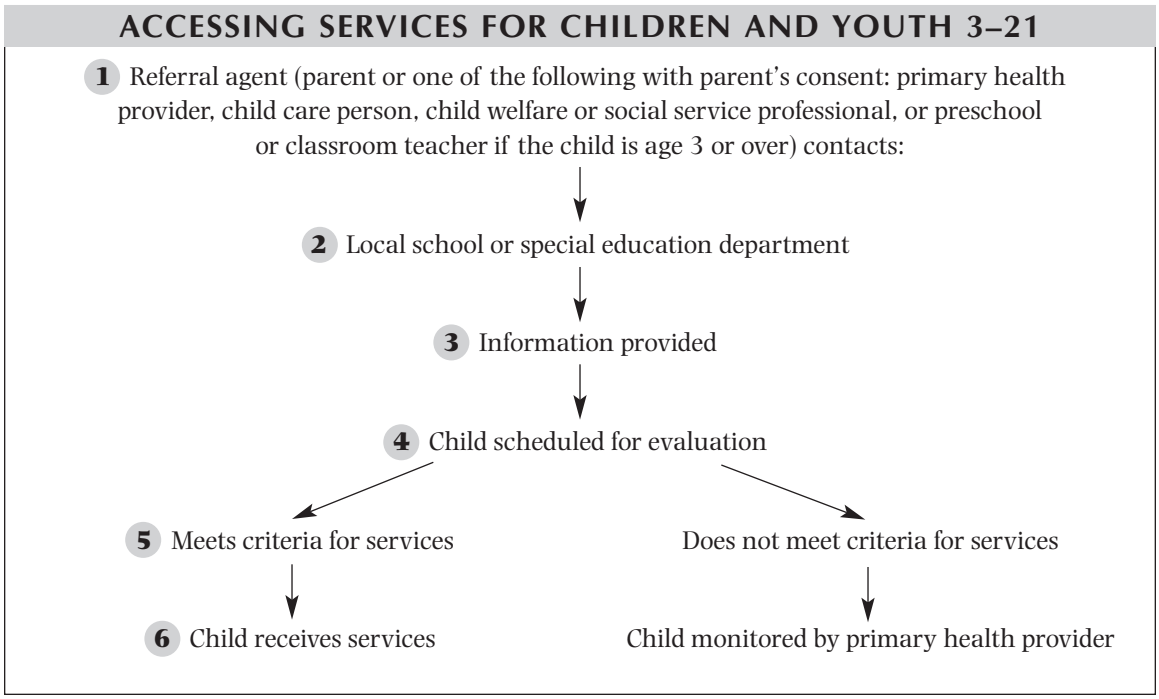
families would access child development professionals within a hospital or professional practice, health department or department of social services, and in others the Early Intervention Program may conduct an multidisciplinary evaluation. The Resource Manual contains information on contacting the state-wide Part C Office in each State.



Following the determination that the child has a delay or disability, the professionals, including a service coordinator from the Part C/Early Intervention Program, will meet with the family to develop the Individualized Family Service Plan (IFSP). The IFSP will delineate the priorities and concerns of the family regarding the child's developmental needs. It will also list the services that the child will receive and where and how often the child will receive those services.

School Age Children and Youth 3–21

A child from 3–21 years of age is eligible for special education and related services under IDEA if he/she is diagnosed with one of the 13 specific disabilities identified in the law *(autism, deafness, deaf-blindness, emotional disturbance, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, traumatic brain injury, visual impairment).* Also, some children up to 8 years of age may receive services if they continue to demonstrate a significant developmental delay but do not meet criteria for any of these disability categories. Evaluations to determine if a school age child meets eligibility criteria can be conducted in a variety of venues. However, the most likely source is the public school system as local school systems are mandated to conduct multidisciplinary evaluations to determine eligibility for special education and related services. Family members can contact their local elementary school to initiate the process.



Following determination of eligibility the school team will meet with the family to develop the Individualized Education Program (IEP). The team that meets with the family includes the specialists who have evaluated the child as well as the classroom teacher, a special educator, and a school administrator. The IEP delineates the services and supports needed by the child to reach the educational goals and objectives described on the IEP.

Child Development Measures

Some of the most common scales used to compare a child's developmental level with the expected level for his or her age group are listed below. These are often used to determine eligibility for service and to determine change in the child's development over time.

TEST	AGE	AREAS MEASURED
Bayley Scales of Infant Development II (BSID)	1 month–42 months	Cognitive, language, and motor skills
Peabody Developmental Motor Scale II (PDMS-II)	birth–6 years 11 months	Gross and fine motor skills
Peabody Picture Vocabulary Test–Revised (PPVT-R)	2.6 years–adulthood	Vocabulary
Receptive Expressive Emergent Language Scale (REEL)	birth–3 years	Receptive and expressive language
Wechsler Preschool and Primary Scale of Intelligence–Revised (WPPSI-R)	3 years–7 years 3 months	Verbal and perceptual intelligence
Wechsler Intelligence Scale for Children III (WISC-III)	6 years–16 years 11 months	Verbal and perceptual intelligence

Providing Services to Children with a Disability or Delay

Infants and Toddlers

Early intervention services are designed to identify a problem or delay in a child's life as early as possible so that the child can receive assistance in working towards achieving developmental skills, compensating for impairments, and remediating developmental delays. Early intervention services are offered through a public or private agency and are provided in different settings such as the child's home, a clinic, a neighborhood childcare center, a hospital, or the local health department.

School Age Children

Services provided to children from 3 through 21 are to assist the child to benefit from an educational curriculum. Services are provided to the children within preschool, elementary and high schools. Services can also be provided to preschoolers attending a Head Start program. Programs can be public or private.

Services Specified Under IDEA

Early intervention and special education services include a wide range of activities, involving many professionals and paraprofessionals. Services indicated in IDEA for children birth through 21 may include, but are not limited to, the following:

Assistive technology devices and services
Audiology
Family training, counseling, and home visits
Health services
Medical services for diagnosis and evaluation
Nursing services
Nutrition services
Occupational therapy
Vision services
Physical therapy
Psychological services
Service coordination
Social work
Special instruction
Speech & language therapies
Transportation and related costs

This list is not intended to be exhaustive and can include other services to assist a child with special needs to benefit from special education and early intervention. This list explicitly mentions recreation services and parent counseling and training for children ages 3–21 and their families.

PROFESSIONALS WHO PROVIDE SERVICES TO CHILDREN WITH DISABILITIES

DISCIPLINE	PRIMARY FOCUS FOR ASSESSMENT	PRIMARY AREA OF INTERVENTION
Assistive Technology Specialist	Need for assistive technology such as computers, communication boards, word processors	Use of technology as an aid to improve outcome
Audiologist	Hearing	Hearing and ear functioning
Infant Specialist	Overall interaction, play, cognitive development, social skills	All areas of functioning in consultation with other specialists
Nutritionist	Feeding skills, oral-motor development, diet analysis, growth	Feeding, oral-motor skill, nutrition education
Occupational Therapist	Fine motor development: hand use, oral motor development, feeding	Feeding, reaching and grasping, dressing, sensory-motor development, perceptual-motor skills
Physical Therapist	Gross motor development: sitting, crawling, standing, walking	Development of locomotion, use of adaptive equipment
Psychologist	Interaction, play, cognitive development, social skills, behavior management, emotional support	Family adjustment, behavior management
Special Educator	Developmental skill acquisition, school achievement	School achievement
Speech Pathologist	Expressive and receptive language, oral motor development, feeding	Communication skills, alternative communication systems

Children and Families Not Eligible for Services Under IDEA

In certain cases children with disabilities and their families may not be eligible for services under IDEA. For instance, a school age child with a physical disability might not receive services under IDEA if it is determined that the disability does not interfere with the child's ability to participate fully in his educational program in the least restrictive environment. Even though the child may be ineligible for services under IDEA, families with children with disabilities may still require assistance or support. In such cases, child welfare workers will need to access resources outside those provided for under IDEA, for example through Section 504 or a child's health care plan.

The Role of Child Welfare Workers

The purpose of this video is to give child welfare personnel basic information on child development, on ways to recognize that a child may not be developing typically, and on referring the child and family to appropriate community-based resources, services and supports. Recognizing the signs of developmental delays or disorders, encouraging families to seek services, and helping families access appropriate community-based services, a child welfare worker broadens the range of services available to families and insures that the child receives all the services they need to develop. Child welfare professionals can also educate caregivers about development. The child welfare system is charged with assuring safety, permanency, and well-

being for children. To do this successfully, the child welfare worker needs to have a clear understanding of a child's developmental needs.

> *If the goal is reunification, children need services to address their health conditions or disability and biological parents need education and support services to enhance their understanding of the child's needs and their own parenting skills. Where the goal is adoption, the service plan should reflect the needs of the child, educate the foster or adoptive parents about health issues and assist parents in accessing referrals* (Dicker & Gordon, 2000).

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DEVELOPMENTAL DISABILITIES

Pre-Post Test, Discussion Questions & Activities

DEVELOPMENTAL DISABILITIES

PRE-POST TEST QUESTIONS

The Pre-Post Test Questions are provided for those individuals who require an objective measure of change following training. Many States that require CEUs also require that training programs conduct a pre-post test. These questions represent material presented in the video and manual. As with all trainings, instructors or trainers may find it necessary to substitute these questions for others to be aligned with individual training programs.

Please choose the BEST answer

1. Which of the following methods of information gathering usually helps the child welfare worker to recognize that a child may be having developmental difficulties?
   a. Giving a standardized test to the child
   b. Observing the child
   c. Reading a birth record
   d. Talking to the neighbors

2. The development of gross motor skills in children begins with
   a. Walking
   b. Head control
   c. Sitting
   d. Reaching and grasping

3. If an infant or toddler's legs feel stiff when they are moved or look stiff when he/she stands it may mean that
   a. The child is ready to stand alone
   b. The child will be an early walker
   c. The child may have a problem with the muscles of his legs
   d. The child is developing on target

4. From the choices given, a preschooler who looks away from his family or others when he is speaking or when spoken to
   a. Is obstinate
   b. Is far sighted
   c. May have a communication problem
   d. Is having a seizure

5. Children with ADHD can be
   a. Hyperactive
   b. Inattentive
   c. Distractible
   d. All of the above

Continued

6. Girls who begin to lose developmental skills at about 5 months of age could have
   a. A learning disability
   b. Rett syndrome
   c. Cerebral palsy
   d. Down syndrome

7. Cerebral palsy is primarily a problem related to
   a. Movement
   b. Thinking
   c. Seeing
   d. Speaking

8. Women who drink alcohol excessively while pregnant may have a child with
   a. Fragile X syndrome
   b. Fetal alcohol syndrome
   c. Down syndrome
   d. Spina bifida

9. One of the most common developmental problems seen in young children is
   a. Asperger disorder
   b. Autism
   c. Speech-language disorders
   d. Mental retardation

10. Failure to attain developmental milestones when expected may indicate all of the following EXCEPT
    a. A developmental delay
    b. Mental retardation
    c. Cerebral palsy
    d. A learning disability

ANSWER KEY FOR PRE-POST TEST QUESTIONS

1. b
2. b
3. c
4. c
5. d
6. b
7. a
8. b
9. c
10. d

DISCUSSION QUESTIONS

1. What are some social factors that can influence development in infants and young children? How do you think they influence development?

2. In what ways can a child welfare worker assist families with a toddler who is acting out?

3. What do you think are some key developmental milestones and their age of attainment? Do you think your idea of key milestones differ from the family members you see? Why or why not?

4. What would lead you to think that certain behaviors are atypical?

5. What kinds of behaviors do you think would be helpful to observe in a child suspected of having autism?

6. What do you think is the importance of early intervention?

7. What impact do you think the behaviors seen in children with ADHD have on a family?

RELATED ACTIVITIES

1. Identify in your community at least two experts or agencies in child development that you can call for further assistance.

2. Develop a family interview guide that is specific for the families in your community.

3. Interview a family with a child with a disability to find out what was most helpful to them while they were trying to determine if their child has a disability.

4. Observe an infant with a caregiver. Jot down all the different ways the infant tries to communicate and the ways the caregiver responds to the infant's attempts at communicating.

5. If a child on your caseload has a disability ask the caregivers if you can talk with those who are providing services. Find out what kinds of activities they are doing, what their expectations are, what strategies they use, and where they provide the service.