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Early Childhood in Portland: Perspectives on Child Care and Development

Emilie Swenson MSW

Susy Hawes

Perspectives on
Child Care
and
Development

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This report was developed for Starting Strong and MaineHealth – Cumberland County Developmental Screening Community Initiative by the Data Innovation Project and Main Access Immigrant Network. Portland, Maine, September 2020.

Authors: Emilie Swenson and Susy Hawes
Contributors: Asha Ali, Mohammed Hassan, Christian Bisimwa, Sana Osman, Sanaa Abduljabbar, Simane Ibrahim, Sarah Lewis

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INTRODUCTION

The purpose of this project was to ascertain a more detailed understanding of parents' views on developmental screenings and family, friend, and neighbor care[1] for young children from immigrant, refugee, and/or asylee[2] communities that speak either Arabic, French, or Somali in Portland, Maine[3] with the intention of informing future strategies that can be implemented by the Cumberland County Developmental Screening Community Initiative (DSCI) and Starting Strong, the early childhood initiative that is a part of Portland ConnectED.

Through a collaborative process, Starting Strong, DSCI, the Data Innovation Project (DIP), and Maine Immigrant Access Network (MAIN) sought to address two distinct research questions: one for the DSCI specific to parents' views on developmental screenings and one for Starting Strong specific to parents' perspectives and use of family, friend, and neighbor (FFN) care. The findings and recommendations from this project are intended to support the shared goals of both groups that all children experience culturally appropriate and relevant developmental screenings and have equitable access to high quality early child care in culturally appropriate ways, which puts them on the pathway to kindergarten readiness and third grade reading proficiency.

This report provides a synthesis of this qualitative study – interviews conducted by Community Health Workers (CHWs) from MAIN and focus groups conducted by DIP staff. The following sections describe the data collection methodology for the project, key findings, recommendations, and discuss opportunities for further research.

> *For more information from the literature on these topics, please see Appendix C Family, Friend, and Neighbor Care and Appendix D Developmental Screenings. Appendices E through H describe developmental screenings in more depth, including previous research collected by the Data Innovation Project for Starting Strong and work done by DSCI member Dr. Rita Gao that relate to this topic.*

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[1] *Family, friend, and neighbor care is defined as*: any regular, non-parental care other than a licensed center, program, or family child care home. FFN care includes relatives, friends, neighbors, and other adults not required to be licensed by the state of Maine to provide child care. https://www.maine.gov/dhhs/ocfs/ec/occhs/ffn-report.pdf

[2] For the purposes of this project, the term *asylee* includes both those who are seeking asylum and those who have already been granted asylum status.

[3] The original focus of this research was to look specifically at the neighborhoods of East Bayside and Riverton, however due to recruitment challenges because of Covid-19, the area of recruitment was expanded to Portland. When possible, Community Health Workers recruited participants from East Bayside and Riverton.

Impact of Covid-19 on process

The influence of the Covid-19 pandemic on this project cannot be overstated. The original project methodology had to be shifted from in person focus groups to telephone interviews. Focus groups, which would have included child care and a shared meal, were initially selected as a data collection tool because of their ability to build trust and foster dialogue. Each focus group would have been facilitated by two CHWs from MAIN who spoke the language of all participants. Because of Covid-19 and the inability to gather in person, this familiar and community-oriented approach could not be implemented. Zoom focus groups were not recommended based on varying levels of technology access of individuals and increased household burdens for many due to school and day care closures and disruption of regularly utilized child care supports. Focus group questions were modified to align with conducting phone interviews. Of the 18 interviews conducted by CHWs, many took up to or over an hour to complete or, since interviewees were often caring for their young children during the interview, needed multiple sessions to successfully walk through all questions. In conversations with CHWs, parents were challenged to even recall what life was like before the pandemic – as one person said, it is "Hard to think about what it used to be. Or the future."

A Message of Gratitude

MAIN's Community Health Workers, the 18 interviewed parents who were all balancing talking on the phone and caring for young children, and six Portland area interpreters must be commended for their patience, compassion, and willingness to dedicate time to contributing to this research in spite of the pandemic. It is the intention of this report to honor the time spent by all of these individuals by lifting up their voices on these topics and sharing their thoughts, experiences, and recommendations with the larger Portland community to inform positive change from which they will see a direct benefit.

Beyond implications to the research plans and processes, the pandemic added a significant and unexpected workload on the CHWs. Because of their multifaceted role at MAIN, CHWs experienced an upsurge in work specifically related to the pandemic as cases of Covid-19 were detected across Portland, including in local immigrant communities. In addition to supporting clients in their regular capacity, CHWs were called on to help families navigate the numerous challenges the pandemic brought on. The need to switch from focus groups to individual telephone interviews asked for significantly more work from CHWs, as they were each tasked with identifying participants, scheduling, and conducting three interviews, and translating and transcribing notes.

Starting Strong is a network of early childhood educators, parents, service providers, health professionals, funders, business leaders, and other community members working together to ensure all children in Portland establish the building blocks for a lifetime of learning. With a focus on birth to age 8, Starting Strong's top priority is to help children enter kindergarten ready to learn and reach reading proficiency by the end of third grade.

MaineHealth (MH) is a not-for-profit health system dedicated to improving the health of our patients and communities by providing high-quality and affordable care, educating tomorrow's caregivers, and researching better ways to provide care. "Working together so our communities are the healthiest in America," MH is committed to better health for all people in the places we serve, and offers programs and services that support care delivery with a focus on standardizing evidence-based patient care across the continuum.

The **Developmental Screening Community Initiative** (DSCI) is a collaborative workgroup made up of medical practices and community organizations in Cumberland County with a common goal of improving coordination of developmental screenings and related services for children.

METHODOLOGY

Two main research questions drove the development of the methodology for this project:

I.   **What are the experiences, expectations and needs of immigrant, refugee and/or asylee families in terms of Family, Friend and Neighbor care for young children?**

II. **What are culturally appropriate ways for providers to assess early childhood development in immigrant, refugee and/or asylee communities?**

Focus groups and interviews were used as the primary data collection strategies to gather qualitative feedback, experiences, and opinions from the target population. Originally, focus groups were planned instead of interviews with the purpose of bringing parents together to talk more about their shared experiences related to the topics of family, friend, and neighbor care and developmental screenings. Focus groups capitalize on group dynamics and through the group can generate data and insights that would be unlikely to emerge without the interaction found in a group. This technique is especially useful in obtaining perceptions, identifying problems and strengths, and generating new ideas.[4] As previously stated, due to Covid-19, in person focus groups were not able to be convened safely and online focus groups with parents were deemed inappropriate. Therefore, a subsequent interview protocol was developed that utilized many of the same focus group questions, shifting how they were introduced and asked when appropriate. Interviews were chosen as they lend opportunity for insight, sharing, and identifying problems and strengths. While conversations may not have been as rich as those of focus groups, many insights, details, and new ideas were shared and when combined can provide a better understanding of how people view these topics.

In order to inform what would be asked of participants, the DIP and MAIN worked with Starting Strong and a group of experts from the early childhood field, including providers, program directors, and policy specialists, as well as the DSCI group to review draft questions based on the overarching research questions. The DIP in collaboration with the CHWs of MAIN then further narrowed the questions and clarified the meaning

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[4] Statements about focus groups adapted from Brenda Joly's *Applied Research & Evaluation Course MPH 650, Collecting Qualitative Evaluation Data presentation*. University of Southern Maine School of Public Health.

and intent of each question. Please see Appendix A and B for the final questions used in the interviews and focus groups.

A focus group with interpreters and cultural brokers proceeded as planned, however, was shifted to a Zoom format. Additionally, an informal focus group was conducted with MAIN CHWs to hear their experiences and facilitate a debrief on the interviews.

Capacity building

In addition to conducting research, the collaborative partnership between the DIP and MAIN intentionally built the research and data collection skills and knowledge of MAIN CHWs. From the start of the project, the DIP engaged CHWs in training and capacity building workshops on qualitative data collection, including developing focus group questions, facilitating focus groups, and notetaking. Select staff were also trained on the basics of coding qualitative data. While it was originally planned that MAIN staff would take the lead on sections of report writing with the support of the DIP, plans changed to accommodate staffing limitations due to Covid-19 and the DIP took the lead role in report writing with consultation and review from the CHW team.

Limitations

The purpose of this research was to gain a better understanding of the topics of developmental screenings and family, friend, and neighbor care. It can be considered exploratory research, which means that the work seeks to explore a topic in greater depth. One of the major limitations to this project was its small sample size. While findings represent the experiences, opinions, and beliefs of those who participated, they cannot be generalized to represent all immigrants and refugees in Portland. For example, the Portland Public Schools reports that over 60 languages are spoken by families in the district, representing countries and regions from all over the globe.[5] Parents who participated in interviews in this study reflected six countries and regions of the Middle East, and North and Central/Eastern Africa. While the findings cannot be generalized, they do align with the literature and point to a number of recommendations that may be implemented in the Portland community.

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[5] Portland Public Schools Multilingual Multicultural Center. (SY 2019-2020.) *Demographic data.* Retrieved from https://mlc.portlandschools.org/about/demographic_data#:~:text=Over%20the%20years%2C%20Portland%20Public,60%2 0different%20languages%20are%20spoken.

Interviews

Description

MAIN Community Health Workers conducted a total of 18 interviews. Participants were recruited by MAIN staff and the following criteria was used to determine eligibility (all participants fit this criteria):

- A person who is a parent to a child who is currently under the age of 5

- Live in either Riverton or East Bayside (defined by elementary school zones for Riverton Community School and East End Community School); if participants could not be recruited from these neighborhoods, MAIN staff recruited Portland residents

- The parent speaks one of these three languages:[6]
  - Arabic
  - French
  - Somali

Recruitment & consent process

MAIN CHWs leveraged their networks and community connections to recruit participants for the interviews. Interested people responded to the request to participate by confirming their commitment to participate in the interview verbally. The facilitator read a verbal consent to participate and explained the purpose of the interview to the participant over the phone. After the interview, participants received a $30 Hannaford gift card to thank them for their time.

Participants

A total of 18 parents were interviewed in May and June of 2020. The average interview lasted one hour and at least five different languages were spoken (Arabic, English, French, Lingala, and Somali). Participants identified six different countries as their home country or country of origin, those included Democratic Republic of Congo, Iraq, Rwanda, Somalia, South Sudan, and Sudan. Among participants, the average number of children was three with an age range of three weeks to 24 years. All participants live in Portland and neighborhoods identified included Bayside, East End, Riverton, Sagamore, and the West End.

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[6] Participants may speak more languages than these three, however these are three of the most common languages spoken in immigrant, refugee, and aslyee communities in Portland and the primary languages spoken by the CHWs.

Focus groups

Description

A focus group with Portland interpreters, translators, and/or cultural navigators was conducted by two DIP staff members. A MAIN staff member provided introductions and a closing. The focus group was conducted in English. The intention of the focus group was to include more qualitative data around the target populations' experiences with child care and developmental screenings.

Recruitment & consent process

As with interview recruitment, MAIN Community Health Workers leveraged their networks and community connections to recruit participants for the focus group. Interested people responded to the request to participate by confirming their commitment to participate in the interview verbally or via e-mail. The facilitator read a verbal consent to participate and explained the purpose of the focus group to the participants over via Zoom. After the focus group, participants received a $30 Hannaford gift card to thank them for their time.

Participants

Six people participated in the 90 minute focus group which was held over Zoom on July 14, 2020. Participants identified as interpreters, translators, and cultural navigators in medical and educational settings in the Portland community. As some were also parents, participants spoke to both their personal and professional opinions and experiences. The six participants spoke Arabic and Somali, in addition to local dialects.

MAIN Interview Debrief Session
In addition to the focus group with interpreters, staff of the DIP conducted an informal focus group and interview debrief session with the MAIN CHWs who were responsible for completing the interviews. Six CHWs participated in the session on June 18, 2020. Moderated questions were designed to both dig deeper into some of the interview responses and explicitly allow CHWs to share their own personal and professional experiences as parents, community health workers, translators, and interpreters within the target communities. The primary languages of the six CHWs are Arabic, French, and Somali.

FINDINGS

This section presents the findings from the interviews, interpreter focus group and interview debrief session with MAIN Community Health Workers. As noted above, the global pandemic had significant implications on this project, from shifting the methodology to overwhelming staffing to influencing the experiences and perceptions of parents as they grappled daily with new challenges. Regardless, this research revealed a number of key findings related to child care choices and experiences with developmental screenings in Portland's immigrant community. While some findings were distinct to each topic, others overlapped, highlighting the impact of broader system and structural level forces. This section details the results related to each research question.

Child care

Through a series of questions, parents were asked to reflect on their experiences, preferences, and hopes for care for their young children.

Important qualities of care

When asked to share what qualities they look for when deciding what their young child (age 4 or under) will do during the day when they are unable to care for them, including where they will

> **CHILD CARE PRIMARY RESEARCH QUESTION**
> What are the experiences, expectations and needs of immigrant, refugee and/or asylee families in terms of Family, Friend and Neighbor care for young children?

be and who they will be with, parents most consistently cited **safety**. As one person responded, "Safety is the most important part. Any location that can provide them with supervision from a trusted adult in a safe environment." Parents also often noted the importance of an **acceptance and appreciation of the parent or family's home culture**. This included supporting the child to learn (hear and speak) their culture's language, eat culturally familiar food, and have a general connection to their family's culture. As one parent shared, "Making sure they don't forget their culture. My son who is six asked me once why don't they speak about Eid. They only talk about Christmas. I had to explain

> **"They don't know anything about our culture. I think they should know more."**

to him that we live in a Christian country and this is what they celebrate. I feel American kids should know about our culture more. I remember when I came to this country, when I was younger and in school still, kids would ask me 'Why you are still wearing a scarf? You are in a free country

now, you don't have to wear it.' They don't know anything about our culture. I think they should know more."

Parents also reported that **engaging activities** and **socialization** were important qualities when looking for care. They spoke to the importance of limiting screen time, engaging children in educational activities, and supporting their social development through play with peers, all of which would help them prepare for Kindergarten.

A number of parents spoke to the importance of **trust**. In addition to being mentioned explicitly several times, the theme of trust was also embedded within a number of other qualities, such as safety and acceptance and appreciation of the parent's home culture. When parents were asked about what their children do during the day and what their ideal situation would be, their ability to trust the caregiver plays a key role in those decisions.

Many parents described that **ideally, their child would be cared for primarily by the mother or another close relative** for at least the first year of the baby's life. As people reflected on what care was like in their home countries, the majority said that young children were cared for by relatives. As one person said, "I know that back home child care is easier than here because you get help from parents and relatives and usually you don't worry about help if you need." One parent shared this preference for relative care, but noted that many immigrants lack family connections and have few direct kin in their new communities with whom they can share these responsibilities. "And the lucky people who have a family here it's amazing. They live in heaven!" they exclaimed.

While parents noted the preference for relative care, the majority were clear that although at times they had older siblings care for younger children, this was not their preference. They worried that when siblings (teens or younger) cared for younger children they would not be able to adequately supervise.

While relative care and family support were the ideal scenarios for many parents, this was not possible for everyone. A number of parents reported sending their children to either in-home or center-based daycare facilities. Others reported splitting their child care shifts between parents or neighbors (e.g., one parent works in the morning while the other parent is with the child; then they switch). Even though sibling care was not preferred, a number of parents also reported that older siblings do look after the younger children because they have no other options.

Challenges of child care choices

Families reported facing numerous challenges as they consider care for their young children. For parents who are unable to be home with their young children, challenges of child care choices include the **high price of daycare**; **daycare hours that do not match with their work schedules**; and **long wait lists**.

In addition to these challenges, parents reported both overt and covert examples of **racism and discrimination that had a significant impact on their relationship and engagement with childcare providers**. One parent felt that their child did not get the same treatment as other children and described an incident where a daycare provider told them that their child's behavior would lead to "People doing terrorist stuff." This parent decided not to send their child back to daycare because of this experience.

Qualitative data from experiences of participants from this research indicates that immigrant families worry about DHHS involvement, specifically experiences with and fear of daycare providers reporting unfounded cases of child abuse. As one person said, it is "Always in the back of parents' mind that DHHS gets involved fast." Interviews detailed a sense of mistrust between daycare providers and families. They shared parents' fears of and experiences with providers reporting cases of child abuse or neglect when they believed the situations were due to miscommunication, language or cultural barriers, and misunderstandings, or racism and discrimination.

Fear of systems involvement and experiences with racism have serious repercussions for children and families. These situations diminish trust in providers, a key concept that was identified as important for families when choosing child care. This broken relationship harms not only the provider's relationship with that family, but may also break trust with the larger cultural community in Portland. Additionally, if this lack of trust leads a parent to decide not to send their child to daycare, it undercuts the child's opportunity to learn, experience additional social benefits, and potentially fulfil the parent's wishes for their child. When faced with this concern, parents are forced to weigh the benefits of having their child enrolled in daycare with the risks and fear of the repercussions of discrimination that may have series implications for their family.

In summary

Data indicate that although parents would ideally have their children cared for by the mother or another close relative, this is often not an option for immigrant, refugee, and asylee families in the target communities. When considering what is most important for

their child's care, parents identify safety, acceptance, and appreciation of home culture, engaging and educational activities, and socialization. However, their decisions around daycare are often obstructed or determined by both systematic and structural challenges; while parents have a vision for the type of care their child would receive, the challenges they face often make this unachievable.

The findings align with a child care study conducted in Portland, Maine in 2011 with immigrant and refugee parents from Cambodia, Somalia, and Sudan.[7] Parent preferences for familial care in the early years, perceptions of strengths and challenges with child care programs, and experiences and fears of discrimination and racism were consistent across both studies.

A separate study conducted by Maine Children's Alliance[8] that looked at family friend and neighbor (FFN) care reported similar findings including that the main reasons for choosing FFN care were: trust, flexibility (work shift times, only need a small amount of care), need for one-to-one care (special needs), limited access to formal programs, cost (free or low cost). The alignment of the findings from these two previous studies and this study show the key concerns, needs, and hopes that parents have for their children have not changed over time.

Developmental screenings

Participants were asked to reflect on their experiences with developmental screenings for their children. Numerous reflections on screenings as well as general experiences in medical settings were shared. A range of responses was elicited from parents.

DEVELOPMENTAL SCREENINGS PRIMARY RESEARCH QUESTION
What are culturally appropriate ways for providers to assess early childhood development in immigrant, refugee and/or asylee communities?

Positive experiences with screenings
Many parents shared they had positive experiences with developmental screenings. Some stated that the screenings helped them to know more about their child's development and how to support their child. As one parent

[7] Ward H, Oldham LaChance E, Atkins J. (2011). New Americans: Child Care Decision-Making of Refugee and Immigrant Parents of English Language Learners. Portland, ME: University of Southern Maine, Muskie School of Public Service. https://digitalcommons.usm.maine.edu/cyf/1/

[8] Maine Children's Alliance. (n.d.) The value of family, friend, and neighbor care in Maine. Maine Children's Alliance. Retrieved from https://www.mekids.org/site/assets/files/1394/mca_ffnbrief_final.pdf

reflected, "It was important for me know what I can help with my child." A Community Health Worker shared that one interviewed parent was comfortable with the screening because she felt that "her child needs extra help, and she was happy to get her child the support." Parents also responded that when they felt the provider was respectful, they were comfortable. Another observation of the screenings was that "When people know why questions are asked, they like opportunity" to learn more and talk about their children. Another shared they appreciated that the doctor clearly explained the process of the developmental screening.

Questions and concerns about screenings

Many participants reported having questions and concerns about the screenings, including confusion about intent, cultural responsiveness of the tools, and relevance when considering different cultural beliefs around childhood development.

A key finding from this research is that **parents are unsure of the meaning and purpose of the developmental screenings,** likely because such screenings are not common in the parents' home countries. As one person said, "Sometimes for parents with first child or new in the country, [it is] hard to understand what's happening when they are doing

"[It is] hard to understand what's happening when they are doing this."

this." Parents reported feeling overwhelmed, confused, embarrassed, and worried. Some were concerned that because of the questions being asked, they would be told that their child had a developmental problem. At times, parents felt the provider was trying to undermine them. Comments from interpreters and Community Health Workers suggest that parents do not always know that screenings can lead to

benefits, including additional support for the child if needed. As one parent who understood how the developmental screening process worked reflected, "I knew [my child] needed help. Now he doesn't anymore. I didn't grow up in US but I got to learn the system quick and I am still learning. Parents' education about this is very important because it's very important for their kids." Another parent reflected that they were more comfortable with the process with their second child, "I understood that is the way it works in America according to my first experience." However, it is unclear if they understand the intent at that time.

This research revealed a number of ways in which families from the immigrant community question the **cultural responsiveness and sensitivity of developmental screening tools**. Participants shared concern that developmental screenings do not

accurately capture unique knowledge, skills, and abilities of multicultural and multilingual children. As one person stated, "They should also look into the other language and how well they know that language, their home language. We feel like the kids should speak our language and know more of it so they can sustain it or have it." Additionally, some reported the questions were too personal or inconsiderate. For example, practicing Muslims may be offended when asked about alcohol use since their religion considers alcohol "haram" or forbidden.[9]

Parents reported that some questions asked about **concepts that are not present or relevant to their culture**, which lead to embarrassment, confusion, and worry for parents. Because of cultural practices and background, parents themselves do not always know how to do the things that are being asked of the child. There may be a perceived failing of the parent if their child has not yet been exposed to an activity and thus is not able to complete the task. As one person commented, "If a parent doesn't know how to hold a pen or doesn't know how to use scissors, how do we expect a child to know? They are asked and then labeled as special needs when they didn't get exposed to a lot of the activities that they are asked about."

> **"If a parent doesn't know how to hold a pen or doesn't know how to use scissors, how do we expect a child to know? They are asked and then labeled as special needs when they didn't get exposed to a lot of the activities that they are asked about."**

One example provided included cultural norms around scissors. Scissors are considered a dangerous tool for a child to handle, especially for people who come from backgrounds where safety scissors designed specifically for children are not common or available. Young children from these cultures are not provided scissors to use at home. As one interpreter reflected, "I can tell if [the child is] not answering because of disability or learning issue or that he is just not exposed to it. 'Cut shape of animal with scissors.' This child might not have even seen a scissors; they are dangerous, so just keep them away. Not even safety scissors. Think of them just like a knife; so when they ask a child to cut something and they can't do it..." Multiple parents commented the need for providers to "**Consider the cultural**

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[9] Pew Research Center: Religion and Public Life (2013). The World's Muslims: Religion, Politics and Society. Retrieved from https://www.pewforum.org/2013/04/30/the-worlds-muslims-religion-politics-society-morality/

differences" and for providers to "Ask more questions about our culture" in order to enhance understanding between parent and provider and capture a more accurate picture of the child's development.

To some participants, it was **not clear that screenings are supposed to be a universal feature of well child visits**,[10] which elicited additional worries and confusion that their child was being singled out. The long history of racism, discrimination, and colonialism cannot be ignored when it comes to the immigrant experience, especially those of African and Middle Eastern descent, vis-à-vis any system – the medical system being a prime example. As one person expressed, many immigrants have an innate mistrust of medical providers, especially White providers because of generations of colonialism that have harmed people throughout the world. This mistrust can make parents feel like they are being more carefully watched, particularly when they interact with formal systems of care. As one person reflected, "[Immigrant parents] think vaccine is causing autism and that it's making their kids very active or out of control. They think White people are trying to destroy their kids." While this relates more specifically to vaccines, it transcends that specific topic and is something that should be of concern to the wider community of medical providers and systems more generally as it speaks to the need to understand culture, context, and the history of relationships and of the medical field before working with any patient.

Additional questions and concerns about developmental screenings stem from **different cultural or family expectations around child development**. Multiple parents responded that they had no previous experience with developmental screenings in their home

"If child start talk will be late to walk. If start walk will be late to talk!...In my culture, he will learn when its time."

country and that the attitude toward early childhood developmental milestones such as walking and talking was that the "child will be okay." Rather than putting emphasis and concern around each action the child takes, there was greater emphasis on the flow

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[10] While it is considered best practice to conduct screenings at regular intervals (the American Academy of Pediatrics recommends screenings at 9, 18, 24, and 30 months old), according to National Survey of Children's Health data from Maine, only 35.7% of children ages 9 through 35 months received a developmental screening using a parent-completed screening tool in the past year. Data from: Maine Department of Health and Human Services. (2020 January). Report: Resolve, to improve access to early and periodic screening, diagnostic, and treatment services for children. Retrieved from https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/Early-Periodic-Screening-Diagnostic-Tx-Svs-for-Children-Birth-to-8-Years-LD-1635-Report-01-2020.pdf
Centers for Disease Control and Prevention. (2020). Developmental monitoring and screening for health professionals. Retrieved from https://www.cdc.gov/ncbddd/childdevelopment/screening-hcp.html

of development and that those milestones would happen over time. The same parent continued, "They will speak, even if a little delay, they will be normal later on. Every family has differences but at the end all will be normal. My mom told me this." Another

"We say wait and they will get better and they usually do."

echoed this sentiment, "We never had this in our country. I had a sister who was talking at 3 years old and we were ok with that. We never had any concern. And now she's ok. She talks, no cognitive delays no other problems." One parent also highlighted another difference in approach as it relates to culture, development, and raising children: "We are different. American kids are more self-reliant and they have specific skills at certain age and the parents know what to look for. If a child from our communities doesn't know they are considered special needs they have to label them. In Sudan we say wait and they will get better and they usually do."

Communication and Interpretation

When asked what makes the developmental screening process for their children more or less comfortable there were a range of responses and a number of clear considerations. Interpreters were a central topic of discussion. Many people felt that **interpreters play a helpful role in the process**. Interpreters were seen as helpful not only for providing clear interpretation, but also as one parent described, it was helpful to have a "witness" or someone who is part of their community and familiar with both cultures to understand that "I am getting good information for my kid." As one Community Health Worker also observed, many interpreters are also parents and therefore can also relate to the experience.

However, feedback also revealed a **number of challenges and questions around using in-person interpreters** during developmental screenings. One of the top concerns for parents was the fear of their privacy being exposed. Immigrant communities in Portland are often small and close-knit; according to participants, news can travel fast within communities. Since interpreters are often a part of the immigrant community, parents shared worry that if they expressed something to a provider using an in-person

interpreter that their private information could be brought back to their community. To ameliorate this, parents described that phone interpreters can be helpful since they do not necessarily have any tie to the Portland community. As one parent stated, "Best is not having someone in person who you know, someone not from your country." One challenge of this is that sometimes a phone interpreter speaks a different dialect than the parent, therefore making it challenging to understand one another and accurately convey the proper information shared by either party. Another challenge described was the need to reschedule appointments due to the provider being unable to find an in person interpreter on the day of the appointment. While this was "okay for me" as described by the parent, it means that the person was not able to be seen and the provider lost out on being able to fill that appointment time.

Some parents stated that they prefer to be their own interpreter in order to maintain privacy. Parents described using Google Translate as a tool to support the conversation with their provider as well as asking a lot of clarifying questions or asking the provider to use simple language. When reflecting on an interview with a parent who didn't use an interpreter, a Community Health Worker shared that, "Relying on herself makes her more comfortable." One parent expressed they chose this method because of their desire to be self-reliant. Another Community Health Worker shared that while one parent did not have any issues with their interpreter, "Things could have been better if she were able to directly communicate her concerns with the doctor."

Another strategy used to address the language barrier was to have both parents (or one parent and a supporting family member) present to help one another understand. This also gave parents a greater sense of comfort in being

able to talk through questions together and increase their understanding. Parents also stated that at times older siblings were used to interpret.

While parents employ a range of strategies to support communication and understanding during their visits with providers, one perspective shared was that "people need interpreters even if they think their English is good." While this differs from the self-reliance and sufficiency perspective, it suggests that professional interpreters could be offered as support for all non-native English speakers to ensure communication is clear – that the parent is able to clearly understand what is happening and communicate concerns or questions, and that the provider is able to clearly understand the parent and communicate potentially complicated or unfamiliar topics.

Interpretation is just the tip of the iceberg when it comes to effective communication and understanding for developmental screenings. Not only do parents, interpreters, and providers need to be able to understand word for word, but they also need to be able to understand concepts that may be unfamiliar. It may be challenging for non-native English speakers to interpret for themselves while also trying to understand concepts or topics that are potentially unfamiliar as a new parents. Additionally, there are numerous concepts and words that do not directly translate to other languages – either they need a greater explanation, concepts do not exist in other culture, or are taboos and therefore challenging to interpret properly and respectfully. As one person shared, "There were questions that needed more time to understand because sometimes the word in English cannot be translated in Somali with only one word but needs explanations and examples to understand it." While another spoke to the need for longer explanations to ensure that the concept was properly conveyed (rather than a simple word for word

interpretation), "When I am translating I have to find a different word. It's not like a taboo, but kind of, to use the word autism. I understand, don't want to say that directly. Might use the symptoms, but not the word 'autism.' You just have to say he learns a different way."

Additional challenges

In addition to considerations around interpretation, interviews and focus groups revealed additional challenges related to experiences in medical settings, including experiencing long wait times with no communication about the wait; lack of communication between doctors, nurses, and patients; and the parent feeling rushed by the provider. As one parent shared, "Some questions were not clear at beginning and I usually ask clarifications and examples if I don't understand the question, providers are short of time so sometimes if I have other questions about child health not related to developmental screening they ask me to get another appointment for that issue if they are not urgent and that makes me less comfortable." One parent responded that they had a very negative experience with a provider due to the harshness of their tone and the way information was communicated to them about their child. Another shared that responding to questions about family medical history was challenging because they didn't know the answers.

While not specific to developmental screenings, data revealed questions, concerns, and fear around medical providers making unfounded reports to DHHS. As was discussed in relation to child care choices, there is an issue of trust that goes beyond individual family relationships to providers; as one person shared, "They will call DHS for that parent, so that parent will go tell the community, 'so and so did this to me,' that's when the trust issue comes. They won't trust that school nurse, that doctor." While this was not something that came up for many people through the course of the interviews, it is important to highlight and again speaks to experiences of discrimination and racism.

CONCLUSION AND RECOMMENDATIONS

While the backgrounds, cultural beliefs, and experiences of the families and individuals included in this research differ, analysis indicates a series of key findings and related recommendations that are summarized here to inform future strategies and conversations around child care and developmental screening for immigrant families in Portland. As discussed above, a preliminary review of the literature on both topics suggests these findings align with existing research and recommendations in the field.

Child care findings

While the majority of participants report they would ideally have the mother or a close relative care for a young child for at least the first year of life, this is often not an option for immigrant, refugee and asylee families. This is particularly true for this target population as they often move to communities alone or without their extended families for support. When considering alternative options for care, the most important qualities include safety, acceptance and appreciation of the family's home culture, engaging and educational activities, and socialization. Encompassing all these is the need for an innate sense of trust between the parent and provider. Parents most often report using in-home or center based care, splitting care between parents or relying on older siblings to care for younger children. However, with these choices came concerns about the cost of care, hours that do not match work schedules and long wait lists. Additionally, parents reported experiencing racism and unequal treatment, and shared examples and fears of unfounded reports to DHHS when their children are involved in more formal systems of care.

Developmental screenings findings

When they understood the purpose of developmental screenings and were spoken to with respect, parents saw the screening process for young children as an opportunity to learn more about their child's development and get access to additional support, as needed. However, the majority of participants included in this research shared questions, confusion, and concern with developmental screenings and the processes surrounding their use. Many parents did not understand the intention of the tools; they found questions and concepts overwhelming, embarrassing, and caused them to worry about their child's development. Additionally, participants provided multiple examples of ways in which the tools lacked cultural sensitivity or responsiveness, likely resulting in irrelevant or inappropriate results that are not reflective of children's actual development. Data indicate the tools do not take into account different cultural beliefs

around development, which may lead parents to question the results or recommendations of providers.

When considering the need for interpretation for non-native English speakers, participants shared a variety of experiences and beliefs. While some found that either in-person or telephonic interpreters were helpful (each for distinct reasons), others preferred to manage the appointments on their own, utilizing a variety of strategies to aid effective communication.

Considerations
This research opens up a number of questions regarding developmental screenings and how to best work with families from diverse backgrounds who may have different understandings or norms around development compared to US medical systems. They are offered here for consideration and reflection:

- To what extent should providers rely on screenings to direct and inform care?
- What are the most critical pieces of information to be obtained from screenings?
- How should systems working to support families navigate concerns of both parents and providers?
- How should the language skills and abilities of multilingual children be taken into account in relation to screenings? Research shows that bilingual children may appear to have a delay if they are measured using a monolingual measure, however this is likely false evidence of delay.[11] How can this research be incorporated into best practices for providers who conduct screenings to ensure that children are not misdiagnosed and that multilingual children are appropriately assessed?

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[11] Byers-Heinlein, K., & Lew-Williams, C. (2013). Bilingualism in the Early Years: What the Science Says. LEARNing landscapes, 7(1), 95–112. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6168212/

Recommendations

The following recommendations regarding child care and developmental screenings represent ideas that emerged from participants in this project as well as interpreted by the research team.

Child care

The following recommendations relate specifically to child care. While some speak more directly to the immigrant and refugee experience in Portland, the majority speak to universal needs related to child care as established by other research efforts nationally and locally.

1 *Support families to find child care that meets their needs.*

Regardless of immigration or citizenship status, families need support in finding child care that meets their unique hopes and needs. This is especially true for new immigrants who do not yet understand the multitude of child care choices, the importance of getting on wait lists, the cost of care, and typical hours of service.

> **Provide clear guidance about eligibility criteria for child care subsidies and how families can find appropriate child care.** Ensure parents who are enrolled in educational programs (e.g., Portland Adult Education, English classes, or other courses) can utilize state child care subsidies and additional supports. Consider offering child care programming at the education location while parents are in classes.

> **Provide clear information about Head Start registration.** Offer opportunities for families who want educational programming and activities for their children while they are on the waitlist.

> **Provide middle ground programming** (in between full day, everyday day care center programming and family, friends, neighbor care) for parents who cannot afford daycare, but want their children to participate in community or supportive programs to build connections and provide children with opportunities for learning, socialization, and activities, as well as gain exposure to the English language. Connect this programming to opportunities for parents to "receive some financial support and opportunities to involve their kids with other kids, and learn the English language for kindergarten."

2

Provide targeted support to help people open licensed home daycares.
There is community interest in opening home-based daycare sites. One major concern shared was the challenge with the licensing process and the amount of time it takes. Many did not know how to find any information about licensing. Targeted support to immigrant communities about the process and working through the steps may expedite the time it takes and allow more people to create much needed daycare spots. This recommendation also aligns with qualities that parents search for, including supporting children to learn more about their culture, hear and learn their family's language, and have the chance to socialize with other children and adults. This strategy is critical dealing with the child care shortage in Portland (and in Maine).[12] Covid-19 has only exacerbated this shortage and made finding child care even more challenging as numerous providers have had to shut their doors either temporarily or permanently because of health concerns.[13] Most established daycares have long waitlists, which means that parents are sometimes told that they would have to wait years for a spot to open up. Ideas for sharing information may include videos on how to fill out forms and partnership between organizations such as Maine Roads to Quality and MAIN to share information and make sure that it is translated appropriately and understood by different language communities.

3

Address the issue of child care affordability.
Child care is too expensive for working parents who do not qualify for vouchers. [14]

4

Advocate for paid parental leave.
State and local policy should support a minimum of 6 months to one year of paid parental leave[15] so that at least one parent can spend time with their infant and support family bonding. This also delays the need to find child care in the first year.

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[12] For more information on this issue in Maine, visit Maine Public's Deep Dive into Child Care: Accessibility (2019) http://projects.mainepublic.org/child-care-deep-dive
[13] WGME. (2020 March 19). Hundreds of Maine day cares close due to Covid-19; other stay open for working parents. Retrieved from https://wgme.com/news/coronavirus/hundreds-of-maine-day-cares-close-due-to-covid-19-others-stay-open-for-working-parents#:~:text=Citing%20the%20Office%20of%20Child,and%20family%20child%20care%20facilities.
[14] For more information on this issue in Maine, visit Maine Public's Deep Dive into Child Care: Affordability (2019) http://projects.mainepublic.org/child-care-deep-dive
[15] The United States is one of the only countries in the world without a national paid family leave policy. Research shows that "paid family leaves of adequate duration and wage replacement lead to more income and gender equality, significant reductions in infant, maternal, and even paternal mortality, improved physical and mental health for children and parents, greater family stability and economic security, business productivity, and economic growth."
Schulte, B., Durana, A., Stout, B., and Moyer, J. (2017 June). Paid family leave: How much time is enough? *New America: Better Life Lab.* Retrieved from https://www.newamerica.org/better-life-lab/reports/paid-family-leave-how-much-time-enough/

5

Support a community builder or cultural navigator role to bridge and build understanding and trust among community members and daycare providers.
This role could serve as a resource for daycare providers to ask questions, for parents as a support to understand the US child care and educational system and expectations, and act as a liaison to promote general understanding and positive relationships between families and providers. This role may build trust and decrease the number of calls to DHHS that stem from misunderstandings.

6

Provide regular training for daycare providers in care settings on cultural humility, inclusion, and bias.
Encourage daycare providers to be more informed of other cultures, their needs and wants for child care, and how to work with families from diverse backgrounds.

7

Build diversity of daycare center staff.
Daycare centers should strive for staff to reflect the diversity of children that they serve. A diverse and educated staff can provide additional support to families through language and cultural understanding. This may also support centers to consider the food served and integrate different cultural dishes into mealtimes. Staff that reflect the local community and share understanding can provide support to parents and build trust. This may also decrease the number of calls to DHHS that stem from misunderstandings between providers and parents.

Developmental screenings
The following recommendations relate specifically to the developmental screening tools and processes.

1

Increase parent understanding of what developmental screenings are and what to expect in visit with their doctor or other provider who conducts screenings.
Send screening tool and/or questions to families before their visit, in preferred language for the family as appropriate. The tool for the next visit could also be provided to the parent while they are in the office for the previous well child visit (e.g. at the 12 month visit, provide the family with the 18 month screening tool). This may help parents learn more about what is coming in the future and provide additional information about what they might expect their child to be able to do in the upcoming months.

Include developmental screening information in orientations to the medical system (e.g., in a workshop through an organization that all asylees or refugees engage with, such as Catholic Charities or Adult Education or through familiar community members who can share information about the process in order to build trust and understanding). Provide additional general education on the health care system and how it works so people understand how the screening process fits into the general systems of care.

Provide information/education on developmental screening. Providers should explain why screenings are happening and why the particular timeline is used (e.g., in order to support children early on in their development) and explain that all children participate in developmental screenings. Providers may also provide brochures to read during or after the experience that people can bring home and share with their families. All materials would need to be provided in the appropriate language for the family. To consider potential challenges regarding literacy levels, providers may also consider implementing additional strategies to build understanding such as working with Community Health Workers or other trusted community members to ensure that families understand the process and what to expect. Other ideas for sharing information included: sharing a link to a website with information about screenings in multiple languages (development of this if there isn't anything that currently exists or would be appropriate); hosting seminars for families about the process with Community Health Workers and cultural brokers to clarify information.

2 *Promote family involvement in the process.*
Providers should make it clear that both parents or another trusted family member or friend are welcome to attend the developmental screenings (and all medical appointments).

3 *Educate parents about their rights.*
Ensure that parents know their rights about accepting or refusing services and that parents understand what the next steps are after a screening occurs.

>   **Be clear about privacy and rules around interpreter's roles and HIPAA**. While this may not assuage all concerns around privacy and interpreters who are a part of their communities, this may be one way of addressing the fear that interpreters may share information about what a parent says or what a child is able or not able to do. Teach families about the medical

interpreters' code of ethics[16] and work with interpreters to make sure they follow the code.

4

Consider the extent to which screenings respect culture and language.

Adjust screening protocols to meet the needs of individual families. When working with families from diverse cultures, consider the extent to which providers can appropriately frame and introduce questions to make them more relevant to the family. For example, if questions about alcohol or other substance use must be asked, practitioners may consider how they can frame the question in a way that recognizes and respects their clients' beliefs and customs. In screenings that ask about the utilization of various tools or objects, consider what cultural expectations are around those tasks or activities and whether or not parents would deem them appropriate. Consider if there are alternative questions, tools, or objects that get to the same evaluation of a skill and are more relevant to the family.

Consider the extent to which screenings take into account multilingual children and differences in language acquisition.

5

Ensure positive and respectful communication with families.

Providers should be encouraged to take the time to speak with families and as one parent said, "listen to parent's views about their children." Respect is a cornerstone to the parent-provider relationship. Previous recommendations listed here may help providers think of ways to show respect to families. One suggestion also involved deepening the relationship between providers and families and increasing communication. This may look like regular calls to check in or home visits (to give providers more information and understanding). This extra effort and care can show respect and support deeper relationships, which in turn will benefit children and families and allow providers to improve the care they give.

6

Provide training to medical interpreters about developmental screenings so they can more appropriately address questions and concerns of parents.

A key to ensuring that parents understand developmental screenings is to make sure that interpreters have a thorough understanding of what they are interpreting. Ideally, tools will be administered in the language preference of the parent, however if this is not possible, interpreters should have content knowledge about developmental screenings

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[16] The *Medical Interpreters Code of Ethics* can be found here: https://www.imiaweb.org/code/

so that they can accurately interpret for the provider and ensure that parents have a clear understanding of what they are being asked.

Areas for future exploration

Data collected from community members about their personal and professional experiences with child care and developmental screenings revealed both new and expected beliefs, understandings, expectations, and emotions. While the data included recommendations and ideas for consideration that would likely benefit the larger community, it is important to recognize that the views and experiences of those included in this research do not necessarily reflect those of all community members. These topics would greatly benefit from additional research that involves a wider group of immigrant, refugee, and asylee communities in Portland and beyond. Additionally, all interview participants were mothers. Future projects may seek input from fathers or other primary caregivers.

It is important to recognize the dominant spoken and written language used in this project, and consider the role of language in future research. All research protocols for this project were developed in English. Community Health Workers had to translate the data collection material, including the introduction, consent and interview questions, into the primary language of the family for the interview. Although interviews were conducted in the language most comfortable for the CHWs and participants (mainly Arabic, French, or Somali), interview notes were written in English, data was analyzed in English, and the final report is in English. It may be important to develop questions, record notes, and write the report in the language preference of the group who is leading and participating in the research. This may help to maintain the meaning expressed by participants and data recorders through the research and reporting process. While this project worked to incorporate many voices into the research process, other decolonizing methods of research may also be explored, including more deeply incorporating methods of Community Based Participatory Research (CBPR), where community members are at the center of the project design, development, and results.[17]

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[17] For more information about decolonizing research methodologies: Smith, LT. (2013). Decolonizing Methodologies: Research and Indigenous Peoples. London: Zed Books. *And* Datta R. (2018). Decolonizing both researcher and research and its effectiveness in Indigenous research. Research Ethics, 14(2):1-24. https://journals.sagepub.com/doi/full/10.1177/1747016117733296
For more information about CBPR: Policy Link's *Community-Based Participatory Research: A Strategy for Building Healthy Communities and Promoting Health through Policy Change* https://www.policylink.org/sites/default/files/CBPR.pdf and Vaughn LM, Wagner E, Jacquez F. (2013). A review of community-based participatory research in child health. *MCN Am J Matern Child Nurs*, 38(1):48-53.

Groups such as Starting Strong and the DSCI may consider bringing in speakers from different organizations to talk more about these topics. This may include local providers who are doing these things well (e.g., a child care center who has a diverse staff and can speak to how that impacts the care they provide and relationships they have with families) or sharing examples of when Community Health Workers played a role in navigating between a provider and parent with positive results. Insights from the Portland community that speak more directly to these topics will help to continue these conversations specific to the recommendations provided and drive action of partners.

APPENDIX A. INTERVIEW QUESTIONS

Demographic Questions
1. What do you consider your home country or country of origin?
2. What language or languages do you speak?
3. Which neighborhood do you live closest to:
4. How many children do you have?
5. How old are your children?

Child Care Questions
1. What worked well back home with taking care of children? What didn't you like?
    a. What would you like to see here in Portland?
2. What does your child do during the day?
    a. Are you satisfied with this?
        i. Why or why not?
    b. What could make it even better?
3. What is important to you when deciding what your child will do during the day / where they will be / who they will be with?

If there is time, consider asking: Do you have any questions about child care in Portland?

Developmental Screening Questions
1. Have you experienced a developmental screening with your child?
    a. What was the location or setting?
    b. What was it like?
        i. Did you feel comfortable?
            1. Why or why not?
            2. Was there anything the doctor/provider did that made you feel more or less comfortable?
            3. If you had an interpreter, was there anything they did that made you feel more or less comfortable?
            4. What would make you feel more comfortable? What would make the process better?
2. Were there questions that you didn't understand (even if they were translated on paper or you had an interpreter)?
    a. Can you say more about what those questions were?
        i. Why didn't they make sense?
        ii. Were there questions that were hard to answer?
3. What are the best ways for providing information, education, and/or awareness to parents about developmental screenings?
    a. What questions do you have about developmental screenings?

APPENDIX B. INTERPRETER FOCUS GROUP QUESTIONS

Child Care Questions

1. For the families you see or work with who have young children age 4 or under, what do the children do during the day?
   a. What do children do when one or both parents are working?
   b. Do they stay at home with a parent or relative, a neighbor, or do they go to a day care?
   c. For those who do not go to a day care center, who are they usually with?
      i. Can you say more about that?
2. Do you think that people are satisfied with their arrangements for their child or children?
   a. Why or why not?
   b. What do you think would be the ideal arrangement for families?
3. What is important for families when deciding what their child will do during the day / where they will be / who they will be with?

Developmental Screening Questions

4. How many of you have interpreted for a family in a situation where a developmental screening is taking place? (Or if you have not interpreted for a screening, have you experienced a developmental screening with your own child?)
   a. Can you say more about the location or setting?
   b. What was it like?
      i. Did you feel comfortable as the interpreter?
         1. Why or why not?
         2. Was there anything the doctor/provider did that made you feel more or less comfortable?
      ii. Did you feel that the parent was comfortable?
         1. Why or why not?
         2. Was there anything the doctor/provider did that you think made the family feel more or less comfortable?
      iii. What would make the process better?
5. Are/were there questions that are/were hard to interpret?
   a. Can you say more about what those questions were?
      i. Why didn't they make sense?
      ii. Were there questions that were hard to answer?
6. What are the best ways for providing information, education, and/or awareness to parents about developmental screenings?

APPENDIX C. BACKGROUND ON FAMILY, FRIEND, AND NEIGHBOR CARE

Family, friend, and neighbor (FFN) care is defined as: any regular, non-parental care other than a licensed center, program, or family child care home. FFN care includes relatives, friends, neighbors, and other adults not required to be licensed by the state of Maine to provide child care.[18] A 2019 national report found that approximately 23% of infants and toddlers use either unpaid or paid FFN care as their primary child care arrangement.[19] This is the most common form of non-parental care and FFN caregivers tend to share several characteristics. This includes that they are most commonly relatives and most often grandmothers; are usually located in close geographic proximity to the children for whom they care (in both urban and rural settings); are often of the same ethnic background as the children they care for; and often have similar incomes to the families of the children they care for.[20]

Family, friend, and neighbor care in immigrant communities

National research has shown that although there is substantial variation by national origin group, in general, low-income children of immigrants are less likely to access child care and early education outside their homes.[21]

Definitions of quality for family, friend, and neighbor care

Quality is a topic often discussed when looking at child care. While there is no clear definition of what quality means in the FFN care setting, an evaluation of FFN projects through the David and Lucille Packard Foundation found that quality could be defined as: a nurturing adult-child relationship; access to quality resources (i.e., age appropriate

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[18]Definition from Maine Department of Health and Human Services. (2009). Supporting family, friend, and neighbor child care: A strategic plan for Maine.

[19] Paschall, K. (2019 September 4). Nearly 30 percent of infants and toddlers attend home-based child care as their primary arrangement. Child Trends. Retrieved from https://www.childtrends.org/nearly-30-percent-of-infants-and-toddlers-attend-home-based-child-care-as-their-primary-arrangement

[20] Susman-Stillman, A. & Banghard, P. (2008 August). Demographics of family, friend, and neighbor care in the United States. Research Connections: Child Care & Early Education. Retrieved from http://www.nccp.org/publications/pdf/text_835.pdf

[21] Sandstrom, H. & Gelatt, J. (2017 November). Child care choices of low-income, immigrant families with young children: Findings from the National Survey of Early Care and Education. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/94546/child-care-choices-of-low-income-immigrant-families-with-young-children.pdf *Note: while this study was a nationally representative sample of US households with children under 13, most of the people who were LEP or foreign born were from Mexico or another Spanish-speaking country.*

learning resources, kits, and in multiple languages); and safety.[22] More generally, Zero to Three, a national initiative that promotes healthy connections for babies and toddlers, states that "A good caregiver is…loving and responsive, respects the baby's individuality, provides a stimulating and child-friendly environment."[23]

The Early Learning Lab has developed a set of five critical practices that "ensure optimal interactions between adults and young children" called "The Big Five."[24] These include:

- Providing rich learning activities that build on the child's interests;
- Reading, singing, and telling stories;
- Knowing the stage of a child's development and what will come next;
- Creating nurturing relationships and using positive guidance; and
- Being responsive and expanding verbal and non-verbal communication.

Supporting family, friend, and neighbor care providers

Numerous programs and initiatives have been developed throughout the US to find ways to best support FFN care providers. Programming is based in the theory that by providing information to FFN caregivers, and connecting them to resources, to each other, and to formal caregivers, FFN caregivers can create stimulating and rich learning experiences for the children in their care.[25]

Research has shown that oftentimes FFN caregivers do not have extensive formal training, however do have many years of experience in caring for children.[26] Oftentimes they also lack access to information and sources of support around childcare and lack awareness of what support, information, and resources might be available to them.[27]

[22] Engage R&D. (2019). Innovations in family, friend, and neighbor care: Evaluation brief. The David and Lucile Packard Foundation. Retrieved from https://www.packard.org/wp-content/uploads/2019/02/InformalFFN-Care-Cohort-2-Brief.pdf
[23] Zero to Three. (2010 February 8). How to choose quality child care. Retrieved from https://www.zerotothree.org/resources/84-how-to-choose-quality-child-care
[24] Harkin, K. & Garcia, D. (2019 June 11). This is what quality looks like: A visit with families, friends, and neighbors. The David and Lucile Packard Foundation. Retrieved from https://www.packard.org/insights/perspectives/this-is-what-quality-looks-like-ffn/ *For Big Five handout from the Early Learning Lab, visit: https://earlylearninglab.org/wp-content/uploads/2018/06/1803-5-Priority-Practices.pdf*
[25] Harkin, K. & Sangalang, B. (2019 February 7). Creating nurturing early learning experiences: The role of family, friends, and neighbors. The David and Lucile Packard Foundation. Retrieved from https://www.packard.org/insights/perspectives/creating-nurturing-early-learning-experiences-the-role-of-family-friends-and-neighbors/
[26] Alarcon, I. & Sangalang, B. (2015). Informal child care in California: Current arrangements and future needs. The David and Lucile Packard Foundation. Retrieved from https://www.packard.org/wp-content/uploads/2015/06/INFORMAL-CHILD-CARE-IN-CALIFORNIA1.pdf
[27] Ibid.

One example of a program in California for FFN caregiver support included meeting two times per week for eight weeks with the intention of teaching caregivers more about how children develop and learn, offering practical guidance and activity ideas, and strengthening their confidence as influential adults in the lives of the children they care for.[28] Through this program, they also discussed the importance of culture and helping children develop a positive cultural identity and incorporated through experiential learning and discussion the Big Five practices as discussed above. Programs such as this could serve as models for how to support FFN caregivers in Maine as well.

Family, friend, and neighbor care in Maine

More locally in Maine, a study conducted by Maine Children's Alliance[29] looked at FFN care and found that the main reasons for choosing FFN care included: trust, flexibility (work shift times, only need a small amount of care), need for one-to-one care (special needs), limited access to formal programs, cost (free or low cost). Most of the children who were being cared for in this setting were cared for by a relative (48%) or a friend or neighbor (38%). Key findings from that report include how FFN caregivers perceive themselves and that they "rarely consider themselves child care professionals. Rather, they see themselves as

Key recommendations for any program that is seeking to support or engage FFN care providers should acknowledge and include the following:

- Relationships are key
- Initiatives should help FFN caregivers feel more connected with community resources
- Make it convenient to participate - accessible location, food, transportation, child care
- Access to education and training opportunities + opportunities for general education
- Financial incentive for attending training
- Parenting education and home visiting for FFN caregivers (one on one with specialists in the home or community setting)
- Basic health and safety equipment (car seat, cabinet locks, etc.) and training for use should be made available
- If they want to become regulated, support to do so; if they do not still give support to help them improve quality of care
- Recognize diversity of providers and their needs
- Consider language and culture - activities and materials should be linguistically and culturally appropriate

Reference:
National Women's Law Center. (2009). Developing family, friend, and neighbor care initiatives and policies: Tips from experts. *National Women's Law Center*. Retrieved from https://nwlc.org/wp-content/uploads/2015/08/ffn-tipsfromexperts.pdf

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[28] Harkin, K. & Garcia, D. (2019 June 11). This is what quality looks like: A visit with families, friends, and neighbors. The David and Lucile Packard Foundation. Retrieved from https://www.packard.org/insights/perspectives/this-is-what-quality-looks-like-ffn/

[29] Maine Children's Alliance. (n.d.) The value of family, friend, and neighbor care in Maine. Maine Children's Alliance. Retrieved from https://www.mekids.org/site/assets/files/1394/mca_ffnbrief_final.pdf

helping a family member or friend." FFN caregivers also were asked about what type of child development information would be useful to them – they identified discipline, sleeping, toilet training, helping children be ready for kindergarten, dealing with an angry child. In addition, one third of the respondents said they are taking care of a child with special needs, whether cognitive, social-emotional or physical needs. This report also found that in Maine, only about 24% of those who qualify for child care subsidy receive them. However, the barriers for FFN care providers are relatively low and they can accept a subsidy if they pass a background check on all members of household and water quality test.

Previous research with immigrant and refugee communities in Portland and child care decision-making

In 2011, a study[30] on child care was completed with immigrant and refugee parents in Portland from Cambodia, Somalia, and Sudan. This research showed that parents preferred the child to be cared for by the parent, member of their extended family, or from their community in the early years. Parents also shared similar concerns about discrimination and fear of involvement with child welfare agencies or the police.

Benefits of child care reported by parented included: the opportunity to learn, develop social skills, socialize, and learn more about American culture. Parents who had children enrolled in child care centers also felt that child care provided a safe, well-regulated setting and that those programs were also helpful in connected families to other services. Concerns shared by parents included: the hours of operation of child care centers mismatch with work schedules; the high cost; desire to keep children with parents or family members; health and safety concerns; fear of losing their culture and language; fear of violating religious dietary restrictions; concerns about disciplinary practices (both from the parent perspective on what the child care center is doing and from the child care center on what the parent does at home); and discrimination against their children. Parents also reported "incidents in which their children felt hurt by remarks made by other children about their race" and "Some expressed fear for their children's safety in their new neighborhoods and several felt that their neighbors were too quick to report them to the police if they allowed their children to play outside alone."

Recommendations from this report included:

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[30] Ward H, Oldham LaChance E, Atkins J. (2011). New Americans: Child Care Decision-Making of Refugee and Immigrant Parents of English Language Learners. Portland, ME: University of Southern Maine, Muskie School of Public Service.

- Provide opportunities for members of the refugee and immigrant communities to become licensed by addressing licensing and documentation barriers and providing appropriate, culturally sensitive training in the first languages of participants.
- More quality child care programs that can accommodate nontraditional hours.
- Address the shortage of providers with certification in early care and education whose first language is other than English with loan forgiveness programs and other measures.
- Provide more funding for child care providers to hire interpreters and use language services to communicate with parents.
- More bilingual staff for R & Rs to conduct more outreach in the community, assist parents in learning about what quality child care is and how to find it, how to interview providers and how to apply for child care assistance and pay for child care. Have materials translated.
- Provide staff assistance because some parents are illiterate in their native language.
- Expand training opportunities for child care providers in the following topics:
    - Cultural diversity and communication
    - How to be an effective translator and how to work with translators
    - Diversity—how to incorporate multiple cultures into a single classroom
    - How children learn a second language for non-English speaking staff; support services and materials regarding culture, customs and beliefs
    - Understanding immigrant and refugee views of education and educators
    - Beliefs and customs in different cultures, including guidance on nonverbal communication
    - How to choose and read stories to a group of children that speak a different language than the one being read
    - How to more effectively teach non-English speaking children

There were an additional series of recommendations directed specifically to child care providers.

APPENDIX D. BACKGROUND ON DEVELOPMENTAL SCREENINGS

What is a developmental screening?

A look at how a child is learning, growing, and communicating.[31]

Why are they important?

- As many as 1 in 4 children are at risk for developmental delays, therefore universal early childhood screening provides an opportunity to identify delays early and intervene during the most critical period of development.[32]
- Early detection, referral, and treatment can significantly reduce the long-term impact of developmental delays, behavior problems, or both and promote better outcomes for children.[33]
- Only about one third of children with developmental or socioemotional problems are identified before kindergarten. Children with socioemotional problems are especially under-identified.[34]
- Failure to detect problems before school entry is associated with the solidification or escalation of early problems that become increasingly intractable over time.[35]

Conducting screenings with diverse cultures

Screening tools are developed in order to support an understanding of a child's overall behavior and development.[36] However, it is critical to note that such tools are created with a specific cultural perspective that may not take into account a child or family's historical, cultural, community, and familial context.[37] While measures are "typically standardized with ethnically and culturally diverse samples to increase generalizability," they do not always include sufficient numbers of the many diverse

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[31] Family handout from American Academy of Pediatrics on developmental screenings (in English and Spanish). Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Documents/FamilyHandout_ImportanceOfScreening.pdf

[32] American Academy of Pediatrics. *The importance of screening.* Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/The-Importance-of-Screening.aspx

[33] Whitesell, N.R., Sarche, M., Truckess, C., Tribal Early Childhood Research Center SWYC Community of Learning. (2015). The survey of well-being of young children: Results of a feasibility student with American Indian and Alaska Native communities. *Infant Mental Health Journal,* 36 (5), p. 483-505.

[34] Sand et al. (2005). As cited in Whitesell et al. (2015).

[35] Kruizinga, Janse, Carter, and Raat. (2011). As cited in Whitesell et al. (2015).

[36] Kids Mental Health Info. (n.d.). *What are the differences between testing, screening, assessment, and evaluation?* Retrieved from https://www.kidsmentalhealthinfo.com/faq/differences-testing-screening-assessment-evaluation/

[37] Whitesell et al. (2015). p. 488

populations that exist in the United States to support conclusions about the "reliability, validity, sensitivity, or specificity of the screeners for that population."[38]

Many tools include recommendations for working with diverse cultures and examples of modifications that may be made to questions in order to best address the language, environmental, or social context where the screening tool may be used. Basic suggestions include clearly stating to the family the purpose of the tool and how the information will be used and working with a cultural broker to help interpret or translate questions so they make sense related to the family's background.[39] Certain screening tools such as the Ages and Stages Questionnaire (ASQ) also provide guidelines for how to substitute language, materials, or activities within the tool that retain the intent of the original question (e.g. if the intent is to understand whether or not a child is developing their ability to grasp an item, the original tool uses the item "Cheerios." Another similarly sized item that a child could grasp could be substituted in order to gauge the child's skill level).[40] It is important to note that simply translating the language of a tool is not enough to guarantee that the meaning or intent will be understood in the same way once translated.

Limited research on developmental screenings in immigrant and refugee populations exists. Research suggests that tools may reflect cultural bias and that differences in scores may reflect problems in the "construction, design, administration, or interpretation of tests" rather than actual differences in ability.[41] There are multiple layers of considerations that must be made for diverse populations, especially immigrants and refugees who may find screenings anxiety producing or may bring up feelings of fear of judgement, stigma, labeling, or concern that children may be removed from their care.[42] Another layer that should be considered is that even if tools have been normed for specific populations, there are other factors that may influence the screening results, including if families are not familiar with the process or are unable to comfortably communicate with the person working with them to conduct the screening.[43]

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[38] Ibid.

[39] Ages and Stages Questionnaires. (2014 November). Tips for screening children from diverse cultures. *Ages and Stages Questionnaires.* Retrieved from https://agesandstages.com/free-resources/articles/tips-screening-children-diverse-cultures/

[40] Ibid.

[41] Brown, Reynolds, & Whitaker (1999) as cited in Gokiert, et al. (2010). Early childhood screening in immigrant and refugee populations. *Community- University Partnership for the Study of Children, Youth, and Families.*

[42] Gokiert et al (2010).

[43] Gokiert et al (2010).

While a large body of research is lacking, there have been a few more in depth qualitative studies with diverse populations and their experiences with developmental screening tools and beliefs and perceptions around early childhood development. These studies provide helpful examples of how diverse communities can provide input on developmental screenings as well as provide recommendations for understanding and utilizing these tools within diverse populations.

Study example: Early childhood screening in immigrant and refugee populations[44]

One study conducted in Alberta, Canada looked at the validity of the ASQ (18 month) for three prominent immigrant groups (Sudanese, South Asian, and Chinese) and identified themes on "why parents from diverse cultural groups may interpret and respond to questions differently." Through an in depth review of the 18-month ASQ questionnaire and family interviews, this Canadian study found themes that focused on "parenting, interpretation, measurement, exposure, and feeding."[45] They found that for all of these themes, religion, gender norms, parental education levels, socioeconomic status, historical or familial experience, and cultural context, values, and norms also contribute to their experiences with the screening tool.

- **Parenting.** This theme found different cultural expectations of the roles of parents and children. Examples included: in more interdependent cultures, independent skills may not be considered important and therefore parents do more with their children (e.g. instead of encouraging a child to walk down the stairs, parents may carry them); parents may answer based on their "socialized understanding of testing" and answer based on what they think they should say. Oftentimes, caregiving of the child extends beyond just the parents and many ASQ activities require only one-on-one child-parent activities, which may not reflect the general reality of a child's life. [15/30 ASQ questions]
- **Interpretation.** Questions were found to be lengthy, had confusing wording, confusing examples, and included words that had no translation, therefore parents did not always understand the question and were unable to respond accurately. Some confusion was experienced by parents who were unsure if they

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44 Gokiert et al (2010).
45 Gokiert et al (2010).

should be responding to the questions in terms of "their child's English or first language abilities." [Almost all 30 ASQ questions]

- **Measurement.** Many questions focus on the "quantification of developmental skills," e.g., how many words can a child say, however not all cultures focus on quantification. Some cultures also have a belief that children develop at their own pace rather that "prescribed stages of development" that may be assessed by a screening tool. [16/30 ASQ questions]
- **Exposure.** Not all children have the same exposure to the same social or cultural activities or objects at the same ages and therefore questions that refer to specific experiences or objects may be challenging to respond to for children who have not had exposure to those objects (e.g. pens or pencils). Some refugee families may have had limited access to certain things such as children's books and therefore the lack of exposure does not indicate a lack of trying or interest, but rather a reflection of a family's specific experience. [23/30 ASQ questions]
- **Feeding.** A number of issues arose related to "feeding practices, food related responses, respect for food, and hygiene." Numerous questions have the intent to better understand certain developmental skills that are unrelated to eating (e.g. place a cheerio in a container), or related to the usage of utensils (e.g. spoon), however these questions may point to cultural differences rather than a child's ability because of exposure or cultural practices or expectations around feeding. [6/30 ASQ questions]

This research also looked at building an improved process for developmental screenings for a preschool program. They report that "relationship building at the front end of the screening process" was critical in order to break down barriers that would have restricted the family's participation—including "language and cultural barriers, transportation, employment, and financial obstacles." Families who worked with cultural brokers reported that they "enjoyed filling out the ASQ," mainly "due to the individual translation and support in understanding what the questions were asking" through showing the family how to observe their child in the activities from the questionnaire, as well as additional clarifying examples and translation support. Parents reported that it was a useful tool to learn about "Canadian life" and gave them "information to support their child's growth." Parents also learned "more about what their child was capable of and activities that they could try at home." Families who did not receive this support reported that the "wished they had someone from their community work with them to complete the ASQ."

Study example: Survey of Well-Being of Young Children in American Indian and Alaska Native communities[46]

A more in depth analysis of the Survey of Well-Being of Young Children (SWYC) tool[47] was conducted with American Indian and Alaska Native communities in order to better understand what the needs were related to using screening tools and what process considerations should be addressed in order to effectively use the tool. Through focus groups and key informant interviews with education, home visiting, and health care providers, parents of young children, tribal leaders, and other stakeholders, this research provides helpful guidance when considering using developmental screening tools with underrepresented populations.

Benefits of the SWYC tool as noted in this study are that it is free, easy to administer and score, is relatively fast and does not require additional materials or tools, covers a wide span of childhood development, and has been validated. Process considerations included **parental/familial engagement** – ensuring that parents are full partners in the process with a clear understanding of why the screening was being conducted and what would happen with the results once the process was complete. This was seen as a key foundation, especially due to trust issues and hesitance to share information. The tool was also seen as an opportunity for dialogue with parents recommending that there could be additional suggestions about what they can do to support their child's development. Parents also shared feedback that there should be more questions that ask about family or cultural strengths (rather than just family challenges). An additional suggestion was to consider how other family members may be brought into the process if they are spending a significant amount of time with the child. Participants also wondered about the more sensitive family based questions around substance use and depression that felt intrusive, causing people to wonder how families may respond or may choose not to answer. This hesitancy shows the need to approach these types of questions with caution and reverence, considering how it may make a parent or caregiver feel.

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[46] Whitesell Nr, Sarche M, Trucksess C. (2015 Sep-Oct). Tribal early childhood research center SWYC community of learning: The survey of well-being of young children: Results of a feasibility study with American Indian and Alaska Native communities. *Infant Mental Health Journal*, 36(5), 483-505.

[47] The Survey of Well-Being of Young Children (SWYC) screening tool is free and available for use. It was developed by Tufts to be administered to children under 5 years of age. It has been translated into Spanish, Khmer, Burmese, Nepali, Portuguese, Haitian-Creole, Arabic, Somali, and Vietnamese. More information about this tool can be found at https://www.floatinghospital.org/the-survey-of-wellbeing-of-young-children/overview

Language and culture were additional considerations – using the family's native language as well as considering the wording or examples in questions (e.g. asking if the child is saying "mama" or "dada" may not be relevant in their cultural context, therefore changing those words to something that aligns with cultural expectations). Similar to the family based questions as mentioned previously, there may be cultural ceremonies or rituals to be aware of that may influence how families respond to the questions (e.g. a question asks about tobacco use – tobacco is used in rituals or ceremonies so young people may be exposed at some point. Understanding culture more broadly may help providers administering these tools to be able to gain clarity on, for example, the level of exposure and whether or not it is a concern or actually a potential strength.) **Environmental and social** contexts were also addressed – for example if a community has mostly one story houses and there aren't many opportunities for a child to practice using stairs, rather than asking about climbing stairs, the question could ask about climbing on a chair or a couch. Within these considerations was also a more general discussion of thoughtfully reflecting on the **values** of the culture – what are the key values that people have and how does that influence how they raise their children and what traits they expect to see. For example, if listening and observation skills are important, how can those valued skills be represented within the tool.

More macro, **community level** issues and questions also emerged around families receiving services from multiple types of providers and having to complete different screening tools and receiving different information based on the outcomes of the different tools. One recommendation was to consider who should administer these tools and where with the potential ability to share information across service providers so that families weren't receiving mixed messages or having to complete multiple time consuming screenings.

This study provides a window into the importance of reviewing a tool and examining the cultural, environmental, and social implications that it has and how it may be modified to best serve families and providers in order to support a child's development and ensure that they receive the services they need to thrive.

APPENDIX E. DIFFERENCES BETWEEN SCREENING, ASSESSMENT, AND EVALUATION

- *Screening:* A screening is a quick snapshot of a child's overall behavior and development (developmental, sensory - hearing and vision, behavioral).[48] Several brief tests and/or instruments may be used to identify issues.[49]

- *Assessment:* Assessment is an ongoing examination of a child's development over time, to make sure the child is progressing and meeting milestones.[50] More comprehensive process that uses a series of different tests or instruments to help create a picture of your child.[51]

- *Evaluation:* Most comprehensive - may include screening, testing, and assessment. Often include child's history and background.[52]

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[48] Schwartz, Amanda. (2018 October 17). *What's the difference in screening, assessment, and evaluation?* ContinuED. Retrieved from https://www.continued.com/early-childhood-education/ask-the-experts/what-s-difference-in-screening-23019

[49] Kids Mental Health Info. (n.d.). *What are the differences between testing, screening, assessment, and evaluation?* Retrieved from https://www.kidsmentalhealthinfo.com/faq/differences-testing-screening-assessment-evaluation/

[50] Schwatz, Amanda.

[51] Kids Mental Health Info.

[52] Ibid.

APPENDIX F. KEY TAKEAWAYS FROM REPORT ON DEVELOPMENTAL ASSESSMENTS AND SCHOOL READINESS

Produced by the Data Innovation Project for Starting Strong (November 2016)

Key Findings

- Providers use many different tools, but come to similar conclusions, the goal is to better understand where a child is developmentally and then make appropriate referrals to either further assessment or programs, or use the results of the assessment to provide appropriate supports within the program to both child and caregivers.
- The tools provide a framework for discussing areas that contribute to school readiness (e.g. motor or language development or general knowledge such as numbers or colors). Providers expressed that the tools help to facilitate conversations with caregivers around a variety of topics.
- Many of the tools involve self-report surveys on a caregiver's perception of a child's development, they often require more coaching and support because caregivers are not always familiar with the paradigm of early childhood development as defined in American culture.
- *Challenge*: providers need tools to be interpreted. The process then becomes much more time intensive (sometimes double the amount of time). Cultural conceptions around developmental milestones also need to be interpreted and explained to parents, which can also increase the time an assessment takes to complete.
- *Common challenges for families*: housing, transportation, language and interpretation, immigration status, referrals and follow through, and wait lists.
- Providers expressed concern that families are able to follow through with referrals made to specific programs or additional screening. Issues related to housing or transiency, transportation, and whether or not a family has access to health insurance all affected this concern. Related to making referrals, providers were conscientious about making appropriate referrals that both families and programs would be able to follow through with. Wait lists are a common barrier to ensuring families can access these programs quickly.

Developmental Screening Tools and Guidelines Used
Among six providers: City of Portland; Greater Portland Health; MAIN; Maine CDS; Maine Medical Partners; The Opportunity Alliance (Head Start and Maine Families)

Providers use a variety of tools to evaluate developmental milestones (see table below). As reported by all providers, these are done at regular intervals (e.g. in the Head Start program, the ASQ is done within the first 45 days of a child being in the program and on an annual basis; or in the case of the SWYC, Maine Medical Partners uses it at 9-month and 30-month visits). The most frequently cited tools used were the ASQ (four provider locations) and M-CHAT (two provider locations).

- Ages and Stages Questionnaire (ASQ-3)
    o Head Start, Maine Families, Maternal and Child Health Home Visiting Nursing, Child Development Services
- Ages and Stages Questionnaire: Social-Emotional
    o Head Start, Maine Families
- Brigance Early Childhood Screens
    o Child Development Services
- Bright Futures (Framework for Well Child Visits) from the American Academy of Pediatrics
    o Maine Medical Partners
- Learn the Signs CDC guidelines (Developmental Milestone Checklist)
    o Greater Portland Health
- M-CHAT (Modified Checklist for Autism in Toddlers)
    o Greater Portland Health, Maine Medical Partners
- PEDS (Parents' Evaluation of Development Status)
    o Greater Portland Health
- SWYC (Survey of Well-being of Young Children)
    o Maine Medical Partners

Additional assessments

Providers also stated that they have additional assessments or questionnaires around general health, sleep, safety, domestic violence, post-partum depression, food security, and behavioral health. CHOWs use the Community Partnerships for Protecting Children (CPPC) Family Assessment to better understand family needs and assets, while also encouraging families to meet with other providers (such as their pediatrician) to complete a developmental assessment.

APPENDIX G. RECOMMENDATIONS FOR NEXT STEPS FROM MULTI-CULTURAL MATERIALS AND MESSAGING DOCUMENT

Prepared by Dr. Gita Rao for the DSCI group (June 2017)

This brief environmental scan has identified a variety of resources on developmental screening and autism education for families. Incorporating translated materials meaningfully into the practice of developmental screening requires a collaborative educational effort among providers, cultural brokers, and communities. The following recommendations would help providers in Maine further explore the utility of translated materials in developmental screening for families with English as a Second Language (ESL) in Maine.

1. Organize forums for providers implementing developmental screenings to engage with cultural brokers and families on communication strategies related to screening and developmental delays. Facilitate discussions on the current understanding of developmental screening and developmental delays among immigrant communities; review translated materials collaboratively to identify specific materials that provide families with accurate, culturally-relevant education on development across a spectrum of need.
2. Identify existing materials specific to child-serving systems in Maine that should be translated into other languages to best reach all families throughout the state. Partner with MaineCare on the translation of these key materials.
3. Provide multi-disciplinary training opportunities for child-serving providers on how to access and use specific translated materials that have been jointly recommended by families with English as Second Language (ESL), community leaders, and expert providers.

APPENDIX H. BEST PRACTICE RECOMMENDATIONS FOR CULTURALLY RESPONSIVE DEVELOPMENTAL SCREENING

Provided by the Help Me Grow program in Vermont[53]

Prior to the visit:
1. Request a copy of the screening tool to review ahead of time
2. If you or the provider administering the screening are uncertain of the developmental skill/milestone measured by a question, discuss it with someone who is familiar with child development to ensure interpretation is accurately reflecting the intention of the question
3. If an item is not culturally appropriate, discuss it with someone who is familiar with child development and work to find a relevant substitute. The provider administering the screen should record the new item below the original item and note the adaptation

At the Home Visit or appointment:
1. Introductions, a brief explanation of the purpose of the developmental screening, a statement that the screening is confidential, and a review of the process should happen at the beginning of the visit
2. Sometimes children are more comfortable with his/her native language. You can offer this as something to try if the family is uncertain and request alternative examples form the provider and/or the family. This is acceptable and encouraged so that the child is able to demonstrate their skills, regardless of the language

After the screening:
1. Families should be asked if they have ANY questions or concerns.
2. A summary of what has been done, next steps and how the family will receive the results should be shared.

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[53] Developed through QI program under a LAUNCH (Linking Actions for Unmet Needs in Children's Health Grant Program) grant. Shared with the DIP by Lauren M Smith, MA, Help Me Grow VT Coordinator, Division of Maternal and Child Health, Vermont Department of Health. Contact information: Desk: (802) 652-2095; Cell: (203) 910-0075 Lauren.Smith@vermont.gov

3. Any items that you or the family note as confusing or culturally inappropriate should be noted and a file of these notes should be maintained for the next time a screening is administered to a family from a similar cultural background.