RED FLAGS 2018
A QUICK REFERENCE GUIDE FOR EARLY YEARS AND
HEALTH CARE PROFESSIONALS IN YORK REGION
Early Identification of Red Flags in Child Development: Birth to Age Six
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DISCLAIMER NOTICE

Red Flags: A Quick Reference Guide for Early Years and Health Care Professionals in York Region, Early Identification of Red Flags in Child Development: Birth to Age Six is a quick reference guide designed to assist in deciding whether to refer for additional advice, screening, assessment and/or treatment.

It is not a formal assessment or diagnostic tool.

The information contained in the Red Flags: A Quick Reference Guide for Early Years and Health Care Professionals in York Region, Early Identification of Red Flags in Child Development: Birth to Age Six (‘Red Flags’ or ‘this guide’) has been provided as a public service for professionals working with children up to the age of six years. Although every attempt has been made to ensure its accuracy, no warranties or representations, expressed or implied, are made concerning the accuracy, reliability or completeness of the information contained in this guide.

This guide cannot substitute for the advice, formal assessment and/or diagnosis, of professionals trained to properly assess the growth and development of infants, toddlers and preschool children. Although this guide may be helpful to determine when to seek out advice and/or treatment, it should not be used to diagnose or treat perceived growth and developmental limitations and/or other health care needs.

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For more information about this guide please contact York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca
TABLE OF CONTENTS

Disclaimer Notice............................................................................................................. 4

INTRODUCTION .............................................................................................................. 7
Why early identification impacts the successful transition to school ................................. 10
How to talk to parents/caregivers about concerns ............................................................. 11
Cultural competence when working with families ................................................................. 12
Duty to report to child protection services ....................................................................... 13

DOMAINS .......................................................................................................................... 15
Abuse and neglect ............................................................................................................. 17
Anxiety ............................................................................................................................... 19
Attention difficulty and/or hyperactive behaviour ............................................................. 21
Autism Spectrum Disorder (ASD) ..................................................................................... 22
Behaviour ........................................................................................................................ 24
Dental and oral health ................................................................. 26
Feeding skills ............................................................................. 28
Fetal Alcohol Spectrum Disorder (FASD) ................................. 29
Fine motor skills .................................................................... 30
Gross motor skills ...................................................................... 32
Hearing ....................................................................................... 34
Learning Disabilities .................................................................. 37
Maternal mental illness ............................................................... 38
Mild traumatic brain injury (concussion) .................................... 39
Nutrition (overweight and underweight) ................................. 40
Prematurity .................................................................................. 43
Regulation .................................................................................. 44
Relationship and attachment ..................................................... 46
Resilience ................................................................................... 48
Selective mutism ......................................................................... 48
Sensory ....................................................................................... 50
Sleep ............................................................................................. 51
Smoking (second- and third-hand) .............................................. 52
Social/emotional ......................................................................... 54
Speech and language ................................................................... 55
Vision .......................................................................................... 59

RESOURCES ................................................................................. 63
Appendix A .................................................................................. 65
Appendix B .................................................................................. 66
Appendix C ................................................................................... 74
Appendix C-1 ............................................................................. 75
INTRODUCTION
INTRODUCTION TO THE RED FLAGS GUIDE

What is the Red Flags guide?

Red Flags is a quick reference tool to assist early years and health care professionals in knowing when and where to refer children from birth to the age of six years for whom there are potential health, growth and development concerns. A basic knowledge of healthy child development is assumed. Red Flags will assist professionals in identifying when children could be at risk of not meeting their expected health outcomes or developmental milestones. It also includes other areas that may impact child health, growth, and development due to the dynamics of parent-child interaction, such as maternal mental illness, abuse, etc.

Red Flags allows early years and health care professionals to review and better understand, on a continuum, the domains that are traditionally outside of their own area of expertise.

This guide is evidence-informed. References are indicated at the bottom of each page.

The purpose and goal of the Red Flags guide

The purpose of Red Flags is to promote the early identification of children who may be in need of additional resources to meet their developmental milestones and expected health outcomes.

The goal of Red Flags is to ensure that all children in York Region are able to achieve their optimal developmental and health potential.

How to use the Red Flags guide

• If children are not meeting the milestones for their specific age, further investigation is strongly recommended. Refer to the Where to go for help section at the end of each domain

• Screening tools may be used in conjunction with this guide (see Appendix C)

• Cultural competence is vital in assessing child health, growth, and development. Please see the Cultural competence when working with families section for further information

• Refer for further assessment even if you are uncertain whether the Red Flags noted are a reflection of a cultural variation or a real concern

• Note that some of the indicators focus on the parent/caregiver or the interaction between the parent/caregiver and the child, rather than solely on the child

• If a child appears to have multiple domains requiring formal assessment by several disciplines, it is encouraged to refer to all of the appropriate agencies

• Contact information in York Region can be found at the end of each domain under Where to go for help with further description of each contact found in Appendix B

• If referrals are made to private sector agencies, alert families that they will be responsible for costs incurred

Acknowledgement

We would like to acknowledge Simcoe Muskoka District Health Unit for the creation of the original Red Flags — Let’s Grow With Your Child, in 2003. The York Region Red Flags guide is made possible through the joint efforts of community partners and York Region Public Health.

We would like to thank all of our community partners for their contributions to this edition of Red Flags. The name of each contributor and their associated organization/agency is listed at the end of each domain.

The following indicators in the Sensory domain were reproduced with permission from NCS Pearson and WPS.

Editors

The editors for Red Flags included a sub-committee of the York Region Early Identification Network:

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INTRODUCTION | 9
WHY EARLY IDENTIFICATION IMPACTS THE SUCCESSFUL TRANSITION TO SCHOOL

“Children are competent, capable of complex thinking, curious and rich in potential. They grow up in families with diverse social, cultural and linguistic perspectives. Every child should feel that he or she belongs, is a valuable contributor to his or her surroundings, and deserves the opportunity to succeed.”

Starting school is a significant milestone in the life of a family. There are many factors that contribute to a child’s transition to school and ongoing success. The child’s capacity to learn when they enter school is strongly influenced by the neural wiring that takes place in the early years of life. By doing everything possible to enhance early development, a child can be provided with an equal opportunity to maximize their potential.

Current brain research shows that children’s capacity for deep learning begins prior to birth with 700 neural connections being made every second in the first three years of life. The first years of a child’s life are a period of heightened opportunity and also a time of increased risk that can compromise optimal development for life.

To maximize early potential, How Does Learning Happen? establishes four foundational conditions or “ways of being” for children that optimize their learning and healthy development:

- Belonging: a sense of connectedness and relationship to others
- Well-Being: a state of mental wellness and physical health
- Engagement: a sense of involvement, curiosity and wonder
- Expression: the ability to communicate for different purposes and in different ways

These above skills and abilities contribute to a child’s successful transition to school.

Why the Red Flags guide?

Sometimes there are areas of a child’s growth and development that are delayed or not progressing as expected which can hinder the child’s advancement in these skills and abilities. Children “… are not as ready for school as they should be … Ontario children are entering school ‘vulnerable’ with physical, emotional, cognitive or speech/language issues that could be prevented.”

4 Center on the Developing Child at Harvard University. Five numbers to remember about childhood development [Internet]. Cambridge, MA: Center on the Developing Child at Harvard University; [date unknown] [cited 2016 July 12]. Available from: developingchild.harvard.edu/resources/five-numbers-to-remember-about-early-childhood-development/
A ‘wait and see’ approach can be detrimental. Early identification of possible concerns in a child’s development will lead to early referral, assessment and intervention, ensuring that they start school at their full potential, ready to learn.

The community collectively wraps around children and their families and builds on their strengths. The community also comes together to provide supports and services when the progression of a child’s development differs from what is anticipated. The Red Flags guide has been developed to identify those children who need extra support. If there are concerns about a particular area(s) of development for a child, refer to the appropriate domain in this guide (see Table of Contents).

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HOW TO TALK TO PARENTS/ CAREGIVERS ABOUT CONCERNS

Sharing sensitive news

One of the most challenging issues for a health care or early years professional working with young children can be relaying concerns about a child’s health or development to a parent or caregiver. When a potential concern is identified, either by observation or screening, the family should be notified so that positive next steps can be taken. In these circumstances, effective communication is essential. It can be very difficult to relay these concerns to parents and caregivers; however, for a child to reach his or her full developmental potential, it is important to have these conversations. If concerns are presented in a positive and caring manner, this will build trust between the professional and the family.

Sharing sensitive news can be challenging both for the family and the person delivering the news. Upon receiving this information about their child, the parent/caregiver may react with a range of emotions including shock, anger, disbelief, fear and sometimes relief at having their observations and questions about their child acknowledged.

Although there is no single way that works best there are some things to keep in mind when addressing concerns with a family. The following framework will provide some tips and encouragement for sharing concerns in a clear, informative, and supportive manner:

Prepare for a successful conversation
• Know the facts
• Plan to meet face to face
• Meet in a private location
• Allow plenty of time without interruptions

Share the information
• Begin by sharing the child’s strengths and positive behaviours
• Ask the parents/caregivers what they know about their child’s development
• Remember and remind parents/caregivers that they know their child best
• Share observations/concerns that have been noted about the child’s development

• Highlight the expected developmental mile-
stones for the child’s age8

• Show concern and compassion8

• Explain the consequences of not taking action
such as the wait and see approach6,8

• Explain the range of possibilities for supporting the
child such as referral, assessment, intervention, etc.8

Plan for next steps

• Thank parents/caregivers for their support

• Provide available resources for further reading
and information

• Ensure that your concerns have been documented
and that there is a plan for follow-up action

• Empower the parents/caregivers by enlisting
their support to plan a course of action regard-
ing next steps for their child

• Allow time for questions and concerns by the
parents/caregivers

• Provide parents/caregivers with available resources
such as brochures or contact information8

Presenting information in this manner lends
credibility to the concerns identified.6,7

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CULTURAL COMPETENCE WHEN
WORKING WITH FAMILIES

Early years and health care professionals have
the privilege of working with families from many
different cultural groups. Families come to us with
their own culture which is a set of “… distinctive
patterns of beliefs and behaviours that are shared
by a group of people and that serve to regulate
their daily living.”9 “The child-parent relationship
has a major influence on most aspects of child
development”9,10 and, since culture shapes how
parents care for their children,9 it therefore makes
sense that parenting practices impact a child’s
growth and development.9 As such, to better
understand the child within the context of his or
her growth and development, it is important for
professionals to provide culturally competent care
and service. To do so, it is necessary for early years
and health care professionals to become culturally
aware and sensitive.11

Cultural awareness involves the ability to stand
back and be conscious of the similarities and
differences between cultural groups,11 including
one’s own. To be culturally sensitive is to build on
this awareness by recognizing that these similarities
and differences affect one’s values, learning, and
behaviour.12 The components of cultural sensitivity
include valuing and recognizing the importance
of one’s own culture, valuing diversity, and being
willing to learn about the traditions and charac-
teristics of other cultures.12 Cultural competence
builds on sensitivity, and refers to the attitudes,
knowledge, and skills needed to be effective early
years and health care professionals.11

As individuals and professionals, it is important
to acknowledge that personal preferences and
misinformation may contribute to falling into the
stereotyping trap. To stereotype is to create a men-
tal image of a people group, over-generalizing to
ascribe the same characteristics to all members of
that group, regardless of individual differences.13


11 Cultural awareness or sensitivity [webpage online]. Ottawa, ON: University of Ottawa; [cited 2016 Dec 6]. Available from: med.uottawa.ca/sim/data/Cultural_Awareness_e.htm

12 Mavropoulos Y. Welcome to our slide show on families and cultural sensitivity [powerpoint presentation online]. Vermont: University of Vermont; 2000 [cited 2016 Dec 1]. Available from: uvm.edu/~cdci/prlc/unit3_slide/sld001.htm

13 Hate Crimes Community Working Group. Addressing hate crime in Ontario: final report of the Hate Crimes Community
All families, children and individuals are unique. Although their ethnic, cultural, racial and language backgrounds influence them, they are not fully defined by them.\textsuperscript{14} Cultural patterns may or may not be followed by individual parents/caregivers within their cultural group, creating individual variations in child raising practices.\textsuperscript{9,15} Many social and cultural factors powerfully affect each family and each member within that family. Cultures are constantly changing and being reshaped\textsuperscript{15} by a variety of influences, including life experiences in Canada. Therefore, part of the role of the professional in supporting families is helping them to interpret the new and dominant culture in which they find themselves (Canada), helping them to navigate it effectively while adapting and/or assimilating to it. In doing so, social and cultural differences should be used to enhance the interactions between the professional and the family rather than to stereotype.\textsuperscript{15}

The greatest resource for understanding each family’s unique culture is the family themselves. By gaining the necessary knowledge, attitudes and skills of working with families of diverse culture, professionals will develop cultural competence and become effective providers for the clients with whom they work.\textsuperscript{11}

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## Duty to Report to Child Protection Services

We all share a responsibility to protect children from harm. This includes situations where children are abused or neglected in their own homes. \textit{Ontario’s Child and Family Services Act (CFSA)} provides protection for these children. Section 72 of the CFSA states that the public, including professionals who work with children, must promptly report any suspicions that a child is or may be in need of protection to a children’s aid society (CAS). The CFSA defines the phrase “child in need of protection” and explains what must be reported to a CAS. It includes physical, sexual and emotional abuse, neglect, and risk of harm. For more information, refer to the Abuse domain in this guide.

**Who is responsible for reporting a child in need of protection?**

Anyone who has reasonable grounds to suspect that a child is or may be in need of protection must promptly report the suspicion and the information upon which it is based to a CAS. Section 72 describes the specific circumstances that must be reported.

### What are “reasonable grounds” to suspect child abuse or neglect?

It is not necessary for you to be certain a child is or may be in need of protection to make a report to a CAS. “Reasonable grounds” refers to the information that an average person, using normal and honest judgment, would need in order to decide to report.
What is the age of the child to whom the “duty to report” applies?

It applies to any child who is, or appears to be, under the age of 16 years. It also applies to children already under a child protection order who are 16 and 17 years old.

How and when to report

Abuse or neglect should be reported as soon as you suspect it — 24 hours-a-day, seven days-a-week. A phone call to a CAS will bring immediate help to a child at risk. It is not your responsibility to determine whether abuse or neglect has occurred. CAS is responsible for the investigation and the assessment of abuse and neglect of children and also the ultimate management of a case when a child is taken into care. Contact a CAS immediately if you have concerns about a child!

What happens when I call?

When you call, you will speak to a child welfare specialist who is specially trained to listen to your concerns and ask questions before deciding how urgent the situation is and what type of intervention is needed. If a child is in imminent danger, a child protection worker will respond immediately.

Contributor

Peter Ristevski, Supervisor, York Region Children’s Aid Society

Reference

*Child and Family Services Act, R.S.O 1990, c. C.11 as am. by S.O. 2016, c.23, s.38. Available from: ontario.ca/laws/statute/90c11*
DOMAINS
In alphabetical order
**ABUSE AND NEGLECT**

**What is abuse?**

Child abuse has many faces, and while all abuse hurts, different kinds of abuse can hurt in different ways. Below are the definitions of each type of abuse as well as their possible indicators. Abused children do not always show obvious warning signs of abuse or neglect, but sometimes there are subtle indicators. Know the subtle signs of abuse and if you have any concerns at all about a child, contact a CAS immediately.

**Physical abuse**

A child is at risk of or has suffered physical harm inflicted by a person having charge of the child. It also occurs when a person fails to adequately supervise, protect, care for or provide for a child. Physical abuse also includes a pattern of neglect in supervising, protecting, caring for or providing for a child. Physical abuse can be one or two isolated incidents or can occur over a prolonged period of time.

**Sexual abuse**

A child is at risk of or has been sexually molested or sexually exploited by a person having charge of a child or by another person. It also occurs when the person having charge of a child knows, or should know, of the possibility of sexual molestation or exploitation by another person and fails to protect a child. Sexual abuse includes sexual touching, engaging in sexual activity with a child, exposing genitals to a child, and incest.

**Emotional abuse**

A child is at risk of or has suffered emotional harm demonstrated by serious anxiety, depression, withdrawal, self-destructive or aggressive behaviour or delayed development and there are reasonable grounds to believe this harm results from the actions, failure to act or pattern of neglect by the person having charge of the child. It also occurs when a child exhibits the above serious behaviours and the person having charge of the child does not provide services or treatment to alleviate the harm. Emotional abuse can also include exposure to domestic violence. Emotional abuse happens when a caregiver treats a child in an extremely negative way that damages self-esteem and the concept of “self.” This type of behaviour might include constant yelling, demeaning remarks, rejection or isolation, or exposing a child to domestic violence.

**Neglect**

A child is at risk of or has been harmed as a result of the caregiver’s failure to adequately supervise, protect, care for or provide for a child. Neglect also occurs when a child has a medical, mental, emotional or developmental condition that requires services or treatment and the person having charge of the child does not provide these services or treatment.

Most parents and caregivers don’t intend to neglect their children. Instead, neglect is usually the result of ignorance about parenting and an inability to plan ahead. When a caregiver fails to provide a child’s basic needs like food, sleep, safety, supervision, appropriate clothing or medical treatment on a consistent basis, this is neglect.

In addition to the above forms of abuse and neglect, there are other forms of abuse which may be overlooked. These include abandonment/separation, caregiver incapacity, and domestic violence. It is important to consider these in addition to the above forms of abuse and neglect.

**Abandonment/separation**

Abandonment/separation occurs when a child has been left alone unsupervised, or when a parent has died or is unavailable to exercise his or her custodial rights over a child and has not made adequate provision for a child’s care and custody. It also occurs when a child is in residential placement and the parent refuses, or is unable or unwilling, to resume the child’s care and custody.

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*In addition to providing protection from sexual abuse, the *Child and Family Services Act* states that a child is also in need of protection when a caregiver is aware of the possibility of abuse and fails to protect the child.*
Caregiver incapacity

No harm has come to a child and no evidence is apparent that a child may be in need of intervention. However the caregiver demonstrates, or has demonstrated in the past, characteristics that indicate the child would be at risk of harm without intervention. These characteristics can include a history of abusing/neglecting a child, being unable to protect a child from harm, problems such as drug or alcohol abuse, mental health issues or limited caregiving skills.

Domestic violence

Domestic violence is characterized by violent or abusive behaviours which occur within the child’s home environment. Domestic violence includes but is not limited to partner violence. The violence occurs between the child’s parent/primary caregiver and any other adult who resides in or frequents the home. This may include the mother’s partner, adult relative, boarder, or anyone else who has a relationship with the family. The frequency and severity (intensity) of violence can range from homicide or a single very serious incident resulting in injuries that require hospitalization, to a pattern of less serious physical violence (e.g. slapping, pushing) and/or a pattern of verbal abuse, threats of harm or criminal harassment.

Domestic violence can have a profound effect on children and may result in or raise the risk of child abuse or neglect.

PROBLEM SIGNS

If a child presents with one or more of the following indicators of physical abuse consider this a red flag:

**Behavioural indicators**
- Cannot recall how injuries occurred or offers an inconsistent explanation
- Wary of adults
- Cringes or flinches if touched unexpectedly
- Displays a vacant stare (for infant)
- Extremely aggressive or withdrawn
- Indiscriminately seeks affection
- Extremely compliant and/or eager to please

**Physical indicators**
- Injuries such as bruises, welts, cuts, fractures, burns and internal injuries
- Injuries that are not consistent with explanation
- Presence of several injuries that are in various stages of healing
- Presence of various injuries over a period of time
- Facial injuries in infants and preschool children
- Injuries inconsistent with the child’s age and developmental phase

PROBLEM SIGNS

If a child presents with one or more of the following indicators of sexual abuse consider this a red flag:

**Behavioural indicators**
- Age-inappropriate play of sexual nature with toys, self or others
- Age-inappropriate sexually explicit drawing and/or descriptions
- Bizarre, sophisticated or unusual sexual knowledge
- Seductive behaviours

**Physical indicators**
- Unusual or excessive itching in the genital or anal area
- Torn, stained or bloody underwear (may be observed if the child needs bathroom assistance)
- Injuries to the genital or anal areas such as bruising, swelling or infection
- Sexually transmitted disease

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PROBLEM SIGNS
If a child presents with one or more of the following indicators of emotional abuse consider this a red flag:

Behavioral indicators
- Severe depression
- Extreme withdrawal or aggressiveness
- Overly compliant, too well mannered, too neat or too clean
- Extreme attention seeking
- Display of extreme inhibition in play

Physical indicators
- Bed wetting that is non-medical in origin
- Frequent psychosomatic complaints, headaches, nausea, abdominal pains
- Failure to thrive

PROBLEM SIGNS
If a child presents with one or more of the following indicators of neglect consider this a red flag:

Behavioral indicators
- Pale, listless, unkempt
- Frequent absences from school
- Inappropriate clothing for the weather, dirty clothes
- Frequent forgetting of a lunch
- Physical indicators
- Poor hygiene
- Unattended physical problems or medical needs such as dental work or glasses
- Consistent lack of supervision

Where to go for help
If you suspect child abuse or neglect, you are legally obligated to report to one of the local child protection agencies:

- York Region Children’s Aid Society
  1-800-718-3850
- Jewish Family and Child
  905-882-2331

Note: For related medical issues, contact the primary health care provider. Acute injuries may require that the child be taken to the emergency department at the nearest hospital.

For more information about this domain or any others in this guide, please contact York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca

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ANXIETY
Anxiety disorders in children range from 2.4 per cent to 17 per cent. Research suggests that there can be long-term implication of experiencing anxiety in childhood including an increased risk for additional diagnosis, mental health challenges in adulthood, as well as lower functioning in academic performance, peer relationships, and family relationships.

It is important to note that mild fears and anxiety are part of normal human development. The number of fears that children experience typically decrease as children mature. Although childhood fears can be normal experiences, it is important

to pay closer attention to experiences of anxiety that are exaggerated and beyond what one would expect given a situation.

Symptoms of anxiety that become more intense and more extensive, and that interfere with a child’s school, peer or family functioning may warrant mental health interventions. When overly anxious, most children exhibit physical symptoms including increased heart rate, increased breathing, sweating, nausea, stomach aches, headaches, etc. as well as some form of avoidance of situations, people or objects that cause anxiety.

### Types of anxiety in children

#### Specific phobias

Children with specific phobias have fears that are specific to a particular situation or object. In general, these children try to avoid contact with the situation or object. Examples of specific phobias include dogs, the dark, spiders, storms and injections.

#### Separation anxiety

Children with separation anxiety exhibit an excessive fear related to being away from a main caregiver, most commonly the child’s mother. They often fear that something terrible will happen to a parent while they are apart and they will never see the parent again. At times, significant life stressors can trigger separation anxiety such as a change in schools, a move or death of relative.

#### Generalized anxiety

This is a condition in which the child has many worries and fears. Children with generalized anxiety are often described by parents as “worrywarts.” Worries can be in the areas of health, schoolwork, sport performance, bills, burglaries, etc. New situations often provoke an anxiety response.

### Social anxiety

Children with social anxiety exhibit a fear of situations in which they will have to interact with others or be the focus of attention. At the core of social anxiety is a fear of being embarrassed, humiliated or rejected. Typical feared situations include meeting new people, talking on the telephone, joining team sports and talking at school or preschool.

### PROBLEM SIGNS

If a child presents any of the following behaviours, consider this a red flag:

- Consistent avoidance of a specific feared situation or object
- Emotional dysregulation or panicked in the presence of the feared situation or object
- Upset beyond what is expected when separated from primary caregiver
- Child expression of concern about primary caregiver being hurt or getting sick
- Refusal to sleep at other people’s homes if parents are not there
- Complaints of stomach ache, feeling sick or other somatic symptoms in anticipation of being separated from caregiver
- Difficulty staying or going into a room by themselves, “clinging” behaviour, staying close to and “shadowing” the parent around the house
- Difficulty at bedtime and possible insistence that someone stay with them until they fall asleep
- Fear more than usual in new situations
- Fear of making mistakes and not performing well
- Child asks lots of questions and often seeks reassurance from parents
- Worries more than usual after seeing a scary movie or watching a news program

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• Shyness
• Difficulty joining in activities and making new friends
• Avoids speaking to new people or answers with brief responses
• Worries that someone will laugh at them or that they will be embarrassed
• Dislikes being centre of attention³,⁸

Where to go for help
If there are concerns, advise the parent/caregiver to contact:

• Blue Hills Child and Family Centre
  (905) 773-4323
  bluehillscentre.ca
  bluehills@bluehillscentre.ca

• Kinark Child and Family Services
  1-888-454–6275 or 1-888-4-KINARK
  kinark.on.ca
  info@kinark.on.ca

• The York Centre for Children, Youth and Families
  (905) 887-5896
  theyorkcentre.ca
  info@theyorkcentre.ca

• Family Services York Region
  1-888-223-3999
  fsyr.ca

For more information about this domain or any others in this guide, please contact York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca

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ATTENTION DIFFICULTY AND/OR HYPERACTIVE BEHAVIOUR

A child should be referred for assessment if his/her patterns of attention and/or hyperactivity difficulties: interfere with functioning or development; demonstrate symptoms in more than one setting; negatively impact social, academic, or work functioning in a direct way; and some symptoms must be present before age 12.¹⁰

Attention difficulties and/or hyperactive behaviours can be seen at times in all typically developing children so it is important to consider the following prior to making a referral for assessment:

• The child’s developmental age e.g. children under the age of 18 months are generally not formally assessed for attention difficulty and/or hyperactive behaviour; attention span and self-regulation naturally varies in early childhood years

• Situational factors such as stress, time of day, boredom, sleep and diet

• Environmental factors such as family disruption, life changes and cultural influences

There are other developmental/mental health issues that can present with attention difficulty and/or hyperactive behaviours including Learning Disabilities, Autism Spectrum Disorder and Anxiety. Refer to the appropriate domains in the guide to determine other possible referrals for the child/family.

PROBLEM SIGNS

If a child consistently presents any of the following behaviours, consider this a red flag:

Ages 18 months to 5 years
• Unable to concentrate or pay attention for periods of time
• Restless or unable to sit still
• Poorly co-ordinated or clumsy
• Shifts quickly from one activity to another

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• Wanders away\textsuperscript{11}

\textbf{Ages 4 to 6 six years}

• Easily distracted e.g. has difficulty paying attention or listening to the speaker, easily sidetracked

• Excessive levels of activity i.e. hyperactive e.g. has difficulty sitting still, fidgets often regardless of activity

• Impulsive e.g. runs into traffic, takes risky actions without thinking, has difficulty taking turns, interrupts/blurs things when asked not to, talks excessively

• Disorganized e.g. has problems organizing personal belongings, loses things often, has difficulty following schedule or difficulty remembering routines/explanations\textsuperscript{12}

\textbf{Where to go for help}

If there are concerns, advise parents/caregivers to contact their primary health care provider.

Parents/caregivers may also contact:

• Blue Hills Child and Family Centre
  (905) 773-4323
  bluehillscentre.ca
  bluehills@bluehillscentre.ca

• Kinark Child and Family Services
  1-888-454–6275 or 1-888-4-KINARK
  kinark.on.ca
  info@kinark.on.ca

• The York Centre for Children, Youth and Families
  (905) 737-8927
  theyorkcentre.ca
  info@theyorkcentre.ca

• Family Services York Region
  1-888-223-3999
  fsysr.ca

• York Region Health Connection
  1-800-361-5653
  childfamily@york.ca
  TTY 1-866-512-6228

\textbf{AUTISM SPECTRUM DISORDER (ASD)}

Autism spectrum disorder (ASD) is a lifelong developmental disorder characterized by impairments in social communication and the presence of repetitive and stereotyped behaviours. ASD is often associated with other developmental, health and behavioural challenges such as language impairment, uneven cognitive and adaptive skills, seizures, and attention deficit hyperactivity disorder (ADHD).

See the following domains in this guide for more information and other possible referrals:

• Attention difficulty and/or hyperactive behaviour

• Behaviour

• Regulation

• Sensory

• Social/emotional

• Speech and language

The severity of symptoms for ASD can vary widely; however, all individuals with an ASD diagnosis have impairments in the ability to function in social settings and often in many other areas in daily life.

\textsuperscript{11} Achenbach TM, Rescorla LA. Manual for the ASEBA preschool forms and profiles. Burlington: University of Vermont Department of Psychiatry; 2000.

**PROBLEM SIGNS**

If a child presents any of the following behaviours, consider this a red flag:

**Social concerns**
- Does not smile in response to another person
- Poor/decreased eye contact with people, although may look intently at objects
- Lack of “joint engagement” e.g. does not play peek-a-boo games
- Lack of imitation e.g. does not wave bye-bye
- Limited showing, giving, sharing and directing of others’ attention
- Delayed imaginative play or lack of varied, spontaneous make-believe play
- Prefers to play alone i.e. decreased interest in other children
- Poor interactive play
- Regression i.e. any loss of social skills at any age
- Prefers to do things for them self rather than ask for help
- Awkward or absent greeting of others

**Communication concerns**
- Delayed or atypical language
- Unusual language e.g. repeating phrases from movies, echoing other people, repetitive use of phrases, odd intonation (echolalia)
- Inconsistent response or lack of response to their name or instructions i.e. may respond to sounds but not language
- Decreased ability to compensate for delayed speech by gesturing/pointing
- Poor comprehension of language (words and gestures)
- Regression i.e. any loss of language skills at any age (regression), particularly between 15 and 24 months
- Inability to carry on a conversation

**Behavioural concerns**
- Repetitive hand and/or body movements e.g. finger wiggling, hand and arm flapping, tensing of fingers, complex body movements, spinning, jumping
- Severe repeated tantrums due to interruption of routine, interruption of repetitive behaviour or unknown reasons
- Unusual sensory interests e.g. visually squinting or looking at things out of the corner of the eye, smelling, licking, mouthing objects, hyper-sensitive hearing
- Narrow range of interests in which they engage repetitively
- Insistent on maintaining sameness in routine, activities, clothing, etc.
- Unusual preoccupation with objects e.g. light switches, fans, spinning objects, vertical blinds, wheels, balls
- Unusual response to pain i.e. high or low tolerance

**Where to go for help**

If there are concerns, advise parents/caregivers to:
- Arrange a referral to a pediatrician through their child’s primary care provider or
- Contact York Region Early Intervention Services/ York Region Preschool Speech and Language Program 1-888-703-5437

The parent/caregiver may also access the following:
- The Autism Parent Resource Kit from The Ontario Ministry of Children and Youth Services at children.gov.on.ca
- Autism Ontario York Region Chapter at 905-780-1590 or autismontario.com/york
- Geneva Centre for Autism at 416-322-1877 or autism.net

For more information about autism for the professional:
- Improving the Odds Healthy Child Development at ocfp.on.ca/docs/research-projects/improving-the-odds-healthy-child-development-manual-2010-6th-edition.pdf
For more information about this domain or any others in this guide, please contact York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca

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**Sources**
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Dr. Nicola Jones-Stokreef, MD, FRCP(C), Developmental Pediatrician, Orillia Soldiers’ Memorial Hospital and Children’s Treatment Network of Simcoe York

**Reference**

**BEHAVIOUR**
All children engage in challenging behaviour from time to time which may or may not persist or be of concern. Behaviour is often a child’s way of communicating their wants and needs and in some cases may be their only method of communication. A child makes their needs known through observable actions. For example a child may indicate with gestures that they want a certain item or don’t want something they’ve been given, that they want more or less of your attention or that of a peer, that they don’t want to do a certain task or to go to a particular place, or that they don’t want to stop doing an activity that they are enjoying.

Behaviour is also a child’s way of telling their care-giver that he or she is in physical pain or discomfort, tired, hungry or ill.

Generally, a child demonstrates certain behaviour in the presence of certain people and not others, in specific situations or environments, and under some conditions while not in others.

When determining if a behaviour is of concern, it is important to keep in mind the context, the age and stage of the child, as well as to ascertain if there is an explanation for the behaviour.

When challenging behaviour happens many times each day, for long periods of time, or presents an immediate risk to the child or others it may require assessment and intervention from a professional.

**PROBLEM SIGNS**
If a child presents any of the following behaviours, consider this a red flag:

**Self-injurious behaviour**
- Bites self; hits self; grabs at self
- Picks at skin; sucks excessively on skin; bangs head on surfaces
- Eats/ingests inedible items
- Vomits when no obvious illness

**Aggression towards others**
- Hits; kicks; scratches; bites; pulls hair; pushes; shoves
- Cruelty to animals
- Throws objects at a person

**Property destruction**
- Bangs, throws, slams, breaks objects
- Sets fires

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**Difficulties with social behaviour**

- Unable to remain on task for specified length of time\(^{17}\)
- Excessively energetic or physically over active\(^{17}\)
- Restless; unable to sit still; continuously standing up, sitting down, or moving\(^{17}\)
- Screams; cries excessively; swearing and/or verbal threats\(^{17}\)
- Name-calling\(^{17}\)
- Hoards; steals; lies\(^{17}\)
- Has no friends; socially isolated; will not make eye or other contact; withdrawn\(^{16}\)
- Anxious; fearful/extreme shyness; agitated\(^{17}\)
- Sudden mood changes; laughing, crying and/or screaming for no obvious reason\(^{16}\)
- Compulsive behaviour; obsessive thoughts; bizarre talk\(^{17}\)
- Undresses in public\(^{16}\)
- Touches self or others in inappropriate ways\(^{16}\)
- Advanced/inappropriate knowledge/behaviour of a sexual nature for developmental age appropriateness\(^{16}\)
- Flat affect, inappropriate emotions, unpredictable angry outbursts\(^{16}\)

**Cooperation**

- Refusal to follow instructions; needs several verbal prompts to complete a task
- Difficulty following multiple step instructions
- Runs away
- Resists any form of physical contact including when provided assistance\(^{16}\)

**Life skills**

- Deficits in age appropriate skills e.g. eating, toileting, dressing, play, etc.\(^{14}\)
- Loss of skill previously mastered\(^{14}\)
- Change in typical habits e.g. eating, sleeping, toileting, etc.\(^{14}\)

- Difficulty managing transitions/routine changes\(^{16}\)
- Often needs physical prompting to move or to do things; consistently tired or sleepy\(^{16}\)

**Sleep**

- Excessive tiredness e.g. yawning, falling asleep
- Reports nightmares, frequent awakenings
- Late/early bedtimes and awakenings\(^{14}\)

**Repetitive behaviour (in excess, or in the absence of functional play skills)**

- Hand-flapping; hand wringing; rocking; swaying\(^{16}\)
- Taps surfaces\(^{16}\)
- Twirling; object manipulation i.e. lining up toys, spinning wheels, etc.\(^{17}\)

**Communication**

Limited or no means of communication through:

- Verbal i.e. words
- Augmentative or alternative communicative system e.g. Picture Exchange Communication System, American Sign Language, Proloquo2Go, etc.
- Engages in any of the above behaviours in order to gain access to items or to avoid or leave a situation\(^{16}\)

If you identify any of the above *Red Flags*, please also refer to the following domains in this guide for other possible referrals:

- Autism
- Nutrition
- Sleep
- Speech and language

**Where to go for help**

If there are concerns, advise the parent/caregiver to contact:

- York Region Early Intervention Services
  1-888-703-5437
DENTAL AND ORAL HEALTH

Poor oral health care can result in the development of early childhood caries (ECC). ECC is a severe form of cavities with tooth decay in the baby teeth of children up to six years of age.\(^\text{18,19}\) It is considered to be a chronic disease which affects more than 10 per cent of preschool-age children in Canada.\(^\text{20}\) ECC often begins on a child’s upper front teeth just under the lip.\(^\text{20}\) Chalky white or brown spots may be signs of caries (tooth decay/cavities).\(^\text{20}\) ECC can lead to pain, infection, difficulty eating and sleeping, speech problems, poor health and higher risk of tooth decay in later years.\(^\text{18}\) Dental problems in early childhood have been shown to impact general growth and cognitive development and cause poor school behaviour and negative self-esteem.\(^\text{19}\) Therefore, access to dental care and early development of good oral hygiene habits are important for children.

PROBLEM SIGNS

If one or more of the following risk factors are present consider this a red flag:

- Exposure of teeth to fermentable carbohydrates (foods/liquids that can easily break down into acids) through:
  - Too much sugar in diet\(^\text{18}\)
  - Going to sleep or walking around with a bottle or sippy cup containing anything but water\(^\text{18}\)
  - Retaining the nipple in an infant’s mouth for prolonged periods when not actively breastfeeding\(^\text{20}\)
  - If using pacifiers, dipping them in anything sweet such as syrup, sugar or honey\(^\text{18}\)
  - Long-term use of sweetened medication\(^\text{18}\)

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18 Oral health for babies and children [Internet]. Newmarket, ON: York Region Community and Health Services, Public Health; c2016 [cited 2016 Nov 21]. Available from: york.ca/wps/wcm/connect/yorkpublic/bec62176-245e-4de4-96e6-6930ba468a0e/Oral+Health+for+Babies+and+Children.pdf?MOD=AJPERES&CACHID=bec62176-245e-4de4-96e6-6930ba468a0e
Physiological factors

• Sharing toothbrushes or utensils or intimate contact such as kissing (this can transfer oral bacteria from parent/caregiver to the child) 19, 20, 21

• Lack of exposure to fluoridated water20

• Factors associated with poor enamel development, such as prenatal nutritional status of mother, poor prenatal health and malnutrition of the child22

• Prematurity or low birth weight (possible enamel deficiencies)22

Other risk factors

• Lack of routine infant oral health care i.e. not wiping baby’s mouth and gums after each feeding18

• Poor oral hygiene i.e. ineffective or infrequent brushing less than twice per day23

• Parent/caregiver not performing tooth brushing or oral health care for child (children up to six years of age are not able to brush or floss effectively, so parent/caregiver has to do it for them)18, 23

• Sibling history of early childhood caries22

• Parent/caregiver with untreated dental disease19, 20

• Lower education level of parent/caregiver25

• Lower socioeconomic status20, 22, 24

• Limited access to dental care25

• Deficit in the parental/caregiver dental knowledge21

• Use of bottle or sippy cup beyond 18 months19

• No dental visit by age one or shortly after primary teeth begin to erupt18, 21, 24

Note: The Canadian Dental Association recommends that the first visit to a dentist should occur within six months of the eruption of the first tooth or by one year of age.24, 26

Where to go for help

If there are concerns, advise parents/caregivers to contact:

• Their dentist

• York Region Public Health Dental Program at 1-800-735-6625 or 905-895-4512. Children may be eligible for the Healthy Smiles Ontario (HSO) program, which provides no-cost urgent or regular dental care to children from families in financial hardship who meet financial eligibility requirements

For more information about this domain or any others in this guide, please contact York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca

Contributor

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22 Avery DR, Dean JA, McDonald RE. McDonald and Avery’s dentistry for the child and adolescent. 9th ed. Maryland Heights: Mosby Elsevier; 2011.


24 Canadian Dental Association. Position paper on access to oral health care for Canadians [Internet]. Ottawa, ON: Canadian Dental Association; 2010 [cited 2014 Jul 8]. Available from: cda-adc.ca/_files/position_statements/accessToCarePaper.pdf


26 Canadian Dental Association. CDA position on the first visit to the dentist [position statement online]. Ottawa, ON: Canadian Dental Association; 2012 [cited 2014 Jul 8]. Available from: cda-adc.ca/_files/position_statements/firstVisit.pdf
FEEDING SKILLS

Good feeding skills are an important part of the overall development in childhood. As they progress in a step-wise manner, each depending on the one before, it is important to support and encourage the progression, especially during the early stages.

PROBLEM SIGNS

If a child experiences one or more of the following, consider this a red flag:

0 to 6 months
- Persistent breast refusal[27]
- Inability to effectively remove adequate milk from breast when latched well[27]
- Inability to co-ordinate sucking, swallowing and breathing during feeding[27]
- Consistent coughing during feeds that is not caused by the flow being too fast[28]
- Insufficient weight gain[29]

6 to 8 months
- Lack of interest in solid foods
- No transition to solids i.e. purees
- No introduction to cup drinking[30]

9 to 12 months
- No transition to table foods i.e. soft pieces of food[30]

12 to 18 months
- No transition to cup drinking
- Not eating a variety of foods from each food group
- Not self-feeding any table foods[30]

18 months
- Not self-feeding most soft table foods[30]

2 years
- Not chewing pieces of a variety of food textures and consistencies[30]

Where to go for help

If there are concerns, advise the parent/caregiver to contact:

- York Region Public Health Breastfeeding Clinic — for telephone support and/or to make an appointment (no charge) call York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca
- Children’s Treatment Network of Simcoe York at 1-866-377-0286, ctnsy.ca

For more information about this domain or any others in this guide, please contact York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca

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FETAL ALCOHOL SPECTRUM DISORDER (FASD)

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term used to describe a variety of effects resulting from exposure to alcohol during pregnancy. If a mother drinks alcohol during pregnancy, this can cause facial abnormalities, growth deficiencies and hearing and vision impairments in the growing fetus. It can also affect learning, behaviour, sleep, social and cognitive skills and mental health concerns. The diagnosis of FASD requires a multidisciplinary team and involves a complex physical and neurodevelopmental assessment. For a diagnosis of FASD to be made, the individual must meet either of two sets of criteria: FASD with facial features or FASD without facial features.

Alcohol exposure does not have the same impact on every fetus and there are many factors that can affect the impact. It is important to remember that each baby is an individual and may be affected differently.

Though exact rates of FASD are not known and vary from community to community, it is estimated that approximately one in 100 Canadians have FAS. FASD crosses all races and socioeconomic boundaries. Although there is no known cure for FASD, it is preventable. With appropriate supports and services, the outcomes for an affected child are much improved. This is why early diagnosis and intervention is critical.

The following are common characteristics of children with FASD:

Infants
- Low birth weight; failure to thrive; small size; small head circumference
- Disturbed sleep; unpredictable sleep patterns/cycles
- Often trembling and difficult to soothe; may cry a lot
- Problems with bonding
- Weak sucking reflex; little interest in food; feeding difficulties
- Weak muscle tone
- High susceptibility to illness
- High sensitivity to sights, sounds and touch

Preschoolers
- Slow to acquire skills
- Feeding and sleep problems
- Poor motor co-ordination and poor fine and gross motor control
- Short attention span
- Difficulty following directions or doing as instructed
- Hypersensitivity i.e. irritability, stiffness when held or touched, refusal to brush hair or teeth, over-reaction to injury
- Easily distracted or hyperactive
- Difficulty with changes and transitions; prefers routines
- Receptive and expressive language delays

School-age children
• Sleep difficulties
• Difficulty processing received information
• Difficulty with comprehension e.g. reading
• Ongoing expressive and receptive language delays
• Poor attention span; low impulse control
• Difficulty keeping up as school demands become increasingly abstract
• Consistent repetition needed to learn a skill or to transfer learning from one situation to another
• Ongoing sensory difficulties which may lead to behaviour changes or challenges
• In need of constant reminders

Where to go for help
If there are concerns, advise the parent/caregiver to contact their child’s primary care provider for referral to one of the following diagnostic centres:

• Motherisk (birth to 16 years of age)
  1-877-327-4636 or 416-813-6780 or motherisk.org

• St. Michael’s Hospital (children and adults)
  416-360-4000 (ask for the FASD Diagnostic Clinic)

For more information on FASD and substance abuse:

• Fasworld Toronto
  416-264-8000
  fasworld.com

• Best Start
  416-408-2249, 1-800-397-9567
  beststart.org

• Canadian Centre on Substance Abuse
  ccsa.ca

• Health Canada
  1-866-999-7612
  hc-sc.gc.ca

• FASD Coalition of York Region
  1-877-464-9675 ext. 2015

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FINE MOTOR SKILLS
Fine motor skills are actions and abilities involving the small muscles in the hands and fingers. Examples of fine motor activities include picking up objects, drawing/writing, dressing, and using hands to eat and play. These skills also involve hand-eye coordination.

Healthy child development
If a child is missing one or more of these expected age outcomes, consider this a red flag:

By 4 months
• Brings hands to mouth
• Turns head from side to side to follow a toy or an adult face
• Brings hands to middle of their body while lying on their back

By 6 months
• Reaches for a toy when lying on back
• Uses hands to reach, grasp, bang and splash

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By 9 months

• Picks up small items using thumb and first finger\textsuperscript{35, 37}
• Passes an object from one hand to the other\textsuperscript{35}
• Releases objects voluntarily\textsuperscript{37}
• Bangs objects on table or floor\textsuperscript{37}

By 12 months

• Holds, bites and chews food, e.g. crackers\textsuperscript{35}
• Takes things out of a container\textsuperscript{35}
• Points with index finger\textsuperscript{35, 38}
• Plays games like peek-a-boo\textsuperscript{38}
• Holds a cup to drink using two hands\textsuperscript{38}
• Picks up and eats finger foods\textsuperscript{34, 38}

By 18 months

• Helps with dressing by putting out arms and legs\textsuperscript{35}
• Stacks three or more blocks\textsuperscript{34, 39}
• Picks up and eats finger foods\textsuperscript{35}

By 2 years

• Puts items into a small container\textsuperscript{35}
• Takes off own shoes, socks or hat\textsuperscript{35, 40}
• Scribbles with crayons or marks paper\textsuperscript{40}
• Eats with a spoon with little spilling\textsuperscript{35, 40}

By 3 years

• Turns the pages of a book\textsuperscript{35}
• Dresses or undresses with help\textsuperscript{35, 41}
• Turns lid off a jar or turns knobs\textsuperscript{35}
• Holds a pencil between thumb and fingers\textsuperscript{42}
• Copies a circle already drawn\textsuperscript{41}

By 4 years

• Holds a crayon or pencil correctly\textsuperscript{35}
• Undoes buttons or zippers\textsuperscript{35}
• Cuts with scissors\textsuperscript{35, 43}
• Dresses and undresses with minimal help\textsuperscript{43}

By 5 years

• Uses scissors to cut along a thick line drawn on paper\textsuperscript{35}
• Dresses and undresses with little help\textsuperscript{35}

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\textsuperscript{38} Markham Stouffville Hospital, York Region Health Services, Early Intervention Services. Early Referral Identification Kit (ERIK)- Referral for 12 months [Internet]. c2013 [cited 2016 Feb 22]. Available from: childdevelopmentprograms.ca/backend/wp-content/uploads/New-ECE-12-month-ERIK-2016.pdf


\textsuperscript{40} Markham Stouffville Hospital, York Region Community and Health Services, Early Intervention Services. Early Referral Identification Kit (ERIK)- Referral for 24 months [Internet]. c2013 [cited 2016 Feb 22]. Available from: childdevelopmentprograms.ca/backend/wp-content/uploads/New-ECE-24-month-ERIK-2016.pdf

\textsuperscript{41} Markham Stouffville Hospital, York Region Community and Health Services, Early Intervention Services, Early Referral Identification Kit (ERIK)- Referral for 36 months [Internet]. c2013 [cited 2016 Feb 22]. Available from: childdevelopmentprograms.ca/backend/wp-content/uploads/New-ECE-36-month-ERIK-2016.pdf


PROBLEM SIGNS

If a child is experiencing any of the following, consider this a red flag:

**Infants**

- Inability to hold or grasp an adult finger or a toy/object for a short period of time\(^3\)

**All children**

- Hands are fisted most of the time
- Inability to play appropriately with a variety of age-appropriate toys; avoids crafts and manipulatives
- Consistently ignores or has difficulty using one side of body; uses one hand/arm\(^3\)

Where to go for help

If there are concerns, advise the parent/caregiver to contact:

- York Region Early Intervention Services at 1-888-703-KIDS (5437)
- The child’s primary care provider

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GROSS MOTOR SKILLS

Gross motor skills are actions and abilities involving the movement of our large muscles. These include movements of our arms, legs, feet or entire body. Examples include crawling, sitting, standing, walking, running, keeping balance, jumping, climbing and changing positions.\(^4\)

Healthy child development

If a child is missing one or more of these expected age outcomes, consider this a red flag:

**By 2 months**

- Holds head up when held to an adult’s shoulder
- Lifts head up when on tummy\(^4\)

**By 4 months**

- Keeps head in line with the middle of their body and brings hands to chest when lying on back
- Lifts head and chest and supports self on forearms when placed on tummy
- Holds head steady when supported in a sitting position\(^4\)

**By 6 months**

- Rolls from back to side\(^4\)
- Pushes up on hands when on tummy\(^4, 46\)
- Sits with support\(^4\)

**By 9 months**

- Sits on floor without support\(^4, 47\)
- Moves self forward on tummy or rolls continuously to get an object\(^4\)
- Stands with support\(^4, 47\)

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By 12 months

• Gets up to a sitting position from lying down without help\textsuperscript{45}
• Pulls to stand at furniture\textsuperscript{45}
• Walks holding onto furniture or hands of an adult\textsuperscript{45, 48}

By 18 months

• Walks alone\textsuperscript{45, 49}
• Crawls up stairs\textsuperscript{49}
• Squats to pick up a toy and stands back up without falling\textsuperscript{45}

By 2 years

• Walks backwards or sideways pulling a toy\textsuperscript{45}
• Able to throw and attempt to catch ball without losing balance\textsuperscript{50}
• Kicks a ball\textsuperscript{51}

By 3 years

• Stands on one foot briefly\textsuperscript{45, 52}
• Climbs stairs using the handrail\textsuperscript{45}
• Throws a ball forward at least one meter (three feet)\textsuperscript{45}

By 4 years

• Stands on one foot for one to three seconds without support\textsuperscript{45}
• Goes up stairs using alternating feet \textsuperscript{45, 53}
• Runs, stops, and starts without falling\textsuperscript{53}
• Catches a large ball with outstretched arms\textsuperscript{45}

By 5 years

• Hops on one foot several times
• Throws and catches a ball successfully most of the time
• Plays on playground equipment without difficulty\textsuperscript{45}

PROBLEM SIGNS

If a child is experiencing any of the following, consider this a red flag:

By 3 months

• Little or no movement in legs; not kicking motion when lying on back
• Unable to lift head when lying on tummy\textsuperscript{50}

By 6 months

• Unable to sit using hands for support
• Difficulty controlling head movements\textsuperscript{50}

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52 Markham Stouffville Hospital, York Region Community and Health Services, Early Intervention Services, Early Referral Identification Kit (ERIK)- Referral for 36 months [Internet]. c2013 [cited 2016 Feb 22]. Available from: childdevelopmentprograms.ca/backend/wp-content/uploads/New-ECE-36-month-ERIK-2016.pdf
By 9 months
• Unable to sit independently
• Uses only one side of the body to move
• Legs crossed or stiff
• Legs unable to bear weight

By 12 months
• Stiff arms or legs
• Not yet pulling to stand
• Only able to sit with weight to one side

By 18 months
• Not able to walk or stand independently

By 24 months
• Not walking up or down stairs even with support
• Falls easily

Where to go for help
If there are concerns, advise the parent/caregiver to contact:
• York Region Early Intervention Services at 1-888-703-KIDS (5437)
• The child’s primary care provider

HEARING
Permanent hearing loss affects approximately one to three children out of 1000. The hearing loss may affect one ear or both and may be of any degree from a mild hearing loss to complete deafness. It can be difficult to identify a child with hearing loss, particularly when the loss is relatively mild since the child may seem to respond to many sounds. Many children may also experience temporary hearing losses, particularly if they have a history of issues with congestion or ear infections. Any degree of hearing loss may have an impact on a child’s ability to learn speech and language or to hear clearly in a noisy situation but this is especially true as the severity of the hearing loss increases.

Healthy child development
If a child is missing one or more of these expected age outcomes, consider this a red flag:

By 6 months
• Makes cooing sounds
• Increases or decreases sucking behaviour in response to sound
• Startles, blinks, cries, quiets or changes breathing rate in response to a sound
• Startles in response to sudden, loud noises
• Stirs or awakens when sleeping quietly and someone talks or there is a sudden noise
• Makes different cries for different needs—such as hungry, tired
• Recognizes familiar voices and quiets when spoken to

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• Responds to changes in the tone of parent/care- giver voice
• Watches parent/caregiver’s face as they speak
• Smiles and laughs in response to parent/caregiver’s smiles and laughs
• Imitates coughs or other sounds e.g. ah, eh, buh
• Babbles for attention and uses vocal play
• Turns head toward voices and interesting sounds
• Enjoys musical toys or toys that make noise

By 9 months
• Responds to their name
• Responds to the telephone ringing or a knock at the door
• Understands being told “no”
• Gets what they want through sounds and gestures, such as reaching to be picked up
• Plays social games with you such as peek-a-boo
• Babbles and repeats sounds e.g. babababa, duhduhduh

By 12 months
• Localizes correctly to sound by turning head toward the sound
• Follows simple one-step directions, for example “sit down”
• Looks across the room to something you point to
• Recognizes words for common items like “cup”, “shoe”, “book” or “juice”
• Uses three or more words
• Uses gestures to communicate, for example waves “bye bye”, shakes head “no”
• Pays attention when spoken to
• Gets parent/caregiver’s attention using sounds, gestures and pointing while looking at their eyes
• “Performs” for attention and praise

By 18 months
• Sometimes startles to sudden loud noises
• Understands the concepts of “in and out”, “off and on”
• Points to several body parts when asked
• Uses at least 20 words
• Starts to put words together
• Responds with words or gestures to simple questions — “Where’s teddy?”, “What’s that?”
• Looks at your face when talking to you
• Makes at least four different consonant sounds — b, n, d, g, w, h
• Enjoys being read to and looking at simple books with you

By 2 years
• Follows two-step directions, for example “Go find your teddy bear and show it to Grandma”
• Uses 100 or more words
• Understands more words than they can say
• Uses at least two pronouns, e.g. “you”, “me”, “mine”
• Uses own name
• Consistently combines two or more words in short phrases - “daddy hat”, “truck go down”
• Asks simple questions, for example “What’s that?”
• Enjoys being with other children
• Begins to offer toys to peers and imitates other children’s actions and words
• People can understand their words 50 to 60 per cent of the time
• Takes turns in a conversation
• Forms words and sounds easily and effortlessly
• “Reads” to stuffed animals or toys
By 3 years

- Is alert to environmental sounds
- Responds to someone talking out-of-view (particularly when there are no distractions)
- Responds to voices on the telephone
- Understands the concepts of size (big/little) and quantity (a little, a lot, more)
- Uses some adult grammar — “two cookies”, “bird flying”, “I jumped”
- Uses more than 350 words
- Uses action words, for example “run”, “spill”, “fall”
- Uses sentences of three or more words most of the time
- Answers simple questions, for example “Where is the car?”
- Participates in short conversations
- Begins taking short turns with other children, using both toys and words
- Puts sounds at the start of most words
- Produces words with two or more syllables or beats, for example “ba-na-na”, “com-pu-ter”, “a-pple”
- Listens to and enjoys hearing stories for longer periods of time
- Remembers and understands familiar stories

By 4 years

- Tells a short story or talks about daily activities
- Talk in sentences with adult-like grammar
- Generally speaks clearly so people understand
- Hears you when you call from another room
- Listens to television at the same volume as others
- Answers a variety of questions
- Understands words for some colours, like red, blue and green

By 5 years

- Pronounces most speech sounds correctly
- Participates in and understand conversations even in the presence of background noise
- Recognizes familiar signs, for example stop sign
- Makes up rhymes
- Hears and understands most of what is said at home and school
- Listens to and retells a story and asks and answers questions about a story
- Understands words for order like first, next and last
- Understands words for time like yesterday, today and tomorrow
- Follows longer directions like “Put your pajamas on, brush your teeth and then pick out a book”
- Follows classroom directions like “Draw a circle on your paper around something you eat”

PROBLEM SIGNS

If a child is experiencing any of the following, consider this a red flag:

- Early babbling stops
- Frequently gets colds and ear infections
- Frequently pulls at ears
- Does not understand people unless facing them
- Intently watches the face of the person speaking
- Speaks loudly or turns up the volume of the television or radio
- Does not respond when called
- Uses “what?” or “huh?” frequently

• Has difficulty understanding speech in group activities

**Where to go for help**

If there are concerns for a child under 24 months of age:

• Contact the Tri-Regional Infant Hearing Program:
  → Call 1-888-703-5437 (choose option 4 for Infant Hearing) or
  → Download a referral form from childdevelopmentprograms.ca/resource/hearingreferral and fax it to 905-472-7553

**Note:** Referrals can be made by the parent/caregiver or an early years/health care professional

If there are concerns for a child over 24 months of age:

• Refer the child to an audiologist:
  → With a referral from the child's family physician or
  → Contact the Ontario Association of Speech-Language Pathologists and Audiologists at 1-800-718-6752 or visit osla.on.ca for a list of private audiologists

For more information on hearing:

• American Speech-Language and Hearing Association (ASHA)
  asha.org/Default.aspx

• Canadian Academy of Audiology
  canadianaudiology.ca

• National Institute on Deafness and Other Communication Disorders
  nidcd.nih.gov/health/voice/pages/speechand-language.aspx

• Speech-Language & Audiology Canada
  sac-oac.ca/public/children

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**Contributor**

Louise Tanaka, Audiologist, Clinical Coordinator for Screening and Audiology, Tri-Regional Infant Hearing Program

**LEARNING DISABILITIES**

Learning Disabilities (LDs) are the result of impairment in one or more psychological processes that affect acquisition, retention, understanding, organization or use of verbal and/or non-verbal information. LDs are lifelong. LDs are distinct from intellectual disabilities as they are specific, not global impairments. LDs may co-exist with other conditions including attention disorders, behavioural and emotional disorders, sensory impairments or other medical conditions.

LDs can affect how a person interprets, remembers, understands and expresses information. LDs take many forms and vary in severity and intensity and may impact many areas of functioning from childhood into adulthood. LDs may affect academic performance (e.g. spelling, reading, listening, focusing, remembering and writing), social functioning, life skills (e.g. planning, organizing, predicting) and physical interaction with the world (e.g. balance, coordination, movement).

Between five and 10 per cent of Canadians have LDs. LDs are not widely understood and are not caused by factors such as cultural or language differences, inadequate or inappropriate instruction, socioeconomic status or lack of motivation.

Typically, LDs are diagnosed by an educational psychologist only after the child enters school and is learning to read and write.

**PROBLEM SIGNS**

If a child is experiencing a delay in one or more of the following domains in this guide consider this a red flag:

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• Attention Difficulty and Hyperactive Behaviour
• Behaviour
• Fine motor skills
• Social/emotional
• Speech and language

Where to go for help
Refer to the specific domains above to find out where to go for help as early as possible to reduce the impact on the child’s learning. Long term support is usually indicated.

For more information about learning disabilities:
• Learning Disabilities Association of York Region at 905-884-7933
  info@ldayr.org
  ldayr.org

Contributor
Stephanie Gatti, Program Coordinator, Learning Disabilities Association of York Region

MATERNAL MENTAL ILLNESS
Mental illnesses such as depression and anxiety are conditions where a person’s thinking, mood and behaviours severely and negatively impact how a person functions in his or her life. Mental illness that occurs in pregnancy or after having a baby is referred to as maternal mental illness.

If left untreated, maternal mental illness can have negative effects on both the mother and her baby. For example, it can put a woman at risk for premature delivery or may affect her ability to meet her own self care needs and those of her child. This can put the child’s health and development at risk.63

PROBLEM SIGNS
If a mother is experiencing any of the following for more than two weeks after the birth of a baby, consider this a red flag:
• General feelings of unhappiness without reason
• Crying
• Mood swings
• Anxiety
• Insomnia
• Changes in appetite
• Irritability
• Loneliness or isolation
• Worry about their ability as a mother
• Conflicts in their roles and relationships
• Inability to cope64

Postpartum or baby blues are very common. Up to 84 per cent of new mothers will experience it. The negative feelings usually peak on day three to five postpartum and will improve by day 12.65

Depression occurs in up to 19 per cent of women.64 Encouraging women to speak to a health care provider and get help early benefits both themselves and their children.

Women with certain risk factors may be more vulnerable to experiencing maternal mental illness.

If a woman has any of the following risk factors, consider this a red flag:
• Personal history of anxiety, depression or other mental illnesses
• Family history of poor mental health
• Conflict with the partner relationship

• Lack of practical, financial or emotional supports
• Poor social support
• Stressful life events, e.g. infertility, pregnancy loss, unhealthy relationships, loss of a family member or friend

Where to go for help
If there are concerns of maternal mental illness, or if the woman has risk factors:
• Advise the woman/family to contact her primary health care provider

For further support, the woman may also contact:
• York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228 or email childfamily@york.ca to access the following York Region Public Health programs:
  → Healthy Babies Healthy Children program
  → Transition to Parenting group
  → Bounce Back Program offered by Canadian Mental Health Association

Postpartum psychosis is a rare but serious mental illness with risks to the mother and baby. The onset usually happens rapidly, in the first few weeks after childbirth. Postpartum psychosis requires immediate medical attention.

If the mother is experiencing any of the following symptoms of postpartum psychosis, consider this a red flag:
• Dramatic changes in mood i.e. from elated to depressed
• Out of touch with reality; cognitive impairment
• Delusions and/or hallucinations
• Severe depression
• Agitation
• Confusion
• Thoughts of harming self or baby

If the mother has any of the above symptoms of postpartum psychosis, do not wait:
• Establish the safety of the baby and/or child(ren)
• Do not leave the mother alone
• Get help:
  → Contact Community Crisis Response Services 24 hour crisis line: 1-855-310-COPE (2673), TTY 1-866-323-7785 or
  → Accompany the mother to your local hospital’s emergency department

Contributor
Pauline Ingber-Brooks, Public Health Nurse, York Region Public Health

MILD TRAUMATIC BRAIN INJURY (CONCUSSION)

A mild traumatic brain injury is also called “concussion.” In children under the age of six years, concussions are most commonly caused by falls, motor vehicle crashes, bicycle crashes or other sports related injuries, being struck by/against objects, and assault. It can be more difficult to recognize the symptoms of a concussion in infants, toddlers or preschoolers because they communicate differently than older children.

PROBLEM SIGNS

If a child experiences one or more of the following consider this a red flag:

• Headache or persistent rubbing of their head
• Nausea or vomiting
• Unsteady walking, loss of balance or poor coordination
• Loss of ability to carry out newly learned skills, e.g. toilet training, speech
• Lack of interest in favourite toys
• Cranky, irritable or difficult to console
• Changes in eating or sleeping patterns
• Tiring easily or listlessness
• Sensitivity to light or noise
• Visual problems

If any of the following symptoms develop, consider this a red flag and take the child to the local emergency department/seek medical attention immediately:

• Loss of consciousness
• Large bumps, bruising or unexplained swelling on the head
• Increased drowsiness or difficult to rouse
• Neck pain
• Repeated vomiting
• Blood or fluid in the ear
• Pupils are unequal in size
• Seizures
• Increased confusion e.g. cannot recognize people or places

Where to go for help

If you suspect a child has had a concussion:

• Take the child to the local emergency department/seek medical help immediately

Contributor

Karen Dillon, Manager, Children’s Treatment Network of Simcoe York

Source

Jennifer Saltzman-Benaiah, PhD, CPsych, Clinical Neuropsychologist, Behaviour and Health Sciences Centre, Mackenzie Health, and the Children’s Treatment Network of Simcoe York

NUTRITION (OVERWEIGHT AND UNDERWEIGHT)

Poor nutrition in babies and young children can lead to many negative outcomes such as failure to thrive, obesity, anemia, restrained eating, poor eating habits that become lifelong, lack of school readiness and inability to learn at school. Further investigation, including possible referral to a registered dietician (RD) for nutrition assessment and ongoing follow-up may be warranted for infants and children who present with Red Flags.

PROBLEM SIGNS

If one or more of the following risk factors are present, consider this a red flag:

• Slurred speech
• Weakness, numbness in arms/legs
• Changes in behaviour e.g. irritability, aggression

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68 McMaster Children’s Hospital. Do you think your child may have a concussion? [Internet]. Hamilton: Hamilton Health Sciences; [cited 2015 Dec 11]. Available from: mcmasterchildrenshospital.ca/body.cfm?id=438

General nutrition risk factors

• Growth measurements plot below the third or above the eighty-fifth percentile on the WHO Growth Charts for Canada

• There is a sharp incline or decline in serial growth measurements or the growth-line remains flat on the WHO Growth Charts for Canada

• If provided, infant formula is prepared and/or stored incorrectly

• Uses a propped bottle or is not supervised during feeding

• Unsafe or inappropriate foods are given, e.g. raw eggs, unpasteurized milk and foods that are choking hazards

• Feeding is forced or restricted

• Is pressured to eat through prodding, scolding, punishment, pleading, bribing or coercing, e.g. “clean your plate” or “come on, you’ve tried it before”

• Diet is restricted e.g. food allergy, vegan, gluten-free

• Food storage or cooking facilities are inadequate

Age-specific nutrition risk factors

Birth to 6 months

• After five days of age, has less than six wet diapers each day

• Within the first two weeks, loses more than 10 per cent of birth weight

• By two weeks, does not regain birth weight or does not gain 20 grams or more per day

• Not fed based on baby’s cues, e.g. not fed on demand, day and night

• Not receiving vitamin D supplement of 400 IU daily if breastfed or receiving breastmilk

• Drinks cow’s or goat’s milk, vegetarian beverages (e.g. soy, rice, almond), homemade evaporated milk formula, water, juice, herbal teas or other liquids

• Consumes infant cereal or other pureed foods before 4 months, including cereal or pureed foods in a bottle


• Consumes honey, including pasteurized or cooked\textsuperscript{73}

6 to 9 months
• Does not eat iron-rich foods daily, such as meat, meat alternatives and iron fortified cereal
• By nine months, does not eat two to three larger feedings (meals) and one to two smaller feedings (snacks) daily
• Not receiving vitamin D supplement of 400 UI daily if breastfed or receiving breastmilk
• Drinks cow’s or goat’s milk, vegetarian beverages (e.g., soy, rice, almond) or homemade formula as milk source
• Drinks fruit drinks/punch, sports drinks, pop or beverages containing artificial sweeteners or caffeine (e.g. coffee, tea, hot chocolate)
• Drinks more than 175 mL (six oz.) juice a day
• Consumes honey, including pasteurized or cooked\textsuperscript{73}

9 to 12 months
• Does not eat iron-rich foods daily, such as meat, meat alternatives and iron fortified cereal
• By nine months, foods with lumpy textures have not been introduced or consumed
• By 12 months, does not eat a variety of family foods with various textures
• By 12 months, does not eat two to three larger feedings (meals) and one to two smaller feedings (snacks) daily
• Not receiving vitamin D supplement of 400 IU daily if breastfed or receiving breastmilk
• Drinks skim or low-fat cow’s or goat’s milk, vegetarian beverages (e.g. soy, rice, almond) or homemade formula as main milk source
• Drinks fruit drinks/punch, sports drinks, pop or beverages containing artificial sweeteners or caffeine (e.g. coffee, tea, hot chocolate)

1 to 2 years
• Does not eat iron-rich foods daily, such as meat and meat alternatives\textsuperscript{73}
• Does not eat a variety of family foods with varying textures such as ground, mashed or chopped foods with a tender consistency, including finger foods\textsuperscript{73}
• Does not eat three small meals plus two to three nutrient-dense snacks a day, generally following the advice in Canada’s Food Guide\textsuperscript{73}
• Dietary fat intake is restricted\textsuperscript{73}
• Not receiving vitamin D supplement of 400 IU daily if breastfed or receiving breastmilk
• Consumes mostly breastmilk and little solid food\textsuperscript{74,82,83}
• By 18 months, has not transitioned from bottle to an open cup\textsuperscript{84}
• Drinks more than 750 mL (24 oz.) of cow’s or goat’s milk a day\textsuperscript{73}
• Drinks more than 175 mL (six oz.) of juice a day\textsuperscript{73}
• Drinks skim or low-fat cow’s or goat’s milk, vegetarian beverages (e.g. soy, rice, almond) or homemade formula as main milk source\textsuperscript{73}
• Drinks fruit drinks/punch, sports drinks, pop or beverages containing artificial sweeteners or caffeine (e.g. coffee, tea, hot chocolate)\textsuperscript{73}


\textsuperscript{83} Coulthard H, Harris G, Emmett P. Delayed introduction of lumpy foods to children during the complementary feeding period affects child’s food acceptance and feeding at 7 years of age. Matern Child Nutr 2009; 5(1): 75-85.

• By 24 months, often coughs and chokes when eating

• Scores “high nutrition risk” on Toddler Nutri-STEP® nutrition screen nutritionscreen.ca

**2 to 6 years**

• Does not eat a variety of foods from the four food groups in Canada’s Food Guide

• Does not eat three small meals plus two to three nutrient-dense snacks each day

• Drinks large amounts of fluids and little solid food (e.g. more than 750 ml or 24 oz. of milk a day or more than 175 mL or six oz. of juice a day)

• Consumes mostly breast milk and little solid food

• Drinks most of their milk and other beverages from a bottle or sippy cup

• Regularly drinks fruit drinks/punch, sports drinks, pop or beverages containing caffeine, e.g. coffee, tea, hot chocolate

• Rarely or never eats meals with their family

• Depends on vitamin/mineral supplement vs. variety of foods

• Scores “high nutrition risk” on Toddler or Preschooler NutriSTEP® nutrition screen nutritionscreen.ca

**Where to go for help**

If there are concerns, advise the parent/caregiver to:

• Talk to their child’s primary care provider

• Contact EatRight Ontario to speak with a registered dietitian by calling 1-877-510-5102, or using the Email a Dietitian service on the website eatrightontario.ca

For more information on healthy eating:

• York Region Public Health Nutrition Services york.ca/nutrition

**Source**


**Contributor**

Mary Turfryer, Registered Dietitian-Public Health Nutritionist, York Region Public Health

**PREMATURITY**

Typically, a fetus spends an average of 40 weeks growing and developing before birth. According to the World Health Organization (WHO), babies born before completing 37 weeks are defined as preterm or premature. In the majority of cases, these infants are healthy and experience typical development. However, many infants born prematurely require medical care after birth and some have continuing challenges that affect their growth and development. Several factors influence

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85 Nipissing District Developmental Screen Inc. Nipissing District Developmental Screen [Internet]. North Bay: NDDS; 2011[cited 2015 Jun 15]. Available from: ndds.ca/ontario


90 Aboutkidshealth. About premature babies [Internet]. Toronto: Hospital for Sick Children; 2009.; [cited 2016 May 5]. Available from: aboutkidshealth.ca/En/ResourceCentres/PrematureBabies/AboutPrematureBabies/Pages/default.aspx
whether or not a child born prematurely will experience medical care and/or ongoing support. These factors include how prematurely the child was born, the baby’s birth weight, and if the baby experienced complications at birth that are known to put them at risk for challenges as children and adults.91

There are a variety of reasons that children can be born premature. Prematurity may be linked to maternal conditions (e.g. high blood pressure, infection, substance abuse, trauma, chronic illness) or fetal conditions (e.g. fetal malformation, chromosomal abnormalities, infection).90 Sometimes the reason for a premature birth is unknown.

Regardless of the reason for prematurity, there is a higher risk of developmental concerns and these children will need consistent monitoring to ensure that they are developing appropriately for their age. Regular monitoring of a child’s growth and development by a professional is important to ensure that children at risk can access appropriate services. York Region Early Intervention Services (EIS) provides this support in partnership with the three York Region hospitals (Mackenzie Health, Markham Stouffville Hospital and Southlake Regional Health Centre) at Neonatal Follow-Up Clinics located within each hospital. The Neonatal Follow-Up Clinics are staffed by multidisciplinary teams which include physicians, physiotherapists, occupational therapists and early interventionists. The focus of the multidisciplinary clinic team is to provide assessment, monitoring and early intervention to promote optimal developmental outcomes. The Neonatal Follow-Up Clinics specifically target infants/children at the greatest risk for delay including: infants born less than 33 weeks gestation, birth weight less than 2000 grams, at risk for neurological impairments, small for gestational age (SGA), metabolic conditions, or those with complex needs.

**Where to go for help**

Advise the parent/caregiver to contact: 

- York Region Early Intervention Services to obtain the physician’s referral form for the neonatal follow-up clinics 1-888-703-KIDS (5437)

Primary care providers can refer directly to one of the three hospitals’ Neonatal Follow-Up Clinics:

- **Mackenzie Health**
  Telephone: 905-883-1212 ext. 3069
  Fax: 905-883-2052

- **Markham Stouffville Hospital**
  Telephone: 905-472-7534
  Fax: 905-472-7535

- **Southlake Regional Health Centre**
  Telephone: 905-895-4521 ext. 5608
  Fax: 905-830-5982

**Contributor**

Nadia Brown, Clinical Supervisor, Early Intervention Services, York Region Community and Health Services, Social Services Branch

**REGULATION**

The development of self-regulation is rooted in the relationship/attachment system that exists between an infant and his or her caregiver.92, 93, 94 Babies are not born with the capacity to regulate their feelings, actions or bodies and rely completely on their caregivers to attune to their distress. When caregivers can recognize their own stress, stay calm and then provide the nurturing and structure needed to alleviate their baby’s distress they have used their secure relationship to help the child regulate. In the first three years of a child’s life, the child is dependent on his or her parents to interpret their distress and support them to calm down and regulate. This is a process known as co-regulation and its growth and development is closely aligned with the relationship and attachment between a parent and child.92, 93, 95 Beyond the child’s third birthday,
the child begins to meaningfully use words to identify feelings and thoughts. Their emerging language skills then begin to help them think, wait, problem solve, ask for help and remember ways to calm themselves down when they are distressed. Initially infants need a tremendous amount of co-regulation from others to manage distress. They will need less and less adult support as children as their own capacity to regulate increases.92, 93, 95

In the first three years, the role of the parent is to help the child recover from stress and prevent the child from feeling overloaded. Common stressors might include hunger, fatigue, worry, fear, pain, being alone or sensory overload (voice tone, anger, lighting, temperature). Toxic stress occurs when the child experiences distress too frequently, too quickly, when they can’t adapt to “normal” challenges and transitions, when it takes a long time to recover (more than 10 to 20 minutes) or when distress affects a healthy sleep cycle.93 Toxic stress also interrupts a child’s ability to regulate if the caregiver has not been successful or mostly consistent in soothing the child.96, 92, 97 Children who have experienced toxic stress will react more frequently and more intensely with little or no understood provocation. They will react with actions that fall into the categories of fight (physical or verbal), flight (running behaviours) or freeze/immobilize (hiding, spacing out, daydreaming). Children who experience this level of toxic stress tend to have disruptions to normal sleep patterns so that they sleep too much, sleep too little or can’t get into a sleep pattern that allows them to feel rested.93 These children often are defined by what is seen as “bad behaviour” when the root of the reaction is that their needs have not been met and their brain interprets that as dangerous. The brain then reacts with fighting, flight or freezing.93

**Red Flags** exist within this domain for parents who are unable to calm themselves, understand their child’s needs and respond to their child in ways that soothe. The Adverse Childhood Experiences (ACE) Study identifies a number of parental risk factors including involvement in abuse, neglect, substance use, separations or loss, and criminality that might compromise parents’ ability to notice and offer support to their child.93

### PROBLEM SIGNS

If a child presents any of the following behaviours, consider this a red flag:

- Shows distress easily
- Has difficulty adapting to changes
- Has difficulty making transitions
- Takes more than 20 minutes to calm down after being upset
- Sleeps too much for their age
- Sleeps too little for their age
- Reacts frequently with little or no understanding of what provoked them
- Reacts with intensity
- Engages in physical fighting, verbal aggression and poor social skills
- Runs away
- Hides from
- Daydreams more than usual93, 98, 99, 100

### Where to go for help

If there are concerns, advise the parent/caregiver to contact one of the following:

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100 Siegel DJ. The developing mind: how relationships and the brain interact to shape who we are. New York: Guilford Press; 2001.
• Ontario Early Years Centre (OEYC) with locations in Markham, Oak Ridges, Thornhill, Vaughan-King-Aurora, and York North

• To access the contact information for the locations in York Region, visit centralhealthline.ca

• York Region Early Intervention Services 1-888-703-5437

• Blue Hills Child and Family Centre 905-773-4323 bluehillscentre.ca bluehills@bluehillscentre.ca

• Kinark Child and Family Services 1-888-454–6275 or 1-888-4-KINARK kinark.on.ca info@kinark.on.ca

• The York Centre for Children, Youth and Families (905) 737-8927 theyorkcentre.ca info@theyorkcentre.ca

Contributor
Janet MacQuarrie, Registered Psychotherapist, Supervisor of Play and Early Learning, Blue Hills Child and Family Centre

RELATIONSHIP AND ATTACHMENT

One of the most significant contributions to healthy brain development in a child’s life is the parent-child relationship. These interactions form the building blocks for future relationships creating an internal model the child uses to reference how all future relationships are interpreted and measured. The new understandings we have from the field of neurobiology lays the foundation for brain development that is rooted in the connection and relationship an infant and child experiences with his or her caregiver.

These relationships can be described and understood in the context of Mary Ainsworth’s four attachment styles: secure, anxious-ambivalent, anxious-avoidant, and disorganized.

It is important to note and remember that most parent child interactions result in a secure attachment pattern.

Secure attachment: This is a relationship in which the infant or child can feel physically and emotionally safe. The parent is able to meet the needs of the child, soothe the child and experience joy in their relationship with the child. The parent, through this experience, “serves” the child positive and rich physical, emotional and verbal messages that the child “returns” to the parent with smiles, gurgles and cuddles. The child experiences a world (the extent of their world is their parent) that is safe, responsive and can make them feel calm when distressed.

Anxious-ambivalent attachment: This is a relationship in which the infant or child experiences some level of uncertainty or stress in their relationship with their parent/caregiver. The anxiety or stress the child experiences may result from a variety of situations such as a loss, illness, parental mental health, poverty, physical abuse, neglect, poor nutrition, prenatal maternal stress and parental trauma where the parent is sometimes attentive and responsive and sometimes not. As a result of this uncertainty, the child might seem unsure and display some ambivalence wanting to approach his or her parent for comfort while also showing some resistance to that approach.

Anxious-avoidant attachment: Much like the anxious-ambivalent attachment pattern, this is a relationship in which the infant or child experiences some level of uncertainty or stress in their relationship with their parent/caregiver. The anxiety or stress the child experiences may result from a variety of situations such as a loss, illness, addictions, parental mental health, poverty, physical


abuse, neglect, poor nutrition, prenatal maternal stress and parental trauma and the parent has proven to the child that his or her responses are not predictable and reliable. As a result of this uncertainty, the child avoids the parent and may either seem inconsolable or show little or no affect.103, 104, 105

Disorganized attachment pattern: The disorganizing attachment pattern is the most concerning and the most difficult to notice. This occurs when the caregiver who is supposed to be the person who responds to the child’s needs for safety, comfort, feeding and connection is actually frightening or frightened of the child. This child is caught in a difficult dilemma as the person who is supposed to be safe is actually scary. Survival drives the child to the caregiver but the caregiver is the source of the child’s distress. The frightening parents might be abusive, neglectful or hostile toward the child or they use language or voice tones that are frightening. The developing brain needs cues from the parent’s facial expressions to regulate and grow.102 Examples of the still face experiment show that the infant who does not see responsiveness in the parent’s facial expression becomes distressed and dysregulated.103, 104, 105

The parent who is frightened of their child may be slow to move in to respond, unable to read his or her baby’s cues and know what the baby actually needs from them. This parent is unable to consistently calm his or her child or respond to the child, and often carries a worried look on their face. This stresses the child who is then unable to respond to the parent in ways that encourage the parent to engage with them again.106

A child who has experienced an insecure or disorganizing caregiver might:

• Explore their environment and other people only minimally either reluctantly or without interest
• Be preoccupied and clingy with the parent
• Become distressed and anxious if the parent leaves, even for a short period
• Reach out for the parent and then resist them
• Seem angry and rejecting toward the parent
• Seem passive in relating to the parent
• Show minimal interest in the parent
• Seem independent resisting help from others
• Explore the room and toys busily
• Not use the parent as a secure base to seek proximity when stressed
• Show minimal acknowledgement when the parent leaves the child
• Ignore or avoid the parent when the parent returns to the room
• Easily go with strangers or talk to strangers
• Be overly sensitive to sounds, textures, food or smells
• Be overly tolerant/ignoring of things like noises, dirty hands, lighting or wet clothing
• Be reactive and angry without noticeable provocation
• Fight, flee (run) or freeze when in distress (become immobile, look dazed, daydream, forgetful, shut down emotionally)
• Cry with a weak or angry response
• Whine constantly
• Resist cuddling
• Use poor eye contact or seem uncomfortable with eye contact
• Not respond to smiles
• Show delayed physical motor skill development (in combination with other flags)103, 104, 106, 107

Where to go for help

If there are concerns, advise the parent/caregiver to contact one of the following:

• Ontario Early Years Centre (OEYC) with locations in Markham, Oak Ridges, Thornhill, Vaughan-King-Aurora, and York North

106 Siegel DJ. The developing mind: How relationships and the brain interact to shape who we are. New York: W.W. Norton & Company; 2001.
RESILIENCE

Resilience is the ability to “bounce back” from stressors and difficult situations. It helps adults and children handle stress, overcome childhood disadvantage, recover from trauma and reach out to others. Studies show that resilient people have happier relationships and are less prone to depression, more successful in school and jobs, and live healthier and longer lives.\(^{108}\) The way a person thinks about life’s challenges can affect his or her ability to cope with them. Parents have “thinking habits” that can help or hinder responses to stressful situations. Young children mimic the way significant adults in their lives respond to these situations. If the parent or caregiver demonstrates any of the red flag thinking habits, the child may develop these thinking habits too.

PROBLEM SIGNS

If a child habitually uses the following ways of thinking, consider this a red flag:

- Takes things personally and blames self or others for the stressful situation
- Expresses belief that the stressful situation is permanent
- Expresses belief that the stressful situation will affect many areas of life\(^{109}\)

Where to go for help

If there are concerns, advise parent/caregiver to contact:

- York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca for resources, programs, and possible referrals

Children often rely on their parent/caregiver for support and comfort during times of stress. If a parent/caregiver’s ability to provide support and comfort is compromised, it is important to refer the parent/caregiver to York Region Health Connection for information on community resources and supportive programs.

SELECTIVE MUTISM

Selective mutism is the persistent inability to speak in specific situations where speaking is expected, despite being able to speak in other situations. This difficulty must last beyond one month and must not be limited to the first month of school or daycare. Selective mutism typically emerges when children are two to five years old.

Contributor

Janet MacQuarrie, Registered Psychotherapist, Supervisor of Play and Early Learning, Blue Hills Child and Family Centre

Gail Lyubarsky, Public Health Nurse, York Region Public Health
Despite this early age of onset, children with this disorder are most commonly identified when they first enter daycare or school, when a lack of verbal communication is first observed outside of the home. Research suggests that selective mutism occurs in up to two per cent of children in elementary school and occurs one and half to two times more often in girls than in boys. The most common profile of children with selective mutism are those that speak freely at home, are less comfortable speaking freely outside of the home — for example, at the grocery store, or at a restaurant — and least comfortable speaking at school. Factors that contribute to the development of selective mutism include a shy or anxious temperament, a family history of anxiety or shyness, speech and language challenges, adjustment to a new culture, and limited social interactions with peers outside of school.

**PROBLEM SIGNS**

If a child is experiencing any of the following behaviours, consider this a red flag:

- Does not speak in a specific situation, for more than one month, excluding the first month of school or daycare
- Clear discrepancy in the quality and quantity of spoken language between the home and other environments
- Relies heavily on nonverbal communication in certain situations; for example, pointing, nodding, and other gestures
- Speaks “through” the parents in public situations such as whispering to them instead of conversing directly to others
- Reluctance to speak to teachers, students, principals or school secretaries
- Avoids speaking and will respond with averted gaze, blushing or other symptoms of anxiety
- Speaks quietly or privately to other children, but not to adults
- May express a fear of being heard or seen speaking in specific situations
- Covers mouth when speaking so others cannot see his or her lips moving
- Experiences accompanying somatic symptoms, particularly when going into unfamiliar environments where speaking is required

**Where to go for help**

If there are concerns, advise the parent/caregiver to contact:

- Blue Hills Child and Family Centre
  905-773-4323
  bluehillscentre.ca
  bluehills@bluehillscentre.ca
- Kinark Child and Family Services
  1-888-454–6275 or 1-888-4-KINARK
  kinark.on.ca
  info@kinark.on.ca
- The York Centre for Children, Youth and Families
  (905) 737-8927
  theyorkcentre.ca
  info@theyorkcentre.ca
- Family Services York Region
  1-888-223-3999
  fsyr.ca

**Contributor**

Zia Lakdawalla, Ph.D., Psychologist, Kinark Child and Family Services

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SENSORY

Sensory processing or sensory integration refers to the ability of our nervous system to receive information through our senses (taste, smell, auditory, visual, touch, movement and body position) and organize it in a meaningful and appropriate way.\(^{115}\)

PROBLEM SIGNS

If a child presents any of the following behaviours in extreme or with exaggeration, and these behaviours do not seem typical for a child of his or her age, consider this a red flag:

Auditory

- Responds negatively to unexpected or loud noise\(^ {116}\)
- Is distracted or has trouble functioning if there is a lot of background noise\(^ {116}\)
- Enjoys strange noises/seeks to make noise for noise sake\(^ {116}\)
- Seems to be “in their own world”\(^ {117}\)

Visual

- Needs help to find objects that are obvious to others\(^ {117}\)
- Avoids eye contact\(^ {117}\)
- Squints or looks out of the corner of the eye\(^ {118}\)
- Is attracted to bright, flashing objects like TV or computer screens\(^ {117}\)
- Is more bothered by bright light as compared to same age children e.g. blinks, squints, cries, closes eyes, etc.\(^ {119}\)

Taste/smell

- Avoids certain tastes/smells that are typically part of the child’s diet\(^ {116}\)
- Chews/licks non-food objects\(^ {120}\)
- Gags easily\(^ {119}\)
- Is a picky eater, especially regarding textures, flavours, smells and temperature\(^ {116}\)

Movement and body position

- Continually seeks out all kinds of movement activities (e.g., being whirled by adult, playground equipment, moving toys, spinning, rocking)\(^ {118}\)
- Becomes anxious or distressed when feet leave the ground\(^ {116}\)
- Has poor endurance – tires easily; seems to have weak muscles\(^ {119}\)
- Avoids climbing, jumping, uneven ground or roughhousing\(^ {120}\)
- Bumps into things, failing to notice people or objects in the way\(^ {117}\)
- Seems not to get dizzy when others usually do\(^ {118}\)

Touch

- Becomes upset during grooming e.g. during hair cutting, face washing, fingernail cutting\(^ {116}\)
- Has difficulty standing in line or close to other people, or stands too close, always touching others\(^ {116}\)
- Shows an emotional or aggressive response to being touched\(^ {119}\)
- Fails to notice when face or hands are messy or wet\(^ {116}\)
- Craves lots of touch: heavy pressure, long-sleeved clothing, hats, and certain textures\(^ {119}\)

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Activity Level

- Always on the go; difficulty paying attention
- Very inactive — seems to tire easily and will often slump in chairs or lean against objects for support
- Seems unaware of pain

Social/emotional

- Needs more protection from life than other children i.e. defenseless physically or emotionally
- Has difficulty with changes in routines, plans or expectations
- Is stubborn or uncooperative; easily frustrated
- Has difficulty making friends
- Has difficulty understanding body language or facial expression
- Does not feel positive about own accomplishments i.e. low self-esteem

Where to go for help

If there are concerns, advise the parent/caregiver to contact:

- York Region Early Intervention Services at 1-888-703-KIDS (5437) or
- The child’s family physician for a referral to a developmental pediatrician or a private occupational therapist

Contributor

Nadia Brown, PT, Clinical Supervisor, Early Intervention Services, York Region Community and Health Services, Social Services Branch

SLEEP

Sleep is a critical activity of child development. Adequate sleep promotes self-regulation, growth, physical health, memory and cognitive functioning. In typically developing infants and toddlers, lack of sleep has been associated with parental stress, attachment difficulties and maternal depression. In atypically developing infants, sleep problems are often attributed to neurological or physical abnormalities, although psychosocial factors also play a role.

It takes time for infants to develop a sleep-wake cycle and some infants take longer than others. Various factors such as time, cues, biology, environment and infant temperament all play a part. The amount of sleep varies greatly from one child to the other. Infants up to six months of age may spend up to 16 hours in a 24 hour day sleeping, but as little as 10 hours has also been reported. Infants from six to 12 months may sleep up to 14 hours per day, toddlers about 10 to 13 hours and preschoolers 10 to 12 hours.

PROBLEM SIGNS

If a child presents any of the following behaviours, consider this a red flag:

- Dependence on caregiver presence and soothing actions i.e. nursing or rocking
- Resistance to or fears and anxieties around sleeping
- Poor airway functioning/airway obstruction i.e. noisy breathing, snoring or breathing pauses due to enlarged adenoids or respiratory infection
- Excessive crankiness or temper tantrums

123 Caringforkids. Healthy sleep for your baby and child [Internet]. Toronto, ON: Canadian Pediatric Society; 2012 [cited 2016 Sep 6]. Available from: caringforkids.cps.ca/handouts/healthy_sleep_for_your_baby_and_child
• Problems in cognitive functioning i.e. attention, learning and memory\textsuperscript{125}

• Coordination problems e.g. accidents, injuries, slower reaction time\textsuperscript{126}

**Where to go for help**

If there are concerns, advise the parent/caregiver to contact their primary health care provider.

The parent/caregiver can also contact:

• Blue Hills Child and Family Centre
  905-773-4323
  bluehillscentre.ca
  bluehills@bluehillscentre.ca

• Kinark Child and Family Services
  1-888-454–6275 or 1-888-4-KINARK
  kinark.on.ca
  info@kinark.on.ca

• The York Centre for Children, Youth and Families
  (905) 737-8927
  theyorkcentre.ca
  info@theyorkcentre.ca

• Family Services York Region
  1-888-223-3999
  fsyr.ca


\textsuperscript{128} U.S. Dept. of Health and Human Services; Centers for Disease Control and Prevention; Coordinating Center for Health Promotion; National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General [Internet]. Atlanta, Ga: US Department of Health and Human Services; 2006 [cited 2016 Aug 10]. Available from: surveongeneral.gov/library/reports/secondhandsmoke/fullreport.pdf


\textsuperscript{130} Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion. Health effects of secondhand smoke [Internet]. Atlanta, Georgia; Centres for Disease Control and Prevention; c2017 [cited 2017 Mar 27]. Available from: cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/health_effects/

While planning for a pregnancy, as well as during pregnancy, exposure to tobacco smoke can affect the health of the baby and it can also make it difficult for individuals to conceive.\(^{132}\)

Children are most at risk for health and growth and development concerns when exposed to second- and third-hand smoke due to the following:

- They breathe faster
- Their bodies are smaller
- It’s harder for them to break down the chemicals found in tobacco smoke
- They cannot remove themselves from smoking environments
- Babies crawl on the floor and put their hands and objects in their mouths taking in more chemicals than adults\(^{133}\)

Children who are regularly exposed to second- and third-hand smoke are at risk for the following:

- Sudden Infant Death Syndrome (SIDS)
- Sleep challenges
- Colic
- Coughing and/or wheezing more frequently
- Asthma
- Bronchitis, ear infections, pneumonia and croup
- Learning challenges that lead to lower scores in math, reading, and logic
- Behavioural issues such as hyperactivity
- Heart disease in adulthood
- Smoking themselves as a teenager or adult\(^{133}\)

### PROBLEM SIGNS

If a child is experiencing the following, consider this a red flag:

- Regular exposure to second- and/or third-hand tobacco smoke
- Frequent asthma attacks, respiratory and ear infections

### Where to go for help

If the parent/caregiver is a tobacco user, encourage them to work toward a tobacco-free life and keep vehicles and homes smoke-free by suggesting they access one or more of the following resources:

- Best Start: A smoke-free environment for your children
  [beststart.org/resources/tobacco/pdf/tobacco_handout_eng_FINAL.pdf](beststart.org/resources/tobacco/pdf/tobacco_handout_eng_FINAL.pdf)
- Smokers’ Helpline
  1-877-513-5333
  [smokershelpline.ca](smokershelpline.ca)
- Break it off
  [breakitoff.ca](breakitoff.ca)
- Pregnets
  [pregnets.org](pregnets.org)
- Dads in Gear: smoke-free dads
  [dadsingear.ok.ubc.ca](dadsingear.ok.ubc.ca)
- Families Controlling and Eliminating Tobacco
  [facet.ubc.ca](facet.ubc.ca)
- York Region Public Health
  [york.ca/tobacco](york.ca/tobacco)

### Contributors

Rosemary Lamont, Public Health Nurse, York Region Public Health, Tobacco-Free Living Services

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\(^{133}\) Best Start Resource Centre. A smoke-free environment for your children [Internet]. Toronto, ON; Best Start Resource Centre; 2010 [cited 2017 Mar27]. Available from: [beststart.org/resources/tobacco/pdf/tobacco_handout_eng_FINAL.pdf](beststart.org/resources/tobacco/pdf/tobacco_handout_eng_FINAL.pdf)
SOCIAL/EMOTIONAL

Social and emotional development encompass both intrapersonal skills (i.e. understanding and managing one’s own emotions) and interperson- al skills (i.e. the ability to effectively verbally and non-verbally communicate with other people), as it looks at the child’s experience, demonstration, and control of emotions and the capacity to create meaningful and reciprocal relationships with others. The main characteristics of social and emotional development in a child include:

- Recognizing and comprehending both his or her own feelings as well as others
- Coping with deep emotions and expressing them in a productive way
- Regulating their behaviour
- Developing and preserving connections with people

It is important to note that social and emotional development is a lengthy process and children continue with development in this domain well into the teenage years and at times into young adulthood.

PROBLEM SIGNS

If a child consistently exhibits any of the following behaviours, consider this a red flag:

**Ages 0 to 9 months**
- Lack of response to sounds
- Lack of expression/smile in response to others/
- Avoids close contact
- Inability to self-soothe or calm themselves

**Ages 9 to 12 months**
- Lack of interest in peers
- Great difficulty waiting for something
- Rigidity in regards to routine, clothing, toys, food, etc.
- Little to no eye contract
- Lack of imitation to simple actions
- Lack of response to his or her name
- Lack of shared attention between two people on an item
- Lack of ability for turn-taking in games
- Responds in the same way with familiar people and strangers

**Ages 1 to 2 years**
- Moves from one activity to another and only stays at an activity for a brief time
- Requires support to stay on task
- Lack of ability to show/explain objects to others
- Frustration when changes occur
- Lack of interest in objects and/or activities in which peers are engaging
- Lack of initiation of self-play

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137 Sundberg ML. VB-MAPP, Verbal behavior milestones assessment and placement program. 2nd ed. AVB Press; 2014.
Ages 2 to 3 years

- Lack of interest in pretend play
- Difficulty with separation from caregiver
- Lack of initiation or response to interactions with peers
- Prefers to play in a different area than peers
- Lack of symbolical use of objects
- Lack of participation in group activities
- Unusual expression in intensity of aggression
- Displays severe fears that hinder daily living

Ages 3 to 5 years

- Lack of initiation or joining in play with peers
- Lack of sharing with peers
- Lack of cooperative play skills e.g. group decisions, role duties, just play
- Inability to select own friends
- Demonstrates dependency on caregivers for majority of needs and wants
- Demonstrates passivity or fearfulness that limits engagement with activities in which peers are participating

Where to go for help

If there are concerns, advise the parent/caregiver to contact their primary health care provider.

The parent/caregiver can also contact:

- Ontario Early Years Centre
  Locations in Markham, Oak Ridges, Thornhill, Vaughan, King, Aurora and North York
  To access the contact information for the locations in York Region visit: centralhealthline.ca

- Early Intervention Services of York Region
  1-888-703-5437

- Blue Hills Child and Family Centre
  905-773-4323
  bluehillscentre.ca
  bluehills@bluehillscentre.ca

- Kinark Child and Family Services
  1-888-454–6275 or 1-888-4-KINARK
  kinark.on.ca
  info@kinark.on.ca

- The York Centre for Children, Youth and Families
  (905) 737-8927
  theyorkcentre.ca
  info@theyorkcentre.ca

- Family Services York Region
  1-888-223-3999
  fsyr.ca

For more information about social/ emotional, contact:

- York Region Health Connection at 1-800-361-5653, TTY 1-866-512-6228, childfamily@york.ca

- Learning Disabilities Association of York Region at 905 884-7933

Contributor

Jenna Emery, Autism Consultant, Kerry’s Place Autism Services

SPEECH AND LANGUAGE

Approximately one in 10 preschool children has difficulties acquiring speech, language and/or social communication. Because communication skills are critical to the child’s future success in socialization, learning to read and write (literacy) and do math (numeracy), it is important to identify those children who might need support in this domain.

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This domain considers development of attention, comprehension, expression via gestures and words, the development of clear intelligible speech, social skills and play skills.

**Healthy child development**

If a child is missing one or more of these expected age outcomes, consider this a red flag:

**By 6 months**

- Turns to source of sounds
- Startles in response to sudden loud noises
- Makes different cries for different needs i.e., hungry, tired
- Watches the face of parent/caregiver as they talk
- Smiles/laughs in response to parent/caregiver smiles and laughter
- Imitates coughs or other sounds such as “ah,” “eh,” “buh”

**By 9 months**

- Responds to his or her name
- Turns to look for a source of sound, or responds to the telephone or a knock at the door
- Understands being told “no” and other short instructions
- Imitates facial expressions

**By 12 months**

- Follows simple one-step directions such as “Sit down”, “Find your shoes”
- Follows simple requests and questions such as “Where is the ball?”
- Looks across the room to something when an adult points to it
- Consistently uses three or more ‘words’ such as “dada” or “mama,” using the same sounds to indicate same object or person, even if these ‘words’ are not pronounced accurately
- Uses specific gestures to communicate needs or to protest e.g. waves hi/bye, shakes head “no”
- Gets attention using sounds, gestures and pointing while looking at the eyes of parent/caregiver

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• Brings/extends toys to show parent/caregiver\textsuperscript{142, 148}
• “Performs” for social attention and praise\textsuperscript{142, 148}
• Combines lots of sounds together as though talking e.g. “abada baduh abee”\textsuperscript{142, 148}
• Shows an interest in simple picture books\textsuperscript{142, 148}
• Starts and plays social games with parent/caregiver; takes turns e.g. “peek-a-boo,” “patty cake”\textsuperscript{146}
• Finger-feeds him/herself some foods\textsuperscript{147}
• Holds, bites and chews crackers\textsuperscript{142, 147}

By 18 months
• Understands the concepts of “in and out,” “off and on”
• Points to three or more body parts when asked
• Responds with words or gestures to simple questions e.g. “Where’s teddy?” “What’s that?”
• Uses at least 20 words consistently, even if not clear
• Makes at least four different consonant sounds e.g. p, b, m, n, d, g, w, h
• Enjoys being read to and sharing simple books
• Points to familiar pictures using one finger
• Demonstrates some pretend play with toys e.g. gives teddy a drink, pretends a bowl is a hat\textsuperscript{142, 149}

By 24 months
• Follows two-step directions e.g. “Go find your teddy bear and show it to grandma”\textsuperscript{150}
• Uses 100 or more words\textsuperscript{150}
• Uses at least two pronouns such as “you,” “me,” “mine”\textsuperscript{150}
• Consistently combines two to four words in short phrases e.g. “daddy hat,” “truck go down”\textsuperscript{150}
• Forms words/sounds easily and effortlessly\textsuperscript{150}
• Uses words that are understood by others 50 to 60 per cent of the time\textsuperscript{150}
• Enjoys being around other children\textsuperscript{150}
• Begins to offer toys to peers and imitate other children’s actions and words\textsuperscript{150}
• Holds books the right way up and turns pages one at a time\textsuperscript{150}
• “Reads” to stuffed animals or toys\textsuperscript{142}
• Scribbles with crayons\textsuperscript{150}

By 30 months
• Understands the concepts of size such as big/little and quantity such as a little/a lot, more\textsuperscript{151}
• Uses some adult grammar e.g. “two cookies,” “bird flying,” “I jumped”\textsuperscript{151}
• Uses more than 350 words\textsuperscript{151}
• Uses action words e.g., run, spill, fall\textsuperscript{151}
• Produces words with two or more syllables or beats e.g. “ba-na-na,” “com-pu-ter,” “a-pple”\textsuperscript{151}
• Uses consonant sounds at the beginning of words e.g. “big” instead of “ig”\textsuperscript{151}
• Begins taking short turns with peers, using both words and toys\textsuperscript{151}
• Demonstrates concern when another child is hurt/sad\textsuperscript{151}
• Demonstrates pretend play involving several actions e.g. feeds dolls and then puts them to sleep; puts blocks in train then drives train and drops blocks off\textsuperscript{151}


\textsuperscript{150} Markham Stouffville Hospital, York Region Community and Health Services, Early Intervention Services. Early Referral Identification Kit (ERIK)-Referral for 24 months [Internet]. c2013 [cited 2016 Dec 3]. Available from: childdevelopmentprograms.ca/backend/wp-content/uploads/New-ECE-24-month-ERIK-2016.pdf

\textsuperscript{151} Markham Stouffville Hospital, York Region Community and Health Services, Early Intervention Services. Early Referral Identification Kit (ERIK)-Referral for 30 months [Internet]. c2013 [cited 2016 Dec 3]. Available from: childdevelopmentprograms.ca/backend/wp-content/uploads/New-ECE-30-month-ERIK-2016.pdf
• Recognizes familiar logos and signs involving print e.g. golden arches of McDonalds, “Stop” sign

• Remembers and understands familiar stories

• Speaks in sentences of at least three words

• Tries to join in with singing songs or making rhymes

• Recognizes self in a mirror or a photo

By 3 years

• Understands “who,” “what,” “where” and “why” questions

• Creates long sentences using five or more words

• Talks about past events e.g. trip to grandparents’ house, day at childcare

• Tells simple stories

• Understood by most people outside of the family, most of the time

• Shows affection for favourite playmates

• Engages in multi-step pretend play with actions and words e.g. pretending to cook a meal or repair a car

• Understands and uses some describing words e.g. “big,” “dirty,” “wet”

• Joins in play with a group of two or more peers

• Listens to stories or music for five minutes with an adult

• Aware of the function of print e.g. in menus, lists, signs

• Beginning interest in, and awareness of, rhyming

By 4 years

• Follows directions involving three or more steps e.g. “Get some paper, draw a picture, and give it to mom”

• Shows four colours when asked

• Asks and answers a lot of questions e.g. “Why?”, “What are you doing?”

• Uses adult-type grammar

• Tells stories with a clear beginning, middle and end

• Talks with adults and other children to try to solve problems

• Speaks clearly enough to be understood by strangers almost all the time

• Demonstrates increasingly complex imaginative play using words, characters, action and interactions with peers

• Able to generate simple rhymes e.g. “cat-bat”

• Matches some letters with their sounds e.g. “letter T says ‘tuh’

• Enjoys singing children’s songs

• Participates with peers in small group activities, sharing and taking turn e.g. catch, snakes and ladders

By 5 years

• Follows group directions e.g. “All the boys get a toy”

• Understands directions involving “if…then” e.g., “If you’re wearing runners, then line up for gym”

• Describes past, present and future events in detail

• Uses almost all of the sounds of their language with few to no errors

• Seeks to please his/her friends

• Shows increasing independence in friendships

• Knows all the letters of the alphabet

• Identifies the sounds at the beginning of some words e.g., “Pop starts with the ‘puh’ sound”

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PROBLEM SIGNS

If a child is experiencing any of the following, consider this a red flag:

• Stuttering i.e. using repetitions of words, syllables, sound prolongations, or blocks e.g. “I-I-I”, “da-da-daddy”, “mmomomy” “b—all”153
• Ongoing hoarse voice or unusual voice quality154
• Difficulty with feeding or swallowing155
• Excessive drooling155

Speech and language challenges are sometimes associated with other developmental concerns. Also refer to the following domains in this guide for other potential referrals:

• Autism Spectrum Disorders (ASD)
• Hearing
• Feeding skills

Where to go for help

If there are concerns:

• Refer to the York Region Preschool Speech and Language Program by completing an ERIK referral available at childdevelopmentprograms.ca; fax referral to 905 762-2115
• Advise parent/caregiver to contact York Region Preschool Speech and Language program at 1-888-703-KIDS (5437) and visit the website at childdevelopmentprograms.ca for resources.

Note: Children must be referred to the York Region Preschool Speech and Language Program before August 31 of the year they begin Junior kindergarten (JK). If there are concerns about stuttering, referrals may be made during the JK year.

If there are concerns after the child starts JK, please advise parent/caregiver to contact the child’s school for referral to a Speech-Language Pathologist through the school board.

For more information about speech and language:

For a list of private Speech-Language Pathologists, visit osla.on.ca or call the Ontario Association of Speech-Language Pathologists and Audiologists at 1-800-718-6752

Contributor

Marlene Green, Speech-Language Pathologist, York Region Preschool Speech and Language Program, Child Development Programs, Markham Stouffville Hospital

VISION

A great deal of a child’s early learning occurs through vision. Children who are born with (or acquire in early childhood) blindness or low vision are at a greater risk for developmental delays and communicative disorders. It is important to monitor a child’s visual development since early identification can often reduce or eliminate the risk of long-term complications. The Canadian Association of Optometrists recommends children have their first eye exam between ages six and nine months, and annually thereafter.156

Healthy child development

If a child is missing one or more of these expected age outcomes, consider this a red flag:

156 Seven tips for good eye health [Internet] Ottawa, ON: Canadian Association of Optometrists; c2014 [cited 2016 Apr 23]. Available from: opto.ca/health-library/six-tips-for-good-eye-health
By 6 weeks
• Stares at surroundings when awake
• Briefly looks at bright lights/objects
• Blinks in response to light
• Eyes and head move together

By 3 months
• Eyes glance from one object to another
• Eyes follow a moving object or person
• Stares at a caregiver’s face
• Begins to look at hands and food

By 6 months
• Eyes move to inspect surroundings
• Reaches for objects
• Looks at more distant objects
• Smiles and laughs when they see you smile and laugh

By 12 months
• Eyes turn inward as objects move close to the nose
• Watches activities in surroundings for longer time periods
• Looks for a dropped toy
• Visually inspects objects and people
• Creeps towards favourite toy

By 2 years
• Uses vision to guide reaching and grasping for objects
• Looks at simple pictures in a book
• Points to objects or people
• Looks for and points to pictures in books
• Looks where they are going when walking and climbing

PROBLEM SIGNS
If a child is experiencing any of the following, consider this a red flag:
• Swollen or encrusted eyelids
• Bumps, sores or sties on or around the eyelids
• Drooping eyelids
• Lack of eye contact by three months of age
• Does not watch or follow an object with the eyes by three months
• Haziness or whitish appearance inside the pupil
• Frequent “wiggling,” “drifting” or “jerky” eye movements; misalignment of the eyes (eye turns or crossing of eyes)
• Lack of co-ordinated eye movements
• Drifting of one eye when looking at objects
• Turning or tilting of the head when looking at objects
• Squinting, closing or covering of one eye when looking at objects
• Excessive tearing when not crying
• Excessive blinking or squinting
• Excessive rubbing or touching of the eyes
• Avoidance of, or sensitivity to, bright lights

Where to go for help
If there are concerns advise the parent/caregiver to contact their local optometrist. To find a local optometrist visit the Ontario Association of Optometrists website at optom.on.ca

The parent/caregiver can also contact the Regional Blind-Low Vision Early Intervention Program at 1-888-703-KIDS (5437) for information about services and/or to make a referral.

157 Ontario Ministry of Children and Youth Services; Blind-Low Vision Intervention Services. Services for children who are blind or have low vision [Internet]. Toronto: The Ministry; c2014 [cited 2016 Apr 23]. Available from: children.gov.on.ca/htdocs/English/documents/earlychildhood/vision/Vision-EN.pdf
family physicians, optometrists or ophthalmologists and other professionals can refer to Tri-Regional Blind-Low Vision Program by downloading a referral form from childdevelopmentprograms.ca/vision/eligibility-criteria-and-referrals/ and faxing it to 905-762-2115 (An ophthalmologist’s referral is needed prior to admission to services; however, this program can assist with obtaining a referral if the family does not already have one and can provide support in the interim)

For more information about vision:

- Ontario Association of Optometrists website at optom.on.ca
- Canadian National Institute for the Blind website at cnib.ca
- Canadian Association of Optometrists website at opto.ca

**Contributor**

Trisha Strong, Manager, Tri-Regional Blind-Low Vision Program
RESOURCES
APPENDIX A
Important telephone numbers

POLICE, AMBULANCE, FIRE
Emergency number ................................................................. 9-1-1

YORK REGIONAL POLICE, NON-EMERGENCY NUMBERS
Markham and Vaughan .......................................................... 905-881-1221
Aurora, Georgina, Newmarket, Nobleton and Sharon .............. 905-895-1221
Oak Ridges, Richmond Hill and Thornhill .............................. 905-773-1221

CRISIS INTERVENTION
York Region Children’s Aid Society ......................................... 905-895-2318
Toll Free ..................................................................... 1-800-718-3850
Jewish Family and Child Services .......................................... 416-638-7800
Kids Help Phone ................................................................. 1-800-668-6868
Community Crisis Response Service ................................. 1-855-310-COPE (2673)
Domestic Abuse and Sexual Assault Care Centre (DASA) ........ 905-832-1406 ext.0
Toll Free ..................................................................... 1-800-521-6004
Women’s Support Network of York Region ......................... 905-895-3646

HOSPITALS
Southlake Regional Health Centre (Newmarket) ..................... 905-895-4521
Mackenzie Health (Richmond Hill) ....................................... 905-883-1212
Markham Stouffville Hospital (Markham) .............................. 905-472-7000

OTHER
York Region Health Connection ............................................. 1-800-361-5653
Telehealth Ontario ............................................................... 1-866-797-0000
APPENDIX B
Contacts and resources

**Autism Ontario:**
York Region Chapter

905-780-1590
autismontario.com/york

Provides information, education, advocacy, and a self-help support group with links to community agencies for families living with autism spectrum disorder (ASD). Twice monthly educational workshops, monthly support group meetings and summer day camp.

**Best Start Resource Centre**
Ontario’s Maternal Newborn and Early Child Development Resource Centre

1-800-397-9567 or 416-408-2249
beststart.org

Works with diverse partners to build healthy, equitable and thriving communities. The Best Start Resource Centre supports service providers who work in preconception health, prenatal health and early child development.

**Blue Hills Child and Family Centre**

905-773-4323
bluehillscentre.ca

A full-service Children’s Mental Health Agency. Working collaboratively with families and with service system partners, children birth to 18 and their families are offered comprehensive supports through various community-based programs, day treatment classrooms and latency-aged residential treatment. Partnership programs supporting the Child Welfare, Education system and Mediation services also are part of the wide array of services.

**Bounce Back Program**
of the Canadian Mental Health Association

1-866-345-0224
cmha-yr.on.ca/programs-services/bounce-back/

An evidenced-based, free self-help program designed to help adults overcome symptoms of mild to moderate depression, low mood, or stress, with or without anxiety. The program is based on a five areas approach which addresses: life situations, problems, and difficulties; symptoms in the body; unhelpful thinking; altered feelings; altered behaviour and reduced activities.

**Canadian National Institute for the Blind (CNIB)**

1-800-563-2642
cnib.ca

Community-based, registered charity committed to research, public education and vision health for all Canadians. CNIB provides the services and support necessary for people to enjoy a good quality of life while living with vision loss. Staff and volunteers often provide support to clients in their homes and in rural communities. CNIB provides vital programs and services, innovative consumer products, research, peer support and one of the world’s largest libraries for people with print disabilities.
Resources

**Canadian Cancer Society Smokers’ Helpline**

1-877-513-5333
smokershelpline.ca

A free, confidential and non-judgmental service available to clients who want to quit tobacco use or need help staying smoke-free. Through a multi-modal approach, Smokers’ Helpline offers evidence-based phone, online and text messaging services. With proven tips and tools, Smoker’s Helpline can significantly increase one’s chance of becoming tobacco-free.

**Canadian Centre on Substance Abuse (CCSA)**

613-235-4048
ccsa.ca

Provides evidence-informed analysis and advice to mobilize collaborative efforts to reduce alcohol-related and other drug-related harms.

**Centre for Behaviour Health Sciences, Mackenzie Health**

905-773-3038 or 705-728-9143

Provides care for individuals living in York Region or Simcoe County who have a developmental disability with a significant cognitive delay, autism or are living with the effects of an acquired brain injury. Services are offered within the community to individuals living in York Region or Simcoe County.

**Children’s Treatment Network of Simcoe York (CTN)**

1-877-719-4795
ctnsy.ca

Serves children with multiple disabilities and their families in Simcoe County and York Region. They include children with physical, developmental and communications needs who may already be receiving services from network partners and require more ongoing, intensive or specialized rehabilitation treatment. Services are available to kids from birth to age 19 with a wide range of disabilities and complex conditions, including: cerebral palsy, muscular dystrophy, acquired brain injury, developmental and learning difficulties, spina bifida, autism or pervasive developmental disorder (PDD), chronic and/or long-term medical conditions that require intensive therapy, specialized equipment or travel to treatment centres outside of the community.

**Community Crisis Response Service of York Support Services Network (YSSN)**

1-855-310-COPE (2673)
yssn.ca/310-COPE

Offers a range of case management and community crisis services to support individuals with a developmental disability and/or a serious mental illness. YSSN also provides services within the Children’s Services Sector, offering Children’s Case Coordination.

**Eat Right Ontario**

1-877-510-5102
eatrightontario.ca

A free service that connects residents of Ontario to the trusted advice of a Registered Dietitian to help you make healthier food choices and answer your nutrition questions.
Family Services of York Region (FSYR)

Georgina
905-476-3611

Markham
1-866-415-9723

Newmarket
1-888-223-3999

Richmond Hill
1-888-820-9986

fsyr.ca

A not for profit, charitable organization committed to excellence in the provision of counselling for children, youth, women, men and their families. All counselling services seek to promote the fullest development of the individual. FSYR partners with agencies across York Region to ensure that clients receive the help they need.

FAS World

416-264-8000
fasworld.com

Provides support and information to parents, caregivers, and professionals dealing with Fetal Alcohol Spectrum Disorders (FASD), as well as individuals living with FASD. Encourages the development of new programs for individuals with FASD and their families, women of childbearing age and their partners, and individuals struggling with alcohol and substance issues.

Fetal Alcohol Spectrum Disorder (FASD) Coalition of York Region

1-877-464-9675 ext. 2015

A regional coalition of service providers that offers a bi-annual conference, periodic educational opportunities for professionals, parents and foster parents, an FASD resource library and a monthly parent/foster parent support group.

Geneva Centre for Autism

416-322-7877
autism.net

Offers a wide range of clinical services which are determined individually for each person with an autism spectrum disorder (ASD). All of the services are supported by a team of speech-language pathologists, behaviour analysts, therapists, early childhood educators, occupational therapists, developmental pediatricians, psychiatrists, psychologists and social workers.

Health Canada

1-800-622-6232
hc-sc.gc.ca

Health Canada is the federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances.

Fetal Alcohol Spectrum Disorder Diagnostic Clinic:
St. Michael’s Hospital

416-360-4000
fasdchildwelfare.ca

Uses a multi-disciplinary team approach to assess individuals of all ages: infants, children and adults. A pre-assessment process is used to determine if criteria for full assessment are met, and to ensure earlier entry into the diagnostic process. The clinic also offers a developmental clinic for infants, toddlers, and children up to seven years old.
Jewish Family and Child, York Region Branch
416-638-7800
jfandcs.com

Has a mandated responsibility for all Jewish children in the Greater Toronto Area, under the age of 16, who are in need of care, protection, and a permanent home. As a Children’s Aid Society, investigates all allegations or reports of child abuse, including neglect. Child welfare social workers are highly trained in recognizing evidence of abuse and in making the difficult decision to apprehend a child. When a child’s safety and well-being are at stake, they may make the decision to take that child into their care.

Kinark Child and Family Services
1-888-454-6275 (Central intake)
kinark.on.ca

A children’s mental health organization that provides help to children and youth, families and communities. Their mission states “caring, helping, healing - so children and youth can live socially and emotionally healthy lives.” Kinark supports children with Autism Spectrum Disorder and their families, as well as offering institutionally and community-based forensic services. Kinark also operates the Kinark Outdoor Centre in Minden Ontario providing programming, respite and therapeutic recreation.

Learning Disabilities Association of York Region
905-884-7933
ldayr.org

Provides information, support, guidance and resources to individuals five years and above with learning disabilities (LD) and attention deficit hyperactivity disorder (ADHD). They try to help people increase their opportunities and realize their potential. Furthermore they provide leadership in learning disabilities advocacy, research, education and services and in advancing the full participation of children, youth and adults with learning disabilities in today’s society.

Motherisk
Motherisk Helpline
416-813-6780 or 1-877-439-2744

Alcohol and Substance
1-877-327-4636

A clinical, research and teaching program at The Hospital for Sick Children in Toronto dedicated to antenatal drug, chemical, and disease risk counselling. Provides evidence-based information and guidance about the safety or risk to the developing fetus or infant, of maternal exposure to drugs, chemicals, diseases, radiation and environmental agents; information on the effects of medication and drugs for the breastfeeding mother and child; FASD diagnostic services.

Neonatal Follow-Up Clinics

Mackenzie Health:
905-883-1212 ext. 3069

Markham Stouffville Hospital:
905-472-7534

Southlake Regional Health Centre:
905-895-4521 ext. 5608

Available for infants and children in York Region at higher risk for development delay who require developmental follow-up. Clinics are available at all three York Region hospitals. The clinics are run in partnership with hospital staff and York Region Early Intervention Services. They are attended by a multi-disciplinary team including a physician (neonatologist or pediatrician), an early interventionist, and either a physiotherapist or occupational therapist. Clinic appointments include developmental screening, education/recommendations, and connections to appropriate services as required for the child’s first three years.
Ontario Association of Speech-Language Pathologists and Audiologists (OSLA)

1-800-718-6752 or 416-920-3676
osla.on.ca

Represents, promotes, and supports its members in their work on behalf of all Ontarians, especially those with communication disorders, swallowing difficulties, or hearing health care needs. OSLA provides a wide range of services, including provincial advocacy, promotion of the professions, educational opportunities, and professional resources. OSLA ensures that speech, language, swallowing, hearing and balance are recognized as part of total wellness. OSLA works with other professional associations and consumer organizations and is dedicated to ensuring Ontarians have access to the services provided by Audiologists and Speech-Language Pathologists.

Ontario Association of Optometrists

1-800-540-3837
optom.on.ca

Professional organization representing nearly 1,600 Doctors of Optometry in Ontario. Learn about vision and/or find a Doctor of Optometry by visiting the website.

Ontario Early Years Centres

Markham:
905-479-0002

Oak Ridges:
905-883-6901 or 1-866-297-9622

Thornhill:
905-709-6159

Vaughan-King-Aurora:
905-751-1011 or 1-866-404-2077

York North:
905-853-0754

centralhealthline.ca

Offer universal access to programs, information services and resources to families with children prenatal to six years, including for children with special needs. Staffed by experts, professionals and volunteers, including early literacy experts.

Ontario Early Year Centres York Region sites include Markham, Oak Ridges, Thornhill, Vaughan-King-Aurora, and York North. Each of these main sites has many satellite sites.

Ontario Ministry of Children and Youth Services (MCYS)

1-866-821-7770
children.gov.on.ca

The purpose of MCYS is to make it easier for families to find the services to give kids the best start in life, access the services they need at all stages of a child’s development, and help youth become productive adults.
The York Centre for Children, Youth and Families
905-737-8927
theyorkcentre.ca

An accredited children’s mental health centre providing day treatment and other mental health services to clients in York Region. There is no residential component to the services. The York Centre will provide a range of preventative, therapeutic and educational interventions developed in partnership with families and community resources.

Tri-Regional Blind- Low Vision Early Intervention Program
1-888-703-KIDS (5437)
childdevelopmentprograms.ca/vision/

Brochure:

Fact Sheet:
childdevelopmentprograms.ca/Tri-Regional-Blind-Low-Vision-Fact-Sheet

Supports families with children who are blind or have low vision. Families are given the resources they need to support the healthy development of their child in the first years of life from birth until they enter grade one. Partnerships have been developed with Canadian National Institute for the Blind (CNIB), and the Ontario Foundation for Visually Impaired Children (OFVIC), infant development and early intervention services as well as the network of pediatric ophthalmologists, optometrists and physicians across the region.

Tri Regional Infant Hearing Program
1-888-703-KIDS (5437)
childdevelopmentprograms.ca/hearing/

Brochure:

Fact Sheet:

A voluntary program funded by the Ontario Ministry of Children and Youth Services. Its goal is to identify permanent hearing loss in infants prior to 4 months of age and provide communication programming by 9 months of age. Early detection and intervention is critical to future language development.

The program provides:

- Hearing screening of all infants in hospital or in the family’s local community
- Audiology assessments of infants who receive a refer result from screening in order to rule out or identify a hearing loss
- Monitoring of infants who may be at risk for hearing loss
- Support to families of infants that have an identified hearing loss
- Communication programming for infants and toddlers who have permanent hearing loss including instruction in American Sign Language and Auditory Verbal Therapy or both prescriptions for assistive devices, if required.
York Region Health Connection
1-800-361-5653
york.ca/healthconnection

A free and confidential health information/education telephone service provided by public health nurses and inspectors. The health care professionals at Health Connection can provide you and your family with current health information and can provide support and counselling for your individual health related concerns and questions. Public health professionals offer confidential information and advice on public health-related topics, resources, services and other community programs, including: family health, infectious disease, sexual health, dental health, and health protection.

York Region Children’s Aid Society (CAS)
1-800-718-3850 or 905-895-2318
yorkcas.org

A non-profit organization whose mission is to work in partnership with our increasingly diverse community to protect children from abuse and neglect and provide a safe, secure and caring environment. CAS works to keep children safe and families together by providing child protection services 24 hours per day, seven days per week, engaging and supporting families at risk, in problem solving, linking with essential community services to ensure the best outcome, and providing prevention and awareness programs to keep children safe and families strong. The CAS goal is, whenever possible, to maintain a child in the home or with extended family, but if this is not viable, children are placed in safe, nurturing environments, including foster homes.

York Region Early Intervention Services (EIS)
1-888-703-5437 (KIDS)
york.ca/childrenservices/specialneedsservices

Available to families and children ages birth to school entry who are at risk of delayed development due to prematurity/low-birth weight, have delayed development, and have a condition such as cerebral palsy, autism or Down syndrome. EIS also provides the Preterm Care Pathways program to children born prematurely (37 weeks gestation or earlier). The different EIS programs will:

- Screen and assess children
- Help families understand their child’s growth and development
- Provide intervention programs
- Assist parents and caregivers to teach children new skills
- Provide occupational and/or physiotherapy consultation
- Offer play groups for children with special needs
- Promote and support participation in a community child care program
- Consult with and support child care providers
- Connect families with community resources
- Offer workshops for parents and caregivers of children with special needs
- Educate the community about developmental delays
- Work closely with school board staff to facilitate a smooth transition to elementary school
York Region Preschool Speech and Language Program (YRPSLP)

1-888-703-KIDS (5437)
childdevelopmentprograms.ca/speech-and-language/

Brochure:

Fact Sheet:
childdevelopmentprograms.ca/YRPSLP-Fact-Sheet

YRPSLP partners with York Region Early Intervention Services and Markham Stouffville Hospital — Child Development Programs (formally known as Beyond Words). Delivers programs which provide services to children from birth to junior kindergarten with a focus on prevention, early identification and treatment of speech and language, hearing, and vision. Programs include York Region Preschool Speech and Language, Tri-Regional Infant Hearing, and Tri-Regional Blind Low Vision.

York Region Breastfeeding Clinic

1-800-361-5653
TTY 1-866-512-6228
childfamily@york.ca
york.ca/healthconnection

Available at no cost for parents who live in York Region. Parents receive breastfeeding support one to one with a registered nurse who has breastfeeding expertise. Clinics are available throughout York Region by appointment.

York Region Public Health Dental Program — Healthy Smiles Ontario (HSO) Program

905-895-4512 or 1-800-735-6625
york.ca/dental

Dental Program provides services to promote the dental health of York Region residents, including health promotion for parents/caregivers, teachers, and students in the school community.

HSO Program provides no cost regular and urgent dental care for families in financial hardship with eligible children, 17 years of age and under.

York Region Public Health — Nutrition Services

1-877-464-9675 ext. 74335
york.ca/nutrition

Offers a range of nutrition programs, resources and services to promote healthy eating, access to healthy food and the development of supportive nutrition environments. Current and reliable information and fact sheets on a variety of nutrition topics including feeding babies and young children available on the website.

York Region Public Health — Quitting Smoking

1-800-361-5653
york.ca/tobacco

Offers supports and resources for quitting smoking.
APPENDIX C
A guide to screening

WHAT IS INVOLVED WHEN SCREENING FOR HEALTH, GROWTH OR DEVELOPMENT CONCERNS?

Screening young children is one way to gauge developmental progress and determine meaningful next steps.1 It is the act of identifying within a large group or population for which concerns have not yet been identified, those individuals who may have needs, issues, or risks that may compromise their healthy development, including parenting ability.2,3,4 Screening involves the use of a brief, inexpensive, standardized tool to identify potential health, growth and development concerns in an individual.5,6 It can be the first step to intervention and must occur early for intervention to be successful.2

What happens after screening?

Screening is the first step in helping to identify the “Red Flags” in development, health and growth for which the child/family may require intervention, and it helps ensure that children and families who need a full assessment receive one. A positive screen should be followed up with “assessment” through referral to professionals who can confirm or exclude the suspected delay or condition, and are able to provide the appropriate services and/or intervention.4 A full assessment can only be performed by a professional in the specific area of expertise.

In this guide, The Where to go for help section in each domain provides a list of the appropriate community resources to which a child/family may be referred for assessment. (See Appendix B for more detailed information on these community resources.)

What screening tools are available?

There are a multitude of available screening tools in Ontario. Some can be used by parents/caregivers while others are for professional use only. Appendix C-1 in this guide outlines a few of the childhood screening tools that are used in York Region. It is important to remember that screening tools assist in early identification of concerns, but cannot substitute for a full assessment by a qualified professional.4

Appendix C-1
Inventory of childhood screening tools used in York Region

Nipissing District Developmental Screen (ndds)

**Focus:** Eight Developmental Domains

1. Emotional
2. Fine Motor
3. Gross Motor
4. Learning and Thinking
5. Self-help
6. Social
7. Communication
8. Vision and Hearing

**Age Range:** 1 month to 6 years

The Nipissing District Development Screen (ndds) is a developmental checklist that follows a child from one month of age to six years. It provides a snapshot of a child’s development and can be completed by a parent, caregiver or professional.

If one or more “No” responses are made, a health care provider should be consulted.

This one-page developmental tool is easy-to-use, and features a detachable sheet of activities for enhancing a child’s development.

There are 13 ndds which are free for Ontario residents.

To access online or to order multiple checklists, please visit ndds.ca

The electronic Nipissing District Developmental Screen (endds) is an online version of the ndds that parents can use to register their child to get email reminders of when it’s time to take the next checklist. Included are tips, suggested activities and resources to help encourage their child’s development.

**Research:** A robust reliability and validation study of the new ndds was completed. A summary of the results are posted on ndds.ca

**Available Languages:**

ndds: English, French, Chinese, Spanish, Vietnamese, Arabic, Russian, Farsi

endds: English, French

NutriSTEP® and Nutri-eSTEP

Nutrition Screening Tools for Toddlers and Preschoolers

**Focus:** Nutrition, weight, feeding and swallowing

**Age Range:** 18 to 35 months, 3 to 5 years

To identify children at nutritional risk.

These tools screen for physical growth and development, weight concerns, food and fluid intake, physical activity, screen time, and factors affecting food intake such as responsive feeding and food security.

**For ages 18 to 35 months**

Toddler NutriSTEP® (print version) and Toddler Nutri-eSTEP (online version)

**For ages 3 to 5 years**

Preschooler NutriSTEP® (print version) and Preschooler Nutri-eSTEP (online version)

An order form for print copies of NutriSTEP® is available at: york.ca/wps/wcm/connect/yorkpublic/8ea76af6-53c0-4564-bce9-2864e32531c2/NutriSTEP+description+and+order+form.pdf?MOD=AJPERES

A Nutri-eSTEP flyer is available to download at: eatrightontario.ca/EatRightOntario/media/ERO_PDF/Promotional%20Material/Nutri-eSTEP-flyerE_2014.pdf

NutriSTEP® is embedded into some Electronic Medical Record (EMR) systems.

For detailed information visit: NutriSTEP.ca

Dental Screening

Focus: Dental and Oral Health

Age Range: 17 years and under

This screening is a quick visual inspection by a dental hygienist to see if an obvious dental condition exists and to identify children at risk for Early Childhood Caries (ECC).

As determined by Ontario Public Health Standards 2016, Child Health Standard as per Oral Health Assessment and Surveillance protocol


Available Languages: English

Dental Screening Tool
Healthy Teeth Healthy Kids

Focus: Dental and Oral Health

Age Range: 18 to 36 months

Early identification of children at risk for or having dental caries (oral diseases and/or disorders).

To help monitor child’s dental development. It also provides dental health care tips.

This tool represents an oral health supplement to the Nipissing District Developmental Screen (ndds)

Research: Validity and reliability testing were conducted. For full details refer to:


Ages and Stages Questionnaire®
(ASQ-3) and Ages and Stages Social Emotional Questionnaire® (ASQ:SE-2)

Focus: Communication, Gross motor, Fine motor, Problem-solving, Personal Social skills

Age Range: 1 month to 5 ½ years of age

A screening and monitoring tool designed to identify infants and children who may require further assessment for possible developmental delays.

ASQ provides reliable, accurate developmental and social-emotional screening for children between birth and age 6. Drawing on parents’ expert knowledge, ASQ has been specifically designed to pinpoint developmental progress and catch delays in young children—paving the way for meaningful next steps in learning, intervention, or monitoring.

ASQ-3 is a low-cost, reliable tool for screening infants and young children for developmental delays.

ASQ:SE-2 is a low-cost, reliable tool for screening infants and young children for social-emotional delays.

Research: Reliability studies completed on the ASQ-3 include test–retest reliability, and inter-observer reliability. In addition, internal consistency of ASQ-3 items was examined using correlational analyses and Cronbach’s coefficient alpha (Cronbach, 1951). For full details refer to: Squires J, Twombly MS, Bricker D. ASQ-3 User’s Guide. Baltimore, MD: Paul H. Brookes Publishing Co; 2009.

Available Languages: English
**ERIK: Early Referral Identification Kit**

- Cognitive delays
- Emergent literacy delays
- Feeding difficulties
- Fine and gross motor delays
- Hearing loss
- Language delays and disorders
- Sensory difficulties
- Social skills difficulties
- Speech and language delays (including motor speech disorders, articulation delays: stuttering; voice disorders)

**Age Range:** 6 months to 4 years

A developmental screening tool for early identification and referral of children at risk for developmental delays to York Region Early Intervention Services and York Region Preschool Speech and Language Program.

Norms and *Red Flags* have been drawn from existing screening tools to form the ERIK.

A parent-friendly ERIK Growth Chart has been developed based on ERIK. This allows parents to track their children’s height as well as development and make referrals when necessary. Norms are listed for children at 6, 9, 12, 18, 24, 30, 36 and 48 months. It includes *Red Flags* for children aged 16 months and older.

ERIK Growth Charts may be ordered through [childdevelopmentprograms.ca](http://childdevelopmentprograms.ca)

To download ERIK:
[childdevelopmentprograms.ca/resource_category/referral-forms/](http://childdevelopmentprograms.ca/resource_category/referral-forms/)

**Research:** Not available

**Available Languages:** English