

SAMPLE ASQ-SE2 (Social Emotional) Referral GUIDANCE

Children birth to three in family home visiting programs

Caregivers are a necessary part of each screening and decision making step. Collaboration with the caregiver begins when introducing the Social Emotional screening tool, ASQ-SE 2nd Edition, explaining the tool, how an agency handles the results, how scores are shared and how the caregiver(s) will get results. This includes informing the caregiver(s) about how to answer the questions in the questionnaire and collaborating with them about options that are available after screening. There are often misunderstandings about what social-emotional development looks like in young children and what a social-emotional screening will indicate.

These misunderstandings may include:

- That screening will result in a diagnosis, the home visitor suspects a problem or the family will be forced into a referral.
- Those results may mean the caregiver is a 'bad' parent.
- That a social-emotional concern means the child is mentally ill, autistic, etc.
- That this is a life-long diagnosis and that the screening will go on the child's school record.
- That screening starts at preschool age/three years old.
- That a child will 'grow out' of it or conversely not knowing that there are home activities that help children grow.

Alternative messages include:

- We screen all children. "Think of this like you do when the Doctor checks your child's height, weight, etc."
- "Social-emotional development in children is a range of typical behaviors and no two children are alike in how they grow the same as other development (i.e. some children are better at sports, some talk earlier, etc.)."
- The ASQ-SE2 will help us identify strengths of your child.
- The ASQ-SE2 will help us look at activities and resources that will support your child in their growth.
- The screening might identify what the child is not doing YET. Then we will work together to see what is a next step.
- There is no 'cheating' on the ASQ, it is OK to practice skills with your child and we can watch as he/she grows!

Universal Screening:

MDH Family Home Visiting Section recommends universal screening for child development, child's social-emotional growth, parent/caregiver depression, intimate partner violence (domestic violence or IPV), chemical and tobacco use and home safety. Universal screens increase screening rates for hard to reach, vulnerable and under-detected populations. Screening reinforces parent and child strengths and supports the home visitor in strategizing planning for visits and interventions.

- Home visiting model, agency protocol and the screening tool used are all considerations when considering when to screen (referred to as periodicity).
- Home visitors might also consider screening between intervals if professional judgement indicates it is needed or previous screens indicate a need for monitoring.
- Part of implementing a screening program is preparing for referrals by developing a referral network and protocol for home visitors.

The words **screening** and **assessment** are often used inter-changeably. For purposes of these materials, screening is short in length, quick to administer and score, and typically identifies if there is a need for further evaluation. Screening results can be used by the home visitor to collaborate with the family to set goals, plan for activities and develop resources to strengthen parenting skills.

Assessment is comprehensive and may be used by health care providers to diagnose a health condition or by other specialists to plan for treatment or intervention services.

Two considerations when approaching caregivers and setting up screening programs:

1. Check with each caregiver to see if the child has been screened, receiving services or if there is already an Individual Family Service Plan (IFSP) done by Early Childhood Special Education (ECSE) within the last 12 months. If there is an IFSP, obtain a release and contact the provider instead of screening. Partner with ECSE or other programs serving the family that will help you in planning for home visits and interventions.
2. Understand the differences in Part C (birth to 3) versus Part B619 (child 3 or older): Eligibility for early intervention is less stringent in Part C. Within 45 calendar days of referral, Early Childhood Special Education (ECSE) is required to contact the parent, evaluate the child and develop an Individual Family Service Plan (IFSP) if indicated at assessment. Services for children birth to three are offered year around under Part C of IDEA (Individuals with Disabilities Education Act). If a screen indicates a referral, then a referral should be offered. (See section: Option No Referral or Services for what to do when a parent declines a referral.)

Training Home Visitors

Developing a plan for staff training has the benefit of increasing accuracy, effecting professional credibility with referral agencies, supporting parent understanding of child, increasing screening rates, positive approaches to families and supporting development of home visiting interventions. This may be through formal training or shadowing/mentoring by another staff. Components to consider when training staff who have not used the ASQ before:

- Formal training with a Brookes trained instructor, which includes accurately choosing and scoring the ASQ-SE2.
- Practice introducing the tool to caregiver. Introducing the concept of social-emotional growth in children and explaining the questionnaire itself can be challenging. Review important tips, the meaning of often/always, sometimes and rarely/never. Include how the results are shared with them, confidentiality and how data will be used.

- Job Shadowing: observing an ASQ in a home visit. Debrief after the screening.
- Review the programs referral resources, ensuring the home visitor knows how a referral to each agency works.
- **Accuracy:** There is some evidence that mistakes are made by screeners in choosing the correct age questionnaire and scoring. Review choosing the correct questionnaire and adjusting for prematurity. (Its highly recommended to use [Ages Stages Prematurity and Omitted Items Calculator](#) for calculating age to increase accuracy)
- Practice scoring when there are omitted items (See page 92 of Brooke’s SE2 User’s Manual when there are 3 or more omitted items).
- Practice approaching parents with results.
- Review program documentation and periodicity procedures.
- Review program recommendations about who to consult with when making referral decisions. (supervisors, managers, team leaders, or consultants)
- Review program protocol for sharing screening results when there is an active Child Protection case.

Partner with the local early childhood community:

Identify who else is screening in your community: Child Protection Services, Early Head Start, Clinics, non-profits, etc. Develop a protocol for sharing screening results, periodicity schedules and minimizing overlapping screenings on the same child.

Develop referral resources:

It is often difficult to discuss a social-emotional referral with caregiver(s). It is important to know local referral resources and have a relationship with them. What is their periodicity schedule? How can we share screening results between agencies? Include guidelines for a two-way consent to release information. If you know something about the provider that you can share—their philosophy, demeanor, expertise, billing—a family may be reassured. It might be beneficial to offer to join the parent in contacting the referral agency, send a letter or summary sheet or make the referral for them.

For social emotional screening, consider a ‘Triple Referral’ model:

Medical:

Since young children don’t tell us what is going on, include a medical evaluation to eliminate a medical condition (such as ear infections). Depending on the health care provider, they can make a referral covered by health insurance for therapies (ex: physical therapy) and tests (such as hearing). Health Care Providers and other professionals are allowed by Minnesota Early Intervention Part C to offer an informed clinical opinion for children under 3 years old when referring for assessment. When approaching a health care provider, it is important to understand that a pediatrician impression alone (without screening) fails to timely identify and refer 60-80% of children with developmental delays. According to AAP surveys, only 48% used a tool in 2009.¹ When developing resources, consider asking:

- Does the child have a primary health care provider?

¹ From (The Importance of Social & Emotional Screening <http://www.urbanchildinstitute.org/articles/updates/the-importance-of-social-and-emotional-screening>)

- How do local health providers handle social-emotional screening and referrals?
- Do they screen using a tool?
- Are they familiar with the ASQ-SE2 tool and accuracy?
- Will they accept a copy of the summary sheet or a letter with a two-way consent for release of information?
- What local referral options do they use when they make a referral for further evaluation or treatment?
- What are the costs and insurance coverage?

Educational:

A referral may be made through Help Me Grow (HMG) [Minnesota Help Me Grow](#) or directly to the local school district for Early Intervention (EI) assessment. Questions to explore:

- Does the parent initiate the contact or might a home visitor? (HMG has a referral portal and score sheets can be attached).
- How will the parent and the agency be notified if there are no concerns?
- How will they be notified if there are concerns?
- What is the process for including home visiting programs who are working with the parent? Will they be included in the Individual Family Service (IFS) plan meeting or home visit? Birth to three services occur with the parent present and often in the home, it makes sense to collaborate on developing a plan with the caregiver(s).
- EI through the school districts is free in Minnesota. If using other types of agencies, gather information on costs.

Mental Health:

Contact your region's local mental health providers, including health care providers who offer mental health counseling and independent resources. Consider the questions included in Medical and Educational referrals above. Gather information about billing and intake. Ask if they will go into the home. It is preferred to use a certified Infant Mental Health (IMH) Provider who has been trained to treat the child, the caregiver AND the relationship between child and caregiver. A list of IMH providers who serve families birth to three from the Department of Human Services (DHS) [MN Dept of Human Services list of Infant Mental Health Providers](#) who might be included in an agencies list of resources.

If an IMH provider is not available locally, then help the caregiver(s) find a licensed mental health provider.

TIPS: When talking to referral resources, talk about your target population. There can be a range of beliefs and practices pertaining to caregiving and mental health issues, so educating your program and the referral resource about the target community is an important step in developing referral resources.

A Triple referral may not be possible in your region or with the type of insurance that the caregiver has, it is important to know what is viable in your region before making a plan.

- Discuss ways that both agencies can collaborate to reduce barriers to services.
- Are they on a bus line or is transportation needed or available?
- Can they bring their child? If not, does the caregiver have resources for childcare?
- Include non-traditional resources for caregiver support. These may be community groups, support groups, church groups, elders, etc.
- Is there a translator available? When using an interpreter, consider preparing the translator before screening; information about social-emotional screening and the ASQ tool, giving the parent sufficient time given to understand items, identify culturally inappropriate items and reviewing consent and confidentiality. It is best not to use a family member and to talk directly to the caregiver(s) and not the interpreter.
- Immigration status may be undocumented or pending application so payment through a Health Provider may not be an option. Non-traditional resources may apply to this situation.
- Are services sensitive to poverty and/or culture if not offered by culturally specific providers?

Whatever the reason for the referral, it is important that the home visitor has discussed the need and reason for the referral. If the family can help choose who the referral would go to, based on past experience, culture or knowledge of the community resources, that should be encouraged. It is important to discuss with the family the referral process and confidentiality. Should the family make the first contact, will the home visitor or will the referral be made together? Is there another screening or assessment that would occur? Is there a cost involved? Should insurance be contacted? When a caregiver(s) voluntarily understands the reason for the referral, who the referral will be made to, and the process involved, the referral is more likely to achieve the desired outcome.

Home Visitor Role:

After discussion about ASQ SE2 results with the family, a collaborative decision is made about referral. Reasons that may factor into making a referral can include:

- The ASQ SE2 scores fall into the referral zone even if the child was previously on schedule;
- The ASQ SE2 falls into the monitor zone and the ASQ-3 or parent indicates concerns;
- There is a current IFSP and services are in place.
- The caregiver does not want a referral. (See Option: No Referral)
- The family makes a request for a referral or there are caregiver concerns even when the ASQ SE2 scores are in the typically developing or monitor zones.
- The home visitor feels that it is outside of the scope of his practice or expertise and would like to recommend another professional view.
- The family prefers to discuss the issue with someone else.

- The professional judgement of the home visitor leads them to raise the recommendation to the caregiver for a referral.
 - During your conversation with the parent, be ready to ‘let go’ of plans, you may have developed. ‘Meet’ the caregiver(s) wherever they are in the process.
 - Respond to their concerns. Include in your discussion:
 - Your agencies protocol, confidentiality and release of information as pertains to referrals.
 - Options for the caregiver, ideally a combination of options representing the 3 ‘legs’ of a triple referral.
 - Consider depression screening if your professional judgement warrants depression screening or screening periodicity requires it.
- If caregiver discloses other considerations such as Intimate Partner/Sexual Violence, Mental Illness, Chemical Abuse, etc., discuss treatment/safety planning options around those issues and development of a support network.
- Discuss treatment priorities for the family. Ideally, referrals include both the child and caregiver(s), but this might not be realistic given your local resources and the family situation.
- Inform families that they may have someone one with them when they meet with the EI or ECSE team to receive information about their assessment. If your program allows, offer to go with the caregiver(s) to be another set of ears that will listen and support them during this process.

ASQ-SE2 Cutoffs:

Refer to the ASQ-SE2 Algorithm for a visual about follow up planning, Consider options that will include both the caregiver, child and family

Below Cutoff:

- Screening is negative for social emotional concerns (white area of summary sheet)
- If there are no caregiver concerns, provide social emotional and parent education activities. Rescreen on normal periodicity schedule
- If there are caregiver concerns: discuss concerns and strengths. Explore monitor or referral zone options.
- Review ASQ-3 scores

Monitor Zone:

- Score is in the monitor zone (gray area of summary sheet)
- Review Scoring accuracy (see page 3: Training Home Visitors: Accuracy) and Factors to Consider (Health/Culture/Environment/Time-Setting): [Ages Stages Factors to Consider](#)
- If the scores are inaccurate or considerations apply, then the screen is invalid. Re-screen
- If the screening is valid:
 - And, YES, there are caregiver concerns: Discuss with caregiver and include strengths to build on.
 - Or, NO, there are no caregiver concerns: Use professional judgement and partner with the caregiver to plan next steps for building on strengths and addressing concerns:

- Review ASQ-3 scores (valid if screened within last 6 months)
- Prepare for conversation. Think about:
 - Review the importance of a referral and offer a referral in partnership with caregiver(s). See referral guidance for expanded information and situations where a referral might be warranted.

AND:

- Offer parent education and child activities.
- Coach caregiver(s) around routines, transitions and other challenges
- Consider increasing contact through text-check-ins or frequency of home visits
- Partner with caregiver(s) in developing a support network including parent education groups, family, friends, non-traditional; culturally specific, community or church groups
- Continue observing parent/child interaction, offer and use your professional judgement to build on strengths and monitor concerns.
- Rescreen in 2 months if there is a concern, no referral made or the child/caregiver(s) are not eligible for services

Above Cutoff:

- Review Scoring accuracy and Factors to Consider (Health/Culture/Environment/Time-Setting)
- If the scores are inaccurate or considerations apply, then the screen is invalid. Re-screen
- If the screening is valid:
 - Review the importance of a referral and offer a referral in partnership with caregiver(s) if in the referral zone or in monitor zone with parent concerns. See referral guidance for expanded information and situations where a referral is warranted.

AND:

- Offer parent education and child activities.
- Coach caregiver(s) around routines, transitions and other challenges
- Consider increasing contact through text-check-ins or frequency of home visits
- Partner with caregiver(s) in developing a support network including parent education groups, family, friends, non-traditional; culturally specific, community or church groups
- Continue observing parent/child interaction, offer and use your professional judgement to build on strengths and monitor concerns.
- Rescreen in 2 months if there is a concern, no referral made or the child/caregiver(s) are not eligible for services

Program Reimbursement:

Providers that meet the instrument-specific criteria for administering the screening tool as outlined by the publisher may perform developmental screenings. Depending on the tool, program reimbursement may include physicians, nurse practitioners, physician assistants,

nurses, medical assistants or other appropriately trained staff. Regulations for reimbursement may differ for the Indian Health Service (HIS). [MN Department of Human Services Provider Manual Child and Teen Checkups.](#)

Resources:

Refer to the ASQ-SE2 Algorithm for a quick visual about follow up planning.

- **Help Me Grow:** [MN Help Me Grow](#)
- **Zero to Three:** Topics for professionals and parents: <https://www.zerotothree.org/>
- **Center for Disease Control:** Learn the signs. Act Early: <http://www.cdc.gov/ncbddd/actearly/milestones/milestones-in-action.html>
- **The American Academy of Pediatrics:** Information for Parents, a trusted resource and has a free app to download for Androids. [Healthy Children Org](#)
- **Factors to Consider when interpreting ASQ results** (Health/Biologic, Family/Culture, Environment, Setting/Time and Parent Concerns) [Ages Stages Factors to Consider](#)
- **Infant Mental Health Providers:** [MN DHS Infant Mental Health Providers](#)
- **9 Best Practices for Using an Interpreter** <http://agesandstages.com/free-resources/articles/best-practices-for-using-an-interpreter-for-asq-completion/>



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