



Red Flags — for children birth to six years

**A quick reference guide for
early years professionals**

Early Identification in
Leeds, Grenville & Lanark



Adapted November 2007

RED FLAGS: Table of Contents

▶ Red Flags Introduction	
• Red Flags Committee	1
• Early Identification	2
• What is “Red Flags”?	2
• Who Should Use “Red Flags”?	2
• How to use this document.....	2
• Sensitive Issues.....	3
▶ Duty to Report.....	5-7
▶ Growth & Development:	
• Attachment.....	8
• Fine Motor.....	9
• Gross Motor	10
• Vision.....	11
• Hearing.....	13
• Sensory.....	14
• Speech & Language	15
• Literacy & Numeracy	18
• Social/Emotional.....	20
• Behaviour	21
▶ Nutrition & Oral Health:	
• Nutrition	22
• Feeding & Swallowing.....	24
• Dental.....	25
▶ Abuse:	
• Witnessing Family Violence.....	26
• Physical.....	28
• Sexual	29
• Emotional	30
• Neglect.....	31
▶ Special Needs:	
• Autism	32
• Fetal Alcohol Spectrum Disorder	33
• Learning Disabilities.....	34
• Intellectual & Developmental Disabilities	35
• Mild Traumatic Brain Injury	36
▶ Other Factors:	
• Family Environmental Stressors	37
• Postpartum Depression.....	38
▶ Getting Ready for Kindergarten.....	39
▶ Subsidy Information.....	40
▶ Where to Go for Help	41

Disclaimer Notice

Red Flags is a Quick Reference Guide designed to assist early years professionals in deciding whether to refer for additional services. **It is not a formal screening or diagnostic tool.**

The information contained in “Red Flags for children, birth to six years” (this document) has been provided as a public service. Although every attempt has been made to ensure accuracy, no warranties or representations, expressed or implied, are made concerning the accuracy, reliability or completeness of the information contained in this document. The information in this document is provided on an “as is” basis without warranty or condition.

This document cannot substitute for the advice and/or treatment of professionals trained to properly assess the development and progress of children, birth to six years. Although this document may be helpful to determine when to seek out advice and/or treatment, this document should not be used to diagnose or treat perceived developmental limitations and/or other health care needs.

This document also refers to websites and other documents that are created or operated by independent bodies. These references are provided as a public service and do not imply the investigation or verification of the websites or other documents. No warranties or representations, expressed or implied, are made concerning the products, services and information found on those websites or documents.

This document is being provided for your personal non-commercial use. This document, or the information contained herein, shall not be modified, copied, distributed, reproduced, published, licensed, transferred or sold for a commercial purpose, in whole or in part, without the prior written consent of the Red Flags Committee, which consent may be withheld at the sole discretion of Red Flags Committee or be given subject to such terms and conditions as Red Flags Committee may, in its sole discretion, impose.

INTRODUCTION TO RED FLAGS

RED FLAGS COMMITTEE

The original Red Flags document was developed by the Simcoe County Early Intervention Council and piloted in 2002. It was printed and disseminated by the Healthy Babies Healthy Children program, Simcoe County District Health Unit as *Red Flags - Let's Grow With Your Child* in March 2003.

Since that time York Region Early Identification Planning Coalition and the Kingston, Frontenac and Lennox & Addington Red Flags Committees have reviewed and revised the original document.

With permission of the Kingston, Frontenac and Lennox & Addington (KFLA) Red Flags Committee, the KFL&A Red Flags document was reviewed and revised by the School Readiness Sub-Committee of the Healthy Babies Healthy Children Coalition of the Leeds, Grenville and Lanark District Health Unit and other early years professionals who serve children in Leeds, Grenville and Lanark. The School Readiness Committee consists of members from:

Brockville and Area YMCA; Catholic District School Board of Eastern Ontario; Children's Resource on Wheels; Connections Program; Developmental Services of Leeds and Grenville-Inclusive Child Care Program; Healthy Babies Healthy Children Program; Infant & Child Development Programs; Lanark County Childcare Providers; Lanark Early Integration Program; Lanark Ontario Early Years Centres-Early Literacy Specialist and Data Analysis Coordinator; Leeds, Grenville and Lanark District Health Unit; North Lanark County Community Health Center; Open Doors for Lanark Children and Youth; The Language Express © Preschool Speech-Language Service System; United Counties of Leeds and Grenville-Ontario Early Years Centres, Early Literacy Specialist and Data Analysis Coordinator; and the Upper Canada District School Board.

Acknowledgments:

The Leeds, Grenville and Lanark District Health Unit would like to acknowledge the following for their contributions to the resource:

Angèle Blaskie, Lanark Early Integration Program

Kathy Boelsma, Early Literacy Specialist, Lanark

Shannon Brown, Early Literacy Specialist, Ontario Early Years Centre, United Counties of Leeds and Grenville

Jill Brulé, Home Visiting Coordinator, Connections Program, Lanark

Rebecca Carnochan, Open Doors for Lanark Children and Youth

Emily Cassell, Data Analysis Coordinator, Lanark

Jessica Deschamp-Baird, Data Analysis Coordinator, United Counties of Leeds and Grenville

Darleen Desgens, Healthy Babies Healthy Children Program Assistant, Leeds, Grenville and Lanark District Health Unit

Fiona Dufour, Public Health Nurse, Leeds, Grenville and Lanark District Health Unit

France Dupuis, Catholic District School Board of Eastern Ontario

Laurie Ann Glenn, Nurse Practitioner, Primary Health Care, North Lanark County Community Health Center

Jane Hess, Director of Family Health, Leeds, Grenville and Lanark District Health Unit

Rebecca Langin, Administrative Coordinator, The Language Express© Preschool Speech - Language Service System

Dixie O'Reilly, Infant & Child Development Program, Leeds and Grenville

Catherine Robinson, Clinical Coordinator, The Language Express© Preschool Speech-Language Service System

Rosemary Sheahan, Healthy Babies Healthy Children Coordinator, Leeds Grenville and Lanark District Health Unit

Oksana Shewchenko, Production Artist, Leeds Grenville and Lanark District Health Unit

Shona Stewart, Inclusive Child Care Program-Developmental Services of Leeds and Grenville

Funding:

Healthy Babies Healthy Children, Leeds, Grenville and Lanark District Health Unit

In-Kind-Committee community partner agencies listed above

For further information, additional copies, to suggest revisions to this document, or for information on sources used, please contact the Leeds, Grenville and Lanark District Health Unit at 613-345-5685 or 1-800-660-5853 or forward an email to: redflags@healthunit.org

Early Identification

Thanks to Dr. Fraser Mustard and other scientists, most professionals working with young children are aware of the considerable evidence about early brain development and how brief some of the “windows of opportunity” are for optimal development of neural pathways. The early years of development from conception to age six, particularly for the first three years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life ¹.

It follows, then, that children who may need additional services and supports to ensure healthy development must be identified as quickly as possible and referred to appropriate programs and services. Early intervention during the period of the greatest development of neural pathways, when alternative coping pathways are most easily built, is critical to ensure the best outcomes for the child. Time is of the essence!

What is Red Flags?

Red Flags is a quick reference guide for Early Years professionals. It can be used in conjunction with a validated screening tool, such as Nipissing District Developmental Screens (the Nipissing Screen ²) or Ages and Stages Questionnaire (ASQ). Red Flags outlines a range of functional indicators or domains commonly used to monitor healthy child development, as well as potential problem areas for child development. It is intended to assist in the determination of when and where to refer for additional advice, formal assessment and/or treatment.

Who should use Red Flags?

This quick reference guide is intended to be used by any professional working with young children and their families. A basic knowledge of healthy child development is assumed. Red Flags will assist professionals in identifying when a child could be at risk of not meeting his health and/or developmental milestones, triggering an alert for the need for further investigation by the appropriate discipline.

How to use this document

This is a quick reference to look at child development by domain, reviewing each domain from birth to six years (unlike screening tools that look at a particular child’s development across many areas of development at a specific age). It includes other areas that may impact child health, growth and development due to the dynamics of parent-child interaction, such as postpartum depression, abuse, etc.

Red Flags allows professionals to review and better understand domains on a continuum that are traditionally outside their own area of expertise. This increased awareness will help professionals better understand when and where to refer for further investigation or treatment.

Use Red Flags in conjunction with a screening tool, such as Nipissing District Developmental Screens or Ages Stages Questionnaire (ASQ) to review developmental milestones and problem signs in a particular domain or indicator. Some information is cross-referenced to other domains, such as speech with hearing, to assist the screener in pursuing questions or ‘gut feelings.’

If children are not exhibiting the milestones for their age, further investigation is needed. If using Nipissing District Developmental Screens, remember that the screening tools are age-adjusted; therefore, the skills in each screen are

Footnotes

1. Early Years Study: reversing the real brain drain, Hon. Margaret McCain and Fraser Mustard, April, 1999. See report at www.eldis.org/.
2. Nipissing District Developmental Screens refer to 13 parent checklists available to assist parents to record and monitor development of children from birth to age 6. The screens cover development related to vision, hearing, communication, gross and fine motor, social/emotional and self-help and offers suggestions to parents for age appropriate activities to enhance child development. Parents are encouraged to call the Health Action Line of the Leeds, Grenville and Lanark District Health Unit at 1-800-660-5853 if two or more items are checked ‘No’. A public health nurse will review the results of the screen and suggest next steps. It is particularly important for a screen to be reviewed by a professional if a problem is identified. For additional information about Nipissing District Developmental Screens or to obtain copies, visit the website at www.ndds.ca

expected to be mastered by most children at the age shown. If there are two or more “No” responses, refer to a professional for assessment.

Refer for further assessment even if you are uncertain if the flags noted are a reflection of a cultural variation or a real concern.

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

Contact information is indicated at the end of the document in the “Where to Go for Help” section.

If a child appears to have multiple domains requiring formal investigation by several disciplines, screeners are encouraged to refer to the agencies that can coordinate a collaborative and comprehensive assessment process.

If referrals are made to private sector agencies, alert families that fees will not be funded by OHIP.

How to Use Red Flags

Service providers may contact any agency for general information. If a specific case will be discussed, ensure consent to share information is obtained in accordance with the Ontario Privacy of Personal Information Act.

Step 1: Identify area of concern.

Step 2: Speak to parents about your concerns.

Step 3: Call agency in the “Where to Go for Help” section for additional advice.

Step 4: Encourage parents to call agency in the “Where to Go for Help” section to initiate a referral.

Sensitive Issues

One of the most difficult parts of recognizing a potential difficulty in a child’s development is sharing these concerns with the parents/guardians. It is important to be sensitive when suggesting that there may be a reason to have further assessment done. You want parents/guardians to feel capable and to be empowered to make decisions. There is no one way that always works best, but there are some things to keep in mind when addressing concerns.

- ▶ Be sensitive to a parent/guardian’s readiness for information. If you give too much information when people aren’t ready, they may feel overwhelmed or inadequate. You might start by probing how they feel their child is progressing. Some parents/guardians have concerns, but have not yet expressed them. Having a parent use a tool such as the Nipissing District Developmental Screen may help open the way for discussion. It may help to specify that the screening tool is given to parents to help them look at their child’s development more easily and to learn about new activities that encourage growth and development.
- ▶ Be sure to value the parent’s/guardian’s knowledge. The ultimate decision about what to do is theirs. Express what it is that you have to offer and what they have to offer as well. You may say something like: “I have had training in child development, but you know your child. You are the expert on your child”. When you try to be more of a resource than an “authority”, parents/guardians feel less threatened. It is best to have the parents/guardians discover how their child is doing and decide whether or not extra help would be beneficial. You may want to offer information you have by asking parents/guardians what they would like to know.
- ▶ Have the family participate fully in the final decision about what to do next. The final decision is theirs. You provide only information, support and guidance.

- ▶ Give the family time to talk about how they feel, if they choose to. If you have only a limited time to listen, make this clear to them, and offer another appointment if needed.
- ▶ Be genuine and caring. You are raising concerns because you want their child to do the best that he can, not because you want to point out “weaknesses” or “faults”. Approach the opportunity for extra help positively; “You can get extra help for your child so he will be as ready as he can be for school”. Also try to balance the concerns you raise with genuine positives about the child (e.g., Johnny is a real delight. He is so helpful when things need tidying up. I have noticed that he seems to have some trouble . . .).
- ▶ Your body language is important; parents may already be fearful of the information.
- ▶ Don’t entertain too many “what if” questions. A helpful response could be, “Those are good questions. The professionals who will assess your child will be able to answer them. This is a first step to indicate if an assessment is needed”.
- ▶ Finally, it is helpful to offer reasons why it is not appropriate to “wait and see”:
 - Early intervention can dramatically improve a child’s development and prevent additional concerns such as behaviour issues.
 - The wait and see approach may delay addressing a medical concern that has a specific treatment.
 - Early intervention helps parents understand child behaviour and health issues, which will increase confidence that everything possible is being done to ensure that the child reaches his full potential.



DUTY TO REPORT

Ontario's *Child and Family Services Act* (CFSA) provides for a broad range of services for families and children, including children who are or may be victims of child abuse or neglect.

- ▶ The paramount purpose of the Act is to promote the best interests, protection and well being of children.
- ▶ The Act recognizes that each of us has a responsibility for the welfare of children. It states clearly that members of the public, including professionals who work with children, have an obligation to report promptly to a children's aid society if they suspect that a child is or may be in need of protection.
- ▶ The Act defines the term "child in need of protection" and sets out what must be reported to a children's aid society. This definition (CFSA s.72(1)) is set out in detail on the following pages. It includes physical, sexual and emotional abuse, neglect and risk of harm.

This section summarizes reporting responsibilities under Ontario's Child and Family Services Act. It is not meant to give specific legal advice. If you have questions about a given situation, you should consult a lawyer or your local children's aid society.

Duty to Report

Responsibility to report a child in need of protection CFSA s.72(1)

If a person has reasonable grounds to suspect that a child is or may be in need of protection, the person must promptly report the suspicion and the information upon which it is based to a children's aid society.

The situations that must be reported are listed in detail below.

Child and Family Services Act CFSA s.72(1)

Despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society.

The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's failure to adequately care for, provide for, supervise or protect the child, or pattern of neglect in caring for, providing for, supervising or protecting the child.

There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's failure to adequately care for, provide for, supervising or protecting the child.

The child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.

There is a risk that the child is likely to be sexually molested or sexually exploited as described in paragraph 3.

The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment.

The child 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 that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

The child has suffered emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.

There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and that the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm.

The child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, treatment to remedy or alleviate the condition.

The child has been abandoned, the child's parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody.

The child is less than 12 years old and has killed or seriously injured another person or caused

serious damage to another person's property, services or treatments are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, those services or treatment.

The child is less than 12 years old and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately.

Ongoing duty to report ***CFSA s.72(2)***

The duty to report is an ongoing obligation. If a person has made a previous report about a child, and has additional reasonable grounds to suspect that a child is or may be in need of protection, that person must make a further report to a children's aid society.

Persons must report directly ***CFSA s.72(3)***

The person who has the reasonable grounds to suspect that a child is or may be in need of protection must make the report directly to a children's aid society. The person must not rely on anyone else to report on his or her behalf.

What are "reasonable grounds to suspect?"

You do not need to be sure that a child is or may be in need of protection to make a report to a children's aid society. "Reasonable grounds" are what an average person, given his or her training, background and experience, exercising normal and honest judgment, would suspect.

Special responsibilities of professionals and officials, and penalty for failure to report ***CFSA s.72(4), (6.2)***

Professional persons and officials have the same duty as any member of the public to report a suspicion that a child is in need of protection.

The Act recognizes, however, that persons working closely with children have a special awareness of the signs of child abuse and neglect, and a particular responsibility to report their suspicions, and so makes it an offence to fail to report.

Any professional or official who fails to report a suspicion that a child is or may be in need of protection, where the information on which the suspicion is based was obtained in the course of his professional or official duties, is liable on conviction to a fine of up to \$1,000.

Professionals affected **CFSA s.72(5)**

Persons who perform professional or official duties with respect to children include the following:

- health care professionals, including physicians, nurses, pharmacists and psychologists;
- teachers and school principals;
- social workers and family counsellors;
- priests, rabbis and other members of the clergy;
- operators or employees of day nurseries;
- youth and recreation workers;
- peace officers and coroners;
- solicitors;
- service providers and employees of service providers; and
- any other person who performs professional or official duties with respect to a child.

This list sets out examples only. If your work involves children but is not listed above, i.e., a volunteer or student, you may still be considered to be a professional for purposes of the duty to report. If you are not sure whether you may be considered to be a professional for purposes of the duty to report, contact your local children's aid society, professional association, or regulatory body.

Professional confidentiality **CFSA s.72(7),(8)**

The professional's duty to report overrides the provisions of any other provincial statute, specifically, those provisions that would otherwise prohibit disclosure by the professional or official.

That is, the professional must report that a child is or may be in need of protection even when the information is supposed to be confidential or privileged. (The only exception for "privileged" information is in the relationship between a solicitor and a client.)

Protection from liability **CFSA s.72(7)**

If a civil action is brought against a person who made a report, that person will be protected unless he acted maliciously or without reasonable grounds for his suspicion.

What will the children's aid society do?

Children's aid society workers have the responsibility and the authority to investigate allegations and to provide services to protect children.

A children's aid society worker may, as part of the investigation and plan to protect the child, involve the police and other community agencies.

WHERE TO GO FOR HELP

If you have concerns about a child, please call your local children's aid society immediately. All CASs have emergency service 24 hours a day, so you can call anytime.

Lanark County: Children's Aid Society,
613-264-9991 or 1-866-664-9991.

Leeds and Grenville Counties: Family and Children's Services of Leeds and Grenville, 613-498-2100 or 1-800-481-7834. After hours, call the local number and the answering service will contact the person on call.

The Ontario Association of Children's Aid Societies www.oacas.org/childwelfare/how then click on 'Report Child Abuse', then 'How and When to Report'.

ATTACHMENT

Children's Mental Health research shows that the quality of early parent-child relationships has an important impact on a child's development and his ability to form secure attachments. A child who has secure attachment feels confident that he can rely on the parent to protect him in times of distress. This confidence gives the child security to explore the world and establish trusting relationships with others. As a result, current mental health practice is to screen the quality of the parent-child interactions.

The following items are considered from the parent's perspective, rather than the child's. If a parent states that one or more of these statements describes their child, the child may be exhibiting signs of an insecure attachment; consider this a **red flag**:

0-8 months

- Is difficult to comfort by physical contact such as rocking or holding
- Does things or cries just to annoy you

8-18 months

- Does not reach out to you for comfort
- Easily allows a stranger to hold him/her

18 months - 3 years

- Is not beginning to develop some independence
- Seems angry or ignores you after you have been apart

3-4 years

- Easily goes with a stranger
- Is too passive or clingy with you

4-5 years

- Becomes aggressive for no reason (e.g., with someone who is upset)
- Is too dependent on adults for attention, encouragement and help

Problem signs ...

if a mother or primary caregiver is frequently displaying **any** of the following, consider this a **red flag**:

- ▶ Being insensitive to a baby's communication cues
- ▶ Often unable to recognize baby's cues
- ▶ Provides inconsistent patterns of responses to the baby's cues
- ▶ Frequently ignores or rejects the baby
- ▶ Speaks about the baby in negative terms
- ▶ Often appears to be angry with the baby
- ▶ Often expresses emotions in a fearful or intense way

WHERE TO GO FOR HELP

See **Attachment** in the **Where to Go for Help** section at the back of this document.

FINE MOTOR

Healthy Child Development

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

By 2 months

- Sucks well on a nipple
- Holds an object momentarily if placed in hand

By 4 months

- Sucks well on a nipple
- Brings hands or toy to mouth
- Turns head side to side to follow a toy or an adult face
- Brings hands to midline while lying on back

By 6 months

- Eats from a spoon (e.g., infant cereal)
- Reaches for a toy when lying on back
- Uses hands to reach and grasp toys

By 9 months

- Picks up small items using thumb and first finger
- Passes an object from one hand to the other
- Releases objects voluntarily

By 12 months

- Holds, bites and chews foods (e.g., crackers)
- Takes things out of a container
- Points with index finger
- Plays games like peek-a-boo
- Holds a cup to drink using two hands
- Picks up and eats finger foods

By 18 months

- Helps with dressing by pulling out arms and legs
- Stacks two or more blocks
- Scribbles with crayons
- Eats foods without coughing or choking

By 2 years

- Takes off own shoes, socks or hat
- Stacks five or more blocks
- Eats with a spoon with little spilling

By 3 years

- Turns the paper pages of a book
- Dresses or undresses with help
- Unscrews a jar lid
- Holds a crayon with fingers
- Draws vertical and horizontal lines in imitation
- Copies a circle already drawn

By 4 years

- Holds a crayon correctly
- Undoes buttons or zippers
- Cuts with scissors
- Dresses and undresses with minimal help

By 5 years

- Draws diagonal lines and simple shapes
- Uses scissors to cut along a thick line drawn on paper
- Dresses and undresses without help except for small buttons, zippers, snaps
- Draws a stick person

Problem signs...

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

- ▶ Infants who are unable to hold or grasp an adult finger or a toy/object for a short period of time
- ▶ Unable to play appropriately with a variety of toys; or avoids crafts and manipulatives
- ▶ Consistently ignores or has difficulty using one side of body; or uses one hand exclusively

WHERE TO GO FOR HELP

See **Fine Motor** in the **Where to Go for Help** section at the back of this document.

GROSS MOTOR

Healthy Child Development

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

By 3 months

- Lifts head up when held at your shoulder
- Lifts head up when on tummy

By 4 months

- Keeps head in midline and brings hands to chest when lying on back
- Lifts head and supports self on forearms on tummy
- Holds head steady when supported in sitting position

By 6 months

- Rolls from back to stomach or stomach to back
- Pushes up on hands when on tummy
- Sits on floor with support

By 9 months

- Sits on floor without support
- Moves self forward on tummy or rolls continuously to get item
- Stands with support

By 12 months

- Gets up to a sitting position on own
- Pulls to stand at furniture
- Walks holding onto hands or furniture

By 18 months

- Walks alone
- Crawls up stairs
- Pushes or pulls toys or other objects when walking

By 2 years

- Walks backwards or sideways pulling a toy
- Plays in a squat position
- Kicks a ball

By 3 years

- Stands on one foot briefly
- Climbs stairs with minimal or no support
- Kicks a ball forcefully

By 4 years

- Stands on one foot for one to three seconds without support
- Goes up stairs alternating feet
- Rides a tricycle using foot peddles
- Walks on a straight line without stepping off

By 5 years

- Hops on one foot
- Throws and catches a ball successfully most of the time
- Plays on playground equipment safely and without difficulty

Problem signs...

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

- ▶ Baby is unable to hold head in the middle to turn and look left and right.
- ▶ Unable to walk with heels down four months after starting to walk.
- ▶ Asymmetry (i.e., a difference between two sides of body; or body too stiff or too floppy).

WHERE TO GO FOR HELP

See **Gross Motor** in the **Where to Go for Help** section at the back of this document.

VISION

Current research suggests that approximately 1 in 6 children has a vision problem. Children born with poor vision do not know what “normal vision” is like. They often think that everyone sees the same way that they do. Therefore, do not wait for your child to tell you that they have a vision problem. An eye examination is covered by OHIP once a year until the individual’s 19th birthday.

The Ontario Association of Optometrists recommended frequency for children’s eye examinations: 6 months of age, 3 years of age and then every 12 months or as recommended by the optometrist

Healthy Child Development

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

0-3 months

- Focuses on your face, bright colors and lights; follows slow-moving, close objects
- Blinks when bright lights come on or if a fast moving object comes into close view
- Watches as you walk around the room
- Looks at hands and begins to reach out and touch nearby objects

4-6 months

- Tries to copy your facial expression
- Reaches across the crib for objects/ reaches for objects when playing with you
- Grasps small objects close by
- Follows moving objects with eyes only (less moving of head)

7-12 months

- Plays games like ‘peek-a-boo’, ‘pat-a-cake’, ‘waves bye-bye’
- Reaches out to play with toys and other objects on own
- Moves around to explore what’s in the room; searches for a hidden object

12 months-2 years

- Moves eyes and hands together (e.g., stack blocks, place pegs)
- Judges depth e.g., climbs up and down stairs
- Links pictures with real life objects
- Follows objects as they move from above head to feet

2-3 years

- Sits a normal distance when watching television
- Follows moving objects with both eyes working together (coordinated)

3-4 years

- Knows people from a distance (across the street)
- Uses hands and eyes together (e.g., catches a large ball)
- Builds a tower of blocks, string beads; copies a circle, triangle and square

4-5 years

- Knows colours and shadings; picks out detail in objects and pictures
- Holds a book at a normal distance

(See VISION problem signs on following page)

VISION *continued*

Problem signs...

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

- ▶ Blinking and/or rubbing eyes often; a lot of tearing or eye-rubbing
- ▶ Headaches, nausea, dizziness; blurred or double vision
- ▶ Eyes that itch or burn; sensitive to bright light and sun
- ▶ Unusually short attention span; will only look at you if he hears you
- ▶ Avoidance of tasks with small objects
- ▶ Turning or tilting head to use only one eye to look at things
- ▶ Covering one eye; has difficulty, or is irritable with reading or with close work
- ▶ Eyes that cross, turn in or out, move independently
- ▶ Holding toys close to eyes, or no interest in small objects and pictures
- ▶ Bumping into things, tripping; clumsiness, restricted mobility
- ▶ Squinting, frowning; pupils of different sizes
- ▶ Redness, soreness (eyes or eyelids); recurring styes; discoloration
- ▶ Constant jiggling or moving of eyes side-to-side (roving)

WHERE TO GO FOR HELP

See **Vision** in the **Where to Go for Help** section at the back of this document.



HEARING

Healthy Child Development

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

0-3 months

- Startles, cries or wakens to loud sounds
- Moves head, eyes, arms and legs in response to a noise or voice
- Smiles when spoken to, or calms down; appears to listen to sounds and talking

4-6 months

- Responds to changes in your voice tone
- Looks around to determine where new sounds are coming from
- Responds to music and people's voices
- Begins to make speech-like sounds e.g., buh, ma, boo

6-9 months

- Turns or looks up when his name is called
- Responds to the word "no"
- Listens when spoken to
- Knows common words like "cup", "shoe", "mom"

9-12 months

- Responds to requests such as "Want more?" "Come here." "Where's the ball?"
- Babbles sounds in a series e.g., bababa, dadada, mememe
- Says first word

12 months-2 years

- Turns toward you when you call their name from behind
- Follows simple commands
- Tries to 'talk' by pointing, reaching and making noises
- Knows sounds like a closing door and a ringing phone
- Listens to simple stories, rhymes, and sings
- Imitates sounds and words

2-3 years

- Listens to a simple story
- Follows two requests (e.g., Get the ball and put it on the table.)
- Learns new words every week

3-4 years

- Hears you when you call from another room
- Listens to the television at the same loudness as the rest of the family
- Answers simple questions
- Speaks clearly enough to be understood most of the time by family

4-5 years

- Pays attention to a story and answers simple questions
- Hears and understands most of what is said at home and school
- Family, teachers, child care providers, and others think he hears fine
- Speaks clearly enough to be understood most of the time by anyone

Problem signs...

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

- ▶ Early babbling stops
- ▶ Ear pulling (with fever or crankiness)
- ▶ Does not respond when called
- ▶ Draining ears; a lot of colds and ear infections
- ▶ Loud talking

WHERE TO GO FOR HELP

See **Hearing** in the **Where to Go for Help** section at the back of this document.

SENSORY

Sensory integration refers to the ability to receive input through all of the senses - taste, smell, auditory, visual, touch, movement and body position, and the ability to process this sensory information into automatic and appropriate responses to the sensation.

Problem signs...

if a child's responses are exaggerated, irrational, extreme, and/or oppositional and do not seem typical for the child's age, consider this a **red flag**:

► Auditory

- Responds negatively to unexpected or loud noises
- Is distracted or has trouble functioning if there is a lot of background noise
- Enjoys strange noises/seeking to make noise for noise sake
- Seems to be "in his own world"

► Visual

- Children over 3 - trouble staying between the lines when colouring
- Avoids eye contact
- Squinting, or looking out of the corner of the eye
- Staring at bright, flashing objects

► Taste/Smell

- Avoids certain tastes/smells that are typically part of a child's diet
- Chews/licks non-food objects
- Gags easily
- Picky eater, especially regarding textures

► Movement and Body Position

- Continually seeks out all kinds of movement activities (being whirled by adult, playground equipment, moving toys, spinning, rocking)
- Becomes anxious or distressed when feet leave ground
- Poor endurance - tires easily; seems to have weak muscles
- Avoids climbing, jumping, uneven ground or roughhousing
- Moves stiffly or walks on toes; clumsy or awkward, falls frequently

- Does not enjoy a variety of playground equipment
- Enjoys exaggerated positions for long periods (e.g., lies head-upside-down off sofa)

► Touch

- Becomes upset during grooming (hair cutting, face washing, fingernail cutting)
- Has difficulty standing in line or close to other people; or stands too close, always touching others
- Is sensitive to certain fabrics
- Fails to notice when face or hands are messy or wet
- Cannot tolerate hair washing, hair cutting, nail clipping, teeth brushing
- Craves lots of touch: heavy pressure, long-sleeved clothing, hats and certain textures

► Activity Level

- Always on the go; difficulty paying attention
- Very inactive, under-responsive

► Emotional/Social

- Needs more protection from life than other children
- Has difficulty with changes in routines
- Is stubborn or uncooperative; gets frustrated easily
- Has difficulty making friends
- Has difficulty understanding body language or facial expressions
- Does not feel positive about own accomplishments

WHERE TO GO FOR HELP See **Sensory** in the **Where to Go for Help** section at the back of this document.

SPEECH & LANGUAGE

Healthy Child Development

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

By 3 months

- Cries and grunts; has different cries for different needs
- Makes a lot of “cooing” and “gooing” sounds
- Responds to parent/caregiver voice (e.g.,, Watches your face as you talk)

By 6 months

- Babbles using different sounds
- Lets you know by voice sounds to do something again
- Makes “gurgling” noises
- Understands some words (e.g., daddy, bye bye)
- Smiles or laughs
- Vocalizes pleasure and displeasure (e.g., squeals with excitement, grunts in anger)
- Enjoys music, songs and rhymes
- Brightens to sound, especially to people’s voices
- Smiles and laughs in response to parent/caregiver smiles and laughs
- Imitates sounds in his/her repertoire (e.g., coughs or other sounds – ah, eh, buh)

By 12 months

- Consistently uses three to five single words
- Takes turns with sounds (e.g., Buh, animal sounds, car noises)
- Waves hi/bye (emerging) and begins to use other gestures (e.g., hands up means pick me up)
- Gives a few familiar objects on verbal request
- Uses a variety of different voice sounds when playing (e.g., bababa, dadada, nanana)
- Combines lots of sounds as though talking (e.g., abada, baduh, abee)

- Tries to copy new sounds (e.g., ba, animal sounds, car noises)
- Makes sounds to get attention, to make needs known, or to protest
- Responds to hearing own name
- Understands “no” and simple requests (e.g.,, Give it to mommy. Don’t touch. Where’s the ball?)
- Plays social games with you (e.g., peek a boo)
- Enjoys being around people

By 18 months

- Tries to copy your sounds (sounds of our language)
- Uses at least 20-50 words consistently; words do not have to be clear
- Understands many more words than he can say
- Understands simple directions or questions (e.g.,, Where is your nose? Get the ball.)
- Demonstrates some pretend play with toys (e.g., give Teddy a drink)
- Enjoys tickle, bounce and nursery rhymes
- Makes at least four consonant sounds from p, b, m, n, d, t, w, h
- Identifies pictures in a book (e.g., Show me the baby)
- Enjoys being read to and looking at books
- Points to familiar people and to some body parts when asked
- Understands the concepts of in and out, off and on

By 2 years

- Tries to copy your words
- Uses a variety of words and gestures to communicate and ask for help (e.g., waving, pushing away, pointing)

continued ...

- Uses 100-150 words and combines 2 words (e.g., More juice. Want cookie.)
- Follows two step instructions (e.g., go find your teddy bear and show it to Grandma)
- Takes turns in a conversation
- Asks for something by pointing and using sounds or words
- Begins to offer toys to peers and imitates other children's actions and words
- People can understand his/her words 50 to 60 per cent of the time
- Uses many different speech sounds at beginning of words (p,b,m,t,d,n,h,w)
- Enjoys being with other children
- Learns and uses one or more new words a week; may only be understood by family

By 30 months

- Understands the concepts of size (big/little) and quantity (a lot, little, more)
- Uses some correct grammar – “two cookies”; “bird flying”
- Uses more than 350 words
- Uses action words – run, fall
- Begins taking turns with other children using both toys and words
- Shows concern when another child is hurt or sad
- Combines several actions in play – feeds dolls then puts him/her to sleep
- Produces words with two or more syllables or beats: ba-na-na, com-pu-ter

By 3 years

- Responds to simple questions or directions
- Understands location words like in, on and under
- Identifies some objects by their functions (e.g., What is a spoon for?)
- Is understood by most people outside of the family most of the time
- Uses long sentences, using 5-8 words

- Uses pronouns: I, you, me and mine
- Understands questions using who, what, why, when and where
- Is learning the meaning of several new words every week (in spoken language)
- Sings simple songs and familiar rhymes
- Talks about past events
- Tells simple stories
- Shows affection for favourite playmates
- Engages in multi step pretend play – cooking a meal, repairing a car
- Shows ability to participate in routines

By 4 ½ years

- Most of the time uses complete sentences with 4 or more words (e.g., I go home now.)
- Uses correct grammar such as plural (e.g., books), past tense (e.g., walked) and pronouns (e.g., I, he, she, me, you)
- Follows directions involving three or more steps “First get some paper, then draw a picture, last give it to mom”
- Tells stories with clear beginning, middle and end
- Talks to try to solve problems with adults and other children
- Demonstrates increasingly complex imaginative play
- Is understood by adults outside the family almost all the time
- Is learning the meaning of and using several “new words” every week (in spoken language)
- Recites nursery rhymes and sings familiar songs
- Understands “just one”
- Enjoys being read to
- Can identify 4-6 colours by name

By 5 ½ years

- Talks easily with other children and adults and is understood
- Understands spatial relationships, on top of, under, behind, in front of, etc.
- Explains concepts using words (e.g. ,What is a cup? What is a car?)
- Understands many descriptive words (e.g., long/short, soft/hard)
- Follows group directions “All the boys get a toy”
- Understands directions involving e.g., “if...then” – “If you are wearing runners, then line up for gym”
- Describes and can retell past, present, and future events in detail
- Seeks to please his or her friends
- Shows increasing independence in friendships
- Uses almost all the sounds of his or her language with few to no errors
- Uses complete sentences with good grammatical structure
- Is learning the meaning of and is using several new words every week (in spoken language)
- Can recall a brief story that has just been heard



Problem signs...

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

- Stumbling or getting stuck on words or sounds (stuttering)
- Ongoing hoarse voice
- Excessive drooling
- Problems with swallowing or chewing, or eating foods with certain textures (gagging).
See also Feeding and swallowing section
- Lack of eye contact and poor social skills for age
- Frustrated when verbally communicating

See also

- Literacy & Numeracy
Speech and language difficulties are often associated with weak literacy skills.

WHERE TO GO FOR HELP

See **Speech & Language** in the **Where to Go for Help** section at the back of this document.

LITERACY & NUMERACY

By 3 months

- Shows interest in contrast between light and dark
- Makes eye contact with pictures in book
- Looks intently at pictures for several minutes

By 6 months

- Enjoys music, songs and rhymes
- Reaches for and explores books with hands and mouth
- Sits on lap and holds head up steadily
- Shows preference for photographs of faces
- Uses both hands to manipulate the book to make the pages open and close

By 12 months

- Shows interest in looking at books
- Holds book with help
- Tries to turn several pages at a time
- Looks at pictures, vocalizes and pats picture
- Sits up without support
- Plays social games with you (e.g., peek a boo)

By 18 months

- Points at pictures with one finger
- Enjoys tickle, bounce and nursery rhymes
- Identifies pictures in a book (e.g., Show me the baby)
- Able to carry book and turn pages well
- Holds a crayon or pencil in fist and marks paper, scribbles
- Labels a particular picture with a specific sound
- Enjoys being read to and looking at books
- Relates an object or an action in a book to the real world

By 2 years

- Asks for favourite books to be read over and over again
- Pretends to read
- Names familiar pictures
- Scribbles
- Holds books the right way up and turns pages easily, one at a time
- Relates events in books to his/her own past experiences
- Notices print rather than just the pictures
- Can join in and recite phrases

By 30 months

- Produces words with two or more syllables or beats: ba-na-na, com-pu-ter
- Recognizes familiar logos and signs - (e.g., stop sign)
- Remembers and understands familiar stories

By 3 years

- Sings simple songs and familiar rhymes
- Pretends to read familiar books aloud
- Knows how to use a book (holds/turns pages one at a time, starts at beginning, points/talks about pictures)
- Looks carefully and makes comments about books
- Fills in missing words/phrases in familiar books that are read aloud
- Holds a pencil/crayon with pincer grasp and uses it to draw/scribble
- Imitates writing with linear scribbles
- Copies a circle, vertical and horizontal lines when shown
- Talks about past events
- Tells simple stories
- Engages in multi step pretend play – cooking a meal, repairing a car
- Is aware of the functions of print – in menus, signs
- Has a beginning interest in, and awareness of, rhyming


- Requests adult to read or write
- Understands that print carries a message
- Shows ability to participate in routines

By 4 ½ years

- Tells stories with clear beginning, middle and end
- Matches some letters with their sounds (e.g., Letter “t” says tuh)
- Recites nursery rhymes and sings familiar songs
- Reads a book by memory or by making up the story to go along with the pictures
- Can guess what will happen next in the story
- Retells some details of stories read aloud but not necessarily in order
- Traces circle, triangle, square using templates
- Recognizes signs and symbols in daily environment (e.g., traffic signs, washroom signs)
- Holds a pencil correctly
- Identifies the names of 10 alphabet letters (likely from own name)
- Understands the concept of rhyme; recognizes and generates rhyming words
- Changes a sound in a word to make a new word in familiar games and songs
- Enjoys being read to
- Is motivated to try to read

By 5 ½ years

- Can match all letter symbols to letter sounds
- Reads some familiar vocabulary by sight (high frequency words)
- Can label pictures quickly
- Knows parts of a book
- Understands the basic concepts of print (difference between letters, words, sentences, how the text runs from left to right, top to bottom, white space between words)

- Knowledge of the basic concepts of print shows in child’s writing (letters instead of scribbles, letter groupings that look like words, invented spelling)
- Points to and says the name of most letters of the alphabet when randomly presented (upper and lower case); recognizes how many words are in a sentence
- Prints letters (by copying, or in her full name, or when attempting to spell words)
- Makes predictions about stories; retells the beginning, middle and end of familiar stories
- Can recall a brief story that has just been heard
- When being read a story, connects information and events to real life experiences
- Can identify the beginning and ending sounds in words e.g., “Pop” starts with the “puh” sound
- Can shift attention from meanings of words to sounds of words
- Draws diagonal lines and simple shapes
- Able to sort objects by size, colour, use, etc.
- Able to understand simple patterning
- One to one correspondence for numbers from 1 through 10  for hel

See also

• Speech & Language

Speech and language difficulties are often associated with weak literacy skills.

Note: Low literacy level of parents is also a risk factor for literacy development.

WHERE TO GO FOR HELP

See **Literacy & Numeracy** in the **Where to Go for Help** section at the back of this document.

SOCIAL/EMOTIONAL

Problem signs ...

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

0-8 months

- Failure to thrive with no medical reason
- Parent/guardian and child do not engage in smiling and vocalization with each other
- Parent/guardian ignores, punishes or misreads child's signals of distress
- Parent/guardian pulls away from infant or holds infant away from body with stiff arms
- Parent/guardian is overly intrusive when child is not wanting contact
- Child is not comforted by physical contact with parent

8-18 months

- Parent/guardian and child do not engage in playful, intimate interactions with each other
- Parent/guardian ignores or misreads child's cues for contact when distressed
- Child does not seek proximity to parent when distressed
- Child shows little wariness towards a new room or stranger
- Child ignores, avoids or is hostile with parent after separation
- Child does not move away from parent to explore, while using parent as a secure base
- Parent/guardian has inappropriate expectations of the child for age

18 months - 3 years

- Child and parent have little or no playful or verbal interaction
- Child initiates overly friendly or affectionate interactions with strangers
- Child ignores, avoids or is hostile with

parent/guardian when distressed or after separation

- Child is excessively distressed by separation from parent
- Child freezes or moves toward parent by approaching sideways, backwards or circuitously
- Child alternates between being hostile and overly affectionate with parent
- Parent/guardian seems to ignore, punish or misunderstand emotional communication of child
- Parent/guardian uses inappropriate behaviour management techniques

3-5 years

- Child ignores adult or becomes worse when given positive feedback
- Child is excessively clingy or attention seeking with adults, or refuses to speak
- Child is hyper vigilant or aggressive without provocation
- Child does not seek adult comfort when hurt, or show empathy when peers are distressed
- Child's play repeatedly portrays abuse, family violence or explicit sexual behaviour
- Child can rarely be settled from temper tantrums within 5-10 minutes
- Child cannot become engaged in self-directed play
- Child is threatening, dominating, humiliating, reassuring or sexually intrusive with adult
- Parent/guardian uses inappropriate behaviour management techniques

WHERE TO GO FOR HELP

See **Social/Emotional** in the **Where to Go for Help** section at the back of this document.

BEHAVIOUR

Children may engage in one or more problem behaviours from time to time. Some factors should be considered in determining whether the behaviour is truly of concern. These include:

- injuring themselves or others
- behaving in a manner that presents immediate risk to themselves or others
- frequency and severity of the behaviour
- number of problematic behaviours that are occurring at one time
- significant change in the child's behaviour
- withdrawal

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

Self-Injurious Behaviour

- ▶ Bites self, slaps self, grabs at self
- ▶ Picks at skin, sucks excessively on skin/ bangs head on surfaces
- ▶ Eats inedibles
- ▶ Intentional vomiting (when not ill)
- ▶ Potentially harmful risk taking (e.g., running into traffic, setting fires)

Aggression

- ▶ Temper tantrums, excessive anger, threats
- ▶ Hits, kicks, bites, scratches others, pulls hair
- ▶ Bangs, slams objects, property damage
- ▶ Cruelty to animals
- ▶ Hurting those less able/bullies others

Social Behaviour

- ▶ Difficulty paying attention/hyperactive, overly impulsive
- ▶ Screams, cries excessively, swears
- ▶ Hoarding, stealing
- ▶ No friends, socially isolated, will not make eye or other contact, withdrawn
- ▶ Anxious, fearful/extreme shyness, agitated
- ▶ Compulsive behaviour, obsessive thoughts, bizarre talk
- ▶ Exhibiting inappropriate behaviour in public (e.g., undressing)

- ▶ Touches self or others in inappropriate ways, precocious knowledge of a sexual nature
- ▶ Flat affect, inappropriate emotions, unpredictable angry outburst, disrespect or striking

Life Skills

- ▶ Oppositional behaviour
- ▶ Running away
- ▶ Resisting assistance that is inappropriate to age

Self-Stimulatory Behaviour

- ▶ Deficits in expected functional behaviours (e.g., eating, toileting, dressing, poor play skills)
- ▶ Regression, e.g., loss of skills, refusal to eat, sleep disturbances
- ▶ Difficulty managing transitions/routine changes
- ▶ Hand-flapping, hand wringing, rocking, swaying
- ▶ Repetitious twirling, repetitive object manipulation

WHERE TO GO FOR HELP

See **Behaviour** in the **Where to Go for Help** section at the back of this document.

NUTRITION

The warning signs of poor nutritional health are often overlooked.

Problem signs...

if an infant/child experiences **any** of the following signs, it should be considered a **red flag**:

0-6 months

- ▶ Typical weight gain guidelines not met:
 - 0-3 months, 4-8 oz (140-227g)/week
 - 3-6 months, 3-5 oz (85-142g)/week
 - Birth weight is expected to be regained by 10 days of age
- ▶ Crosses 2 percentile ranks on the growth chart
- ▶ Sudden and rapid weight loss or gain
- ▶ Diet includes anything other than breastmilk or iron fortified infant formula
- ▶ Breastmilk or formula is not being fed on demand
- ▶ Using softened, distilled or unsterilized water to make formula
- ▶ Infant formula is not stored or prepared correctly
- ▶ Formula fed baby is not held during feeding to ensure safety and promote bonding
- ▶ Pablum is offered in a bottle
- ▶ Honey is given under one year
- ▶ Sudden decrease in wet and soiled diapers
- ▶ Consistent green watery stool
- ▶ Hard pellet like stool
- ▶ Urine has a fishy smell
- ▶ Urine or stool has blood in it

6-9 Months

- ▶ Birth weight not doubled by six months
- ▶ Crosses 2 percentile ranks on the growth chart
- ▶ Typical weight gain guidelines not met - 1.5 – 3 oz (42-85 g)/week
- ▶ Complementary foods have not been introduced
- ▶ Drinking cow's milk
- ▶ Drinking fruit juice/drinks or soft drinks

- ▶ Pablum is offered in a bottle
- ▶ Highly allergenic foods are offered (egg white, nuts, sesame, peanuts, shellfish)
- ▶ Honey is given under one year
- ▶ Formula fed baby is not held during feeding to ensure infant and mother/caregiver bonding
- ▶ Sudden decrease in wet and soiled diapers
- ▶ Consistent green watery stool
- ▶ Hard pellet like stool
- ▶ Urine has a fishy smell
- ▶ Urine or stool has blood in it

9-12 Months

- ▶ Crosses 2 percentile ranks on the growth chart
- ▶ Birth weight not tripled by 1 year old
- ▶ Typical weight gain guidelines not met - 1.5-3 oz (42-85 g)/week
- ▶ Baby is drinking lower fat milk (skim, 1%, 2%), unpasteurized milk, goat's milk or soy/rice milks
- ▶ Drinking more than 4 oz (½ cup) of diluted fruit juice per day
- ▶ Consuming fruit drinks or soft drinks
- ▶ Honey is given under one year
- ▶ Formula fed baby is not held during feeding to ensure safety and promote bonding
- ▶ Still eating only pureed food
- ▶ Eating highly allergic foods (egg white, nuts, sesame, peanut, shellfish)
- ▶ Sudden decrease in wet and soiled diapers
- ▶ Consistent green watery stool
- ▶ Hard pellet like stool
- ▶ Urine has a fishy smell
- ▶ Urine or stool has blood in it

12-24 Months

- ▶ Crosses 2 percentile ranks on the growth chart
- ▶ Birth weight not tripled by 12 months
- ▶ Not eating a variety of foods
- ▶ Refuses mashed or chopped foods
- ▶ Still eating pureed food
- ▶ Drinking lower fat milk (skim, 1%, 2%), unpasteurized milk, goat's milk or soy/rice drinks
- ▶ Drinking more than 4-6 oz (½-¾ cup) per day of diluted fruit juice
- ▶ Consuming fruit drinks or soft drinks
- ▶ Drinking less than 12 oz (1 ½ cups) or more than 20 oz (2 ½ cups) milk/day
- ▶ Not self-feeding
- ▶ Consuming nuts, peanuts, shellfish or sesame
- ▶ Not consuming snacks between meals
- ▶ Not supervised while eating
- ▶ Food allergy symptoms or reactions (e.g., diarrhea, vomiting, hives, swelling of tissues, anaphylaxis, etc.)

Toddlers 2-3 Years

- ▶ Crosses 2 percentile ranks on the growth chart
- ▶ Not eating a variety of foods.
- ▶ Drinking more than 6 oz (¾ cup) of juice per day
- ▶ Consuming fruit drinks or soft drinks
- ▶ Drinking less than 12 oz (1 ½ cups) or more than 20 oz (2 ½ cups) milk/day
- ▶ Still drinking from a bottle
- ▶ Parents/guardians restrict intake or demand increased food consumption
- ▶ Food is used as a reward or punishment
- ▶ Not self-feeding
- ▶ Food allergy symptoms or reactions (e.g., diarrhea, vomiting, hives, swelling of tissues, anaphylaxis, etc.)

Preschooler 3-6 Years

- ▶ Not eating a variety of foods
- ▶ Drinking less than 16 oz (2 cups) or more than 24 oz (3 cups) of milk per day
- ▶ Drinking more than 6 oz (¾ cup) of juice per day
- ▶ Consuming fruit drinks or soft drinks
- ▶ Still being spoon-fed
- ▶ Still drinking from a bottle
- ▶ Does not eat at regular times throughout the day (breakfast, lunch, and supper and 2-3 between meal snacks)
- ▶ Parents/guardians restrict intake or demand increased food consumption
- ▶ Family is experiencing problems around feeding – mealtimes are unpleasant
- ▶ Food is used as a reward or punishment



WHERE TO GO FOR HELP

See **Nutrition** in the **Where to Go for Help** section at the back of this document.

FEEDING & SWALLOWING

Problem signs

It is **advisable** to consult an expert if a child:

- ▶ Has lost weight or has not gained weight within the last month (less time if pertaining to an infant)
- ▶ Must be fed around the clock to gain weight properly (infants require feeds every 2-4 hours)
- ▶ Cannot suck for more than 5 minutes at a time
- ▶ Consistently takes less than 10 minutes or more than 45 minutes to eat a meal
- ▶ Cannot progress from liquids to purees after 6 months, or from purees to pieces by 14 - 16 months
- ▶ Omits complete food groups from his diet (e.g., no meats; no vegetables)
- ▶ Has severe tantrums or aversive behaviours on a regular basis when presented with food or the highchair
- ▶ Cannot eat without major distraction or entertainment
- ▶ Can easily go for hours (if not days) without asking for food
- ▶ Will not feed himself (at least partially) by 14-15 months
- ▶ Most importantly, parents **should** consult an expert if feeding is a frustrating, draining, stress-filled experience day in, day out



See also

- Speech & Language
- Nutrition
- Fine Motor

WHERE TO GO FOR HELP

See **Feeding & Swallowing** in the **Where to Go for Help** section at the back of this document.

DENTAL

The Ontario Association of Public Health Dentistry recommends the first visit to a dentist should occur at one year of age.

Problem signs

...the presence of **any** of the following risk factors for early childhood tooth decay should be considered a **red flag**:

Prolonged exposure of teeth to sugars

- ▶ Through the use of bottle, breast, sippee cups, plastic bottles with straws (includes formula, juice, milk and breast milk)
- ▶ High sugar consumption
- ▶ Sweetened pacifiers
- ▶ Long term sweetened medication
- ▶ Going to sleep with a bottle containing anything but water
- ▶ Prolonged use of a bottle beyond one year
- ▶ Breastfeeding or bottle feeding without cleaning gums and teeth

Physiological Factors

- ▶ Those associated with poor enamel development, such as prenatal nutritional status of mother and child, poor prenatal health, and malnutrition of the child
- ▶ Possible enamel deficiencies related to prematurity or low birth weight
- ▶ Mother and child's lack of exposure to fluoride
- ▶ Transference of oral bacteria from another person to a child between 19-31 months of age, through frequent kissing or sharing of utensils

Other Risk Factors

- ▶ Poor oral hygiene
- ▶ Sibling history of early childhood tooth decay
- ▶ Lack of knowledge of primary caregiver regarding risk
- ▶ Lower socioeconomic status
- ▶ Limited access to dental care
- ▶ Deficits in parenting skills and child management



WHERE TO GO FOR HELP

See **Dental** in the **Where to Go for Help** section at the back of this document.

WITNESSING FAMILY VIOLENCE

When a child is hurt intentionally or when a parent or caregiver fails to protect a child in their care, this is abuse. It is against the law. **When children witness violence at home, the effects are comparable to the child being the direct victim of assault.** It is a misuse of parental power and can lead to lifelong negative consequences. There are different kinds of child abuse: physical abuse, sexual abuse, emotional abuse and neglect. The abuser can be male or female. Abusive behaviour crosses all economic, social and religious boundaries.

One or two of the warning signs are not necessarily an indication of abuse at home. A child displaying several of these signs should raise suspicions that the child may be experiencing some type of disruption in his life.

Physical indicators in children

- ▶ The child does not meet developmental milestones as expected
- ▶ Failure to thrive – e.g., poor weight gain
- ▶ Often complains of medical ailments, nausea, headaches, stomach aches without any obvious reason.
- ▶ Physical harm, whether deliberate or accidental, during or after a violent episode
- ▶ May suffer serious unintended injuries
- ▶ May exhibit signs and symptoms of post traumatic stress syndrome, e.g., nightmares, hypervigilance.
- ▶ Rigid body when experiencing stress
- ▶ Fussy and distressed
- ▶ Listlessness
- ▶ Always tired

Behavioural indicators in children

- ▶ May be aggressive and have temper tantrums, e.g., destructiveness
- ▶ May exhibit regressive behaviours, e.g., bedwetting
- ▶ May show withdrawn, depressed, and nervous behaviours, e.g., excessive shyness, clinging, whining, excessive crying, excessive separation anxieties
- ▶ Acts out what has been seen or heard between the parents, discloses family violence, may act out sexually
- ▶ Tries too hard to be good and to get adults to approve

- ▶ Afraid of:
 - someone's anger
 - self or other loved ones being hurt or killed
 - being left alone and not cared for
 - sudden loud noises
- ▶ Problems sleeping, e.g., cannot fall asleep, heightened fear of the dark, resistance to bedtime, nightmares
- ▶ Sleep disturbances/disruption in eating routines
- ▶ Bed-wetting, food-hoarding
- ▶ Tries to hurt oneself, cruel to animals
- ▶ Stays around the house to keep watch, or tries not to spend much time at home, runs away from home
- ▶ Problems with school
- ▶ Expects a lot of oneself and is afraid to fail and so works very hard, perfectionist
- ▶ Overly responsible
- ▶ Takes the job of protecting and helping the mother, siblings
- ▶ Assumes role of parent
- ▶ Does not get along well with other children
- ▶ May begin to develop the belief:
 - that it is all right for men to hit women
 - that violence is a way to win arguments
 - that men are bullies who push women and children around
 - that big people have power they often misuse
 - that women are victims and can't take care of themselves
- ▶ Scared to explore and play
- ▶ Impulsiveness
- ▶ Attention problems
- ▶ Destruction of property

Behaviours observed in adults

- ▶ Abuser has trouble controlling self
- ▶ Abuser has trouble talking and getting along with others
- ▶ Abuser uses power games
- ▶ Abuser uses threats and violence, e.g., threatens to hurt, kill, or destroy someone or something that is special, cruel to animals, intimidation
- ▶ Forces the child to watch a parent/partner being hurt
- ▶ Abuser is always watching what the partner is doing
- ▶ Abuser insults, blames, and criticizes partner in front of others, distorts reality
- ▶ Abuser instills fear through looks or actions
- ▶ Jealous of partner talking or being with others
- ▶ Abuser does not allow the child or family to talk with or see others
- ▶ The abused person is not able to care properly for the children because of isolation, depression, trying to survive. The abuser uses money to control behaviour and withholds basic needs
- ▶ Holds the belief that the abuser has the power and the partner has to obey
- ▶ Violence is utilized as a way to win, to get what they want - assert power and control
- ▶ Uses drugs or alcohol
- ▶ Discloses family violence
- ▶ Discloses that the abuser assaulted or threw objects at someone holding a child
- ▶ The abused person seems to be frightened, humiliated and full of shame with a heightened sense of powerlessness
- ▶ Inability to take responsibility for their behaviour - blame others



WHERE TO GO FOR HELP

For any child abuse concerns, please call your local Children's Aid Society **immediately**.

In Lanark County, contact the Children's Aid Society of Lanark County at 613-264-9991 or 1-866-664-9991.

For the counties of Leeds and Grenville, contact Family and Children's Service of Leeds and Grenville at 613-498-2100 or 1-800-481-7834. After hours, call the local number and the answering service will contact the person on call.

For additional help, consult the **Where to Go for Help** section at the back of this document.

Interval House:

In Leeds and Grenville counties,
call 613-342-4724 or 1-800-267-4409

In Lanark County, call 1-800-267-7946

PHYSICAL ABUSE

Physical abuse is any deliberate physical force or action (usually by a parent, guardian or caregiver) that results, or could result, in injury to a child.

Physical abuse is also any harm to a child caused by an action or omission of action. It is different from what is considered reasonable discipline. It can include punching, slapping, beating, shaking, burning, biting or throwing a child. Injuries may include bruises, welts, cuts, fractures, burns, or internal injuries. Physical abuse can be one or two isolated incidents or can occur over a prolonged period of time.

The signs and indicators of abuse and neglect may include but are not limited to those that follow. It is important to realize that the presence of any one indicator is not conclusive proof that a child has been abused. In most instances, abused children will exhibit a number of behavioural and physical indicators.

Physical indicators in children

- ▶ 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
- ▶ A lot of bruises in the same area of the body
- ▶ Bruises in the shape of an object, e.g., spoon, hand/fingerprints, belt
- ▶ Burns:
 - from a cigarette
 - in a pattern that looks like an object, e.g., iron
 - wears clothes to cover up injury, even in warm weather
- ▶ Patches of hair missing
- ▶ Signs of possible head injury:
 - swelling and pain
 - nausea or vomiting
 - feeling dizzy
 - bleeding from the scalp or nose
- ▶ Signs of possible injury to arms and legs:
 - pain
 - sensitive to touch
 - cannot move properly
 - limping

- ▶ Breathing causes pain
- ▶ Difficulty raising arms
- ▶ Human bite marks
- ▶ Cuts and scrapes inconsistent with normal play
- ▶ Signs of female genital mutilation, e.g., trouble going to the bathroom

Behavioural indicators in children

- ▶ Cannot remember how injuries happened
- ▶ The story of what happened does not match the injury
- ▶ Refuses or is afraid to talk about injuries
- ▶ Is afraid of adults or of a particular person
- ▶ Does not want to be touched
- ▶ May be very:
 - aggressive
 - unhappy
 - withdrawn
 - obedient and wanting to please
 - uncooperative
- ▶ Is afraid to go home
- ▶ Runs away
- ▶ Is away a lot and when comes back there are signs of healing injury
- ▶ Does not meet developmental milestones as expected
- ▶ Does not get along well with other children
- ▶ Tries to hurt himself, e.g., cutting himself, suicide
- ▶ Discloses abuse

Behaviours observed in adults who abuse children

- ▶ Does not tell the same story as the child about how the injury happened
- ▶ May say that the child seems to have a lot of accidents
- ▶ Severely punishes the child
- ▶ Cannot control anger and frustration
- ▶ Expects too much from the child
- ▶ Talks about having problems dealing with the child
- ▶ Talks about the child as being bad, different, or "the cause of my problems"
- ▶ Shows no affection toward the child
- ▶ Does not go to the doctor right away to have injury checked
- ▶ Has little or no help caring for the child

SEXUAL ABUSE

Sexual abuse is any sexual exploitation of a child by an older person where the child is being used for a sexual purpose. The Criminal Code of Canada identifies a number of types of sexual abuse, including sexual interference, an invitation to sexually touch, sexual exploitation of a young person, parent, guardian or caregiver procuring sexual activity from a child, household permitting sexual activity, exposing genitals to a child, and incest.

The signs and indicators of abuse and neglect may include, but are not limited to, those that follow. It is important to realize that the presence of any one indicator is not conclusive proof that a child has been abused. In most instances, abused children will exhibit a number of behavioural and physical indicators.

Physical indicators in children

- ▶ A lot of itching or pain in the throat, genital or anal area
- ▶ A smell or discharge from the genital area
- ▶ Underwear that is bloody
- ▶ Pain when:
 - trying to go to the bathroom
 - sitting down
 - walking
 - swallowing
- ▶ Blood in urine or stool
- ▶ Injury to the breasts or genital area:
 - redness
 - bruising
 - cuts
 - swelling

Behavioural indicators in children

- ▶ Copying the sexual behaviour of adults
- ▶ Knowing more about sex than expected
- ▶ Details of sex in the child's drawings/writing
- ▶ Sexual actions with other children, including siblings, or adults that are inappropriate
- ▶ Fears or refuses to go to a parent, relative, or friend for no clear reason
- ▶ Does not trust others
- ▶ Changes in personality that do not make sense, e.g., happy child becomes withdrawn
- ▶ Problems or change in sleep pattern, e.g., nightmares
- ▶ Very demanding of affection or attention, or clinging
- ▶ Goes back to behaving like a young child, e.g., bed-wetting, thumb-sucking
- ▶ Refuses to be undressed or, when undressing shows fear
- ▶ Tries to hurt oneself
- ▶ Discloses abuse

Behaviours observed in adults who abuse children

- ▶ May be very protective of the child
- ▶ Clings to the child for comfort
- ▶ Is often alone with the child
- ▶ May be jealous of the child's relationships with others
- ▶ Does not like the child to be with friends unless the parent is present
- ▶ Talks about the child being "sexy"
- ▶ Touches the child in a sexual way
- ▶ May use drugs or alcohol to feel freer to sexually abuse
- ▶ Allows or tries to get the child to participate in sexual behaviour
- ▶ Uses the child to make money, e.g., child pornography

EMOTIONAL ABUSE

Emotional abuse includes all acts of omission or commission which result in the absence of a nurturing environment for the child. It occurs when the parent/guardian/caregiver continually treats the child in such a negative way that the child's concept of "self" is seriously impaired. Emotionally abusive behaviour by the parent/guardian/caregiver can include constant yelling, demeaning remarks, rejecting, ignoring or isolating the child, or terrorizing the child. Emotional abuse can be the most difficult to identify and prove.

The signs and indicators of abuse and neglect may include but are not limited to those that follow. It is important to realize that the presence of any one indicator is not conclusive proof that a child has been abused. In most instances, abused children will exhibit a number of behavioural and physical indicators.

Physical indicators in children

- ▶ The child does not meet developmental milestones as expected
- ▶ Often complains of nausea, headaches, stomach aches without any obvious reason
- ▶ Wets or soils pants
- ▶ Is intentionally not given adequate food, clothing and proper care.
- ▶ May have unusual appearance causing humiliation or embarrassment (e.g., strange haircuts, dress, accessories)
- ▶ Bedwetting, non-medical in origin
- ▶ Child fails to thrive, e.g., poor weight gain

Behavioural indicators in children

- ▶ Is unhappy, stressed out, withdrawn, aggressive or angry for long periods of time
- ▶ Severe depression
- ▶ Goes back to behaving like a young child (e.g., toileting problems, thumb-sucking, constant rocking)
- ▶ Tries too hard to be good and to get adults to approve
- ▶ Too neat or too clean
- ▶ Tries really hard to get attention
- ▶ Tries to hurt oneself

- ▶ Criticizes oneself a lot
- ▶ Does not participate because of fear of failing
- ▶ May expect too much of him so gets frustrated and fails
- ▶ Is afraid of what the adult will do if he does something the adult does not like
- ▶ Runs away
- ▶ Has a lot of adult responsibility
- ▶ Does not get along well with other children
- ▶ Discloses abuse
- ▶ Displays extreme hesitancy in play

Behaviours observed in adults who abuse children

- ▶ Often rejects, insults or criticizes the child, even in front of others
- ▶ Does not touch or speak to the child with affection
- ▶ Talks about the child as being the cause for problems and things not going as wished
- ▶ Talks about or treats the child as being different from other children and family members
- ▶ Compares the child to someone who is not liked
- ▶ Does not pay attention to the child and refuses to help the child
- ▶ Isolates the child, does not allow the child to see others both inside and outside the family (e.g., locks the child in a closet or room)
- ▶ Does not provide a good example for children on how to behave with others (e.g., swears all the time, hits others)
- ▶ Lets the child be involved in activities that break the law
- ▶ Uses the child to make money (e.g., child pornography)
- ▶ Lets the child see sex and violence on TV, videos and magazines
- ▶ Terrorizes the child (e.g., threatens to hurt or kill the child or threatens someone or something that is special to the child)
- ▶ Forces the child to watch someone special being hurt
- ▶ Asks the child to do more than he can do for himself (e.g., extreme chores)

NEGLECT

Neglect occurs when a parent/guardian/caregiver fails to provide basic needs such as adequate food, sleep, safety, supervision, clothing or medical treatment. Most do not intend to neglect their children. It usually results from ignorance about appropriate care for children or an inability to plan ahead.

The signs and indicators of abuse and neglect may include but are not limited to those that follow.

It is important to realize that the presence of any one indicator is not conclusive proof that a child has been neglected.

In most instances, neglected children will exhibit a number of behavioural and physical indicators.

Physical indicators in children

- ▶ Poor hygiene
- ▶ Unattended physical problems or medical needs (e.g., dental work, glasses)
- ▶ Consistent lack of supervision
- ▶ An infant or young child may:
 - not be growing as expected
 - be losing weight
 - look pale
 - not be eating well
- ▶ not dressed properly for the weather
- ▶ dirty or unwashed
- ▶ bad diaper rash or other skin problems
- ▶ always hungry
- ▶ lack of medical and/or dental care

Behavioural indicators in children

- ▶ Pale, listless, unkempt
- ▶ Frequent absence from school
- ▶ Inappropriate clothing for the weather, dirty clothes
- ▶ Frequently forgets a lunch
- ▶ Does not meet developmental milestones as expected
- ▶ Appears to have little energy
- ▶ Cries very little
- ▶ Does not play with toys or notice people
- ▶ Does not seem to care for anyone in particular
- ▶ May be very demanding of affection or attention from others
- ▶ Takes care of a lot of their needs on their own
- ▶ Has a lot of adult responsibility at home
- ▶ Discloses neglect (e.g., says there is no one at home)

Behaviours observed in adults who neglect children

- ▶ Does not provide for the child's basic needs
- ▶ Has a disorganized home life, with few regular routines (e.g., always brings the child very early, picks up the child very late)
- ▶ Does not supervise the child properly (e.g., leaves the child alone, in a dangerous place, or with someone who cannot look after the child safely)
- ▶ May indicate that the child is hard to care for, hard to feed, describes the child as demanding
- ▶ May say that the child was or is unwanted
- ▶ May ignore the child who is trying to be loving
- ▶ Has difficulty dealing with personal problems and needs
- ▶ Is more concerned with own self than the child
- ▶ Fails to use services offered/recommended or to keep child's appointments
- ▶ Does not act on concerns that are discussed

AUTISM

Autism is a lifelong developmental disorder characterized by impairments in all of the following areas of development: communication, social interaction, restricted repertoire of activities and interests, and associated features, which may or may not be present (e.g., difficulties in eating and sleeping, unusual fears, learning problems, repetitive behaviours, self-injury and peculiar responses to sensory input).

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

Social Concerns

- ▶ Does not smile in response to another person
- ▶ Delayed imaginative play - lack of varied, spontaneous make-believe play
- ▶ Prefers to play alone, decreased interest in other children
- ▶ Poor interactive play
- ▶ Poor eye contact - this does not mean it is absent
- ▶ Less showing, giving, sharing and directing others' attention than expected for his age
- ▶ Any loss of social skills at any age (regression)
- ▶ Prefers to do things for himself rather than ask for help
- ▶ Awkward or absent greeting of others



Communication Concerns

- ▶ Language is delayed (almost universal)
- ▶ Inconsistent response or does not respond to his name or instructions
- ▶ Unusual language - repeating phrases from movies, echoing other people, repetitive use of phrases, odd intonation
- ▶ Decreased ability to compensate for delayed speech by gesture/pointing
- ▶ Poor comprehension of language (words and gestures)
- ▶ Any loss of language skills at any age (regression), but particularly between 15 and 24 months
- ▶ Inability to carry on a conversation

Behavioural Concerns

- ▶ Severe repeated tantrums due to frustration, lack of ability to communicate, interruption of routine, or interruption of repetitive behaviour
- ▶ Narrow range of interests that she engages in repetitively
- ▶ High pain tolerance and lack of safety awareness
- ▶ Insistence on maintaining sameness in routine, activities, clothing, etc.
- ▶ Repetitive hand and/or body movements: finger wiggling, hand and arm flapping, tensing of fingers, complex body movements, spinning, jumping, etc.
- ▶ Unusual sensory interests (e.g. visually squinting or looking at things out of the corner of the eye, smelling, licking, mouthing objects and/or hypersensitive hearing)
- ▶ Unusual preoccupation with objects (e.g., light switches, fans, spinning objects, vertical blinds, wheels, balls)

See also

- Speech & Language

WHERE TO GO FOR HELP

See **Autism** in the **Where to Go for Help** section at the back of this document.

FETAL ALCOHOL SPECTRUM DISORDER

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term for the range of harm that is caused by alcohol use during pregnancy. It includes Fetal Alcohol Syndrome (FAS), partial FAS (pFAS), and Alcohol Related Neurodevelopment Disorder (ARND). FASD is preventable, but not curable. Early diagnosis and intervention can make a difference. Children exposed prenatally to alcohol, who do not show the characteristic physical/external or facial characteristics of FAS, may suffer from equally severe brain damage.

The following are common characteristics of FASD:

- ▶ Facial dysmorphism - the characteristic facial features include small eye openings, flat mid-face, thin upper lip, flattened ridges between base of nose and upper lip
- ▶ Low birth weight, failure to thrive, small size, small head circumference, and ongoing slow growth
- ▶ Disturbed sleep, irritability, persistent restlessness
- ▶ Infants may be floppy or too rigid because of poor muscle tone
- ▶ Failure to develop routine patterns of behaviour
- ▶ Excessively “busy” toddlers/preschoolers
- ▶ Hyperactivity
- ▶ Inconsistent behaviours
- ▶ Impulsive
- ▶ Poor memory
- ▶ Unable to relate cause and effect
- ▶ Unable to comprehend danger
- ▶ Easily over-stimulated, sensitive to sound, lights and being touched
- ▶ Highly tactile (likes to touch things)
- ▶ Discrepancy between good expressive and poor receptive language (is less capable than he looks)
- ▶ Information processing problems, problems sequencing and making choices
- ▶ Difficulty with transition
- ▶ Difficulty reading non-verbal cues, poor social judgment
- ▶ Responds better one-on-one
- ▶ Impaired motor skills (e.g., clumsy, poor hand-eye coordination)
- ▶ May have physical birth defects

Caution:

The most sensitive time for brain development is the first trimester; before many women know they are pregnant. Alcohol use, some medications and drugs used during pregnancy can cause similar learning and behaviour problems. Some genetic conditions and acquired brain injury also look similar to FASD. Care needs to be taken when discussing a possible referral for FASD diagnosis, so as not to stigmatize the mother.

WHERE TO GO FOR HELP

See **FASD** in the **Where to Go for Help** section at the back of this document.

LEARNING DISABILITIES

Current research indicates that early appropriate intervention can successfully remediate many disabilities, particularly those related to reading. The following is a list of characteristics that may point to a learning disability. Most people will, from time to time, see one or more of these warning signs in their children. This is normal.

Learning disabilities are related to difficulties in processing information:

- ▶ the reception of information,
- ▶ the integration or organization of that information,
- ▶ the ability to retrieve information from its storage in the brain, and
- ▶ the communication of retrieved information to others.

If a child exhibits **several** of the following characteristics consider this a **red flag**:

Preschool

- ▶ Speaks later than most children
- ▶ Has pronunciation difficulties
- ▶ Slow vocabulary growth, often unable to find the right word
- ▶ Has difficulty rhyming words
- ▶ Has trouble learning colours, shapes, days of the week, numbers and the alphabet
- ▶ Fine motor skills are slow to develop
- ▶ Is extremely restless and easily distracted
- ▶ Has difficulty following directions and/or routines
- ▶ Has trouble interacting appropriately with peers

School Age

Learning Disabilities are diagnosed by a psychologist, and generally after the child enters school and is learning to read and write.

The psychologist will assess:

- auditory and visual perceptual skills (understanding)
- processing speed
- organization
- memory (short and long term storage and retrieval)
- fine motor skills
- gross motor skills
- attention (focus)
- abstractions (interpreting symbolism)
- social competence (effective interactions with others)



WHERE TO GO FOR HELP

See **Learning Disabilities** in the **Where to Go for Help** section at the back of this document.

INTELLECTUAL & DEVELOPMENTAL DISABILITIES

Intellectual and developmental disabilities (mental retardation) refers to a range of cognitive, social/emotional, adaptive and motor delays or impairments. These deficits often impact on the child's ability to communicate, learn, interpret and respond to social cues. The child may also exhibit challenging behaviour (self-injury, aggression, destruction) associated with frustration from the latter deficits.

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

Cognitive Concerns

- ▶ Significant attention difficulties
- ▶ Poor concentration, poorly focused and organized
- ▶ Is extremely restless and distractible
- ▶ Memory impairments
- ▶ Poor problem solving (planning, organizing and initiating tasks)
- ▶ Slow to process verbal information/slow to understand what is said
- ▶ Slow to process visual and non-verbal information (e.g., gestures, signs, social cues)
- ▶ Difficulty learning new tasks
- ▶ Has difficulty following directions and/or routines
- ▶ Poorly developed basic concepts (e.g., colours, shapes, body parts)

Social/Emotional/ Behavioural Concerns

- ▶ Poorly developed play skills (for his age)
- ▶ Awkward or absent greeting of others
- ▶ Has very few friends/alienates other children
- ▶ May be withdrawn/passive due to inability to communicate
- ▶ Has trouble interacting appropriately with peers
- ▶ Narrow range of interests that he engages in
- ▶ Frequent tantrums, aggression, destruction or self-injury due to frustration, lack of ability to communicate, interruption/change in routine, not getting what he wants, mind gets stuck on one issue
- ▶ May present with oppositional/defiant behaviour due to inability to process information - does not know what is expected of him

- ▶ Behaviour affecting ability to learn new things
- ▶ Socially inappropriate behaviour (e.g., taking another child's food, stripping in public)
- ▶ Poor/lack of ability to empathize (e.g., if another child is crying)

Adaptive Concerns

- ▶ Has delays in two or more age-appropriate life skills domains (e.g., toileting, dressing, feeding, face and hand washing)
- ▶ Shows no age-appropriate awareness of danger

Communications Concerns

- ▶ Poor expressive communication (language, gestures, signs)
- ▶ Poor comprehension of language (words, gestures, pictures)

Physical Concerns

- ▶ Poorly developed fine motor skills (e.g., holding a pencil, picking up beads)
- ▶ Poorly developed gross motor skills (e.g., awkward gait, poor coordination, poor balance)
- ▶ Seizures or frequent periods of blank staring

WHERE TO GO FOR HELP

See [Intellectual & Developmental Disabilities](#) in the **Where to Go for Help** section at the back of this document.

MILD TRAUMATIC BRAIN INJURY

Changes in behaviour may be related to a mild traumatic brain injury (e.g., falls, accidents, medical treatment, shaken baby syndrome).

If the child presents with **one or more** of the following behaviours that are different from the child's norm, consider this a **red flag**:

Physical

- ▶ Dizziness
- ▶ Headache, recurrent or chronic
- ▶ Blurred vision or double vision
- ▶ Fatigue that is persistent
- ▶ Reduced endurance that is consistent
- ▶ Insomnia/severe problems falling asleep
- ▶ Poor coordination and poor balance
- ▶ Sensory impairment (change in ability to smell, hear, see, taste the same as before)
- ▶ Significantly decreased motor function
- ▶ Dramatic and consistent increase or decrease in appetite
- ▶ Seizures
- ▶ Persistent tinnitus (ringing in the ears)
- ▶ Retinal hemorrhages
- ▶ Bulging fontanel
- ▶ Bruises

Cognitive Impairments

- ▶ Decreased attention
- ▶ Gets mixed up about time and place
- ▶ Decreased concentration
- ▶ Reduced perception
- ▶ Memory or reduced learning speed
- ▶ Develops problems finding words or generating sentences consistently
- ▶ Problem solving (planning, organizing and initiating tasks)

- ▶ Learning new information (increased time required for new learning to occur)
- ▶ Abstract thinking
- ▶ Reduced motor speed
- ▶ Inflexible thinking; concrete thinking
- ▶ Decreased processing speed
- ▶ Not developing age-appropriately
- ▶ Difficulties with multi-tasking and sequencing

Behavioural/Emotional (Severe)

- ▶ Irritability, aggression
- ▶ Impulsivity, confusion, distractibility, mind gets stuck on one issue, emotional rollercoaster
- ▶ Loss of self esteem
- ▶ Poor social judgment or socially inappropriate behaviour
- ▶ Decreased initiative or motivation, difficulty handling transitions or routines
- ▶ Personality change, sleep disturbances
- ▶ Withdrawal, depression, frustration
- ▶ Anxiety
- ▶ Decreased ability to empathize, egocentrism

WHERE TO GO FOR HELP

See **Mild Traumatic Brain Injury** in the **Where to Go for Help** section at the back of this document.

FAMILY ENVIRONMENTAL STRESSORS

If **any** one of these stressors is found, this could affect a child's development and should be considered a **red flag**:

Parental Factors

- ▶ Misusing adult privilege
- ▶ Bullying behaviours
- ▶ History of abuse as a child
- ▶ History of domestic violence
- ▶ Severe mental health or physical health problems
- ▶ Chronic substance misuse
- ▶ Difficulty controlling anger or aggression
- ▶ Feelings of inadequacy, low self-esteem
- ▶ Lack of knowledge or awareness of child development
- ▶ A young, immature, or developmentally delayed parent
- ▶ History of postpartum depression
- ▶ History of crime or incarceration of parent/guardian
- ▶ Low literacy

Social/Family Factors

- ▶ Multiple partners
- ▶ Family breakdown and/or family violence
- ▶ Multiple births
- ▶ Several children close in age with little family/social support
- ▶ A special needs child
- ▶ An unwanted child
- ▶ Prematurity and low birth weight
- ▶ Personality and temperament challenges in child or adult
- ▶ Mental or physical illness, or special needs of a family member

- ▶ A series of losses in a short time frame
- ▶ Recent death of a parent/child
- ▶ Lack of a support network or caregiver relief
- ▶ Immigrant status, language barrier
- ▶ Experiencing discrimination because of race, culture
- ▶ Substandard shelter
- ▶ No fixed address over a time frame/transient

Economic Factors

- ▶ Inadequate income
- ▶ Unemployment
- ▶ Lack of access to consistent medical care/no health coverage
- ▶ Business failure
- ▶ Debt
- ▶ Inadequate housing or eviction
- ▶ Change in economic status related to immigration

WHERE TO GO FOR HELP

For child protection concerns:

- For Lanark County, contact the Lanark County Children's Aid Society at 613-264-9991.
- For Leeds and Grenville Counties, contact Family and Children's Services of Leeds and Grenville at 613-498-2100 or 1-800-481-7834.
- After hours, call the local number and the answering service will contact the person on call.

For additional help, consult the **Where to Go for Help** section at the back of this document.

POSTPARTUM DEPRESSION

Postpartum “blues” are considered normal. They affect up to 80% of new mothers. They can occur 3 to 4 days after birth and can last up to 2 weeks. With good physical care and emotional support, these symptoms will go away (e.g., crying spells, feeling sad, irritability, frustration).

Untreated postpartum depression impacts a child’s development, as parents may have altered ability to be attentive, attuned and able to respond appropriately to the infant or child(ren). For more information on how red flag behaviours may be present in families experiencing postpartum depression, please see sections on: Attachment, Social/Emotional, Abuse, Behaviour, Family Environmental Stressors.

Postpartum Depression may start prenatally, and is part of the spectrum of postpartum mood disorders. A woman who has a personal or family history of depression/anxiety and/or history of abuse or neglect may be at increased risk of postpartum depression.

Red Flags for Postpartum Depression:

If mom is experiencing **any** of the following beyond 2 weeks of the birth of the child:

- ▶ Sad and tearful
- ▶ Exhaustion
- ▶ Changes in eating and sleeping patterns
- ▶ Feeling overwhelmed with inability to concentrate
- ▶ Reduced interest or pleasure in family and/or activities
- ▶ Hopelessness and frustration
- ▶ Restlessness, irritability or anger
- ▶ Extreme highs, full of energy
- ▶ Guilt and shame, thinking she is not a good mother
- ▶ Poor attachment (e.g., unable to read baby’s cues)
- ▶ Afraid to be alone with baby
- ▶ Repeated scary thoughts about the baby
- ▶ Thoughts of harming self or baby
- ▶ Altered mood; anxiety and/or depression
- ▶ Lack of supports/partner
- ▶ Recent stressful life event
- ▶ Isolation, lack of transportation
- ▶ Financial concerns which may lead to inadequate access to food and/or housing
- ▶ Unrealistic expectations of self or child
- ▶ Substance abuse

WHERE TO GO FOR HELP

See **Postpartum Depression** in the **Where to Go for Help** section at the back of this document.

GETTING READY FOR KINDERGARTEN

Is this child ready for Kindergarten?

The child should be able to:

- ▶ Get dressed
- ▶ Go to the bathroom
- ▶ Engage in healthy practices, i.e. blow nose, wash hands
- ▶ Open lunch items
- ▶ Be away from parent/guardian
- ▶ Ask for help
- ▶ Share and take turns with other children
- ▶ Follow routines
- ▶ Communicate so a teacher and other students can understand
- ▶ Be able to follow one, two, and three step instructions
- ▶ Understand basic safety rules
- ▶ Feel good about trying new things
- ▶ Take part in group activities
- ▶ Do simple chores
- ▶ Know what their printed name looks like
- ▶ Respect authority
- ▶ Communicate feelings
- ▶ Make choices
- ▶ Listen to a story

By Kindergarten entry, children should have:

- ▶ Vision checkup by 6 months of age (www.optom.on.ca)
- ▶ Dental checkup by age 1 (www.oaphd.on.ca)
- ▶ Up to date immunizations

Problem signs...

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

- ▶ Significant attention difficulties
- ▶ Behaviour affecting ability to learn new things
- ▶ Sudden change in behaviour uncharacteristic for the individual
- ▶ Difficulties with pre-academic skills/ concepts (e.g. colours, shapes)
- ▶ History of learning disabilities in the family
- ▶ Delay in self-help skills
- ▶ Inconsistent performances (can't do what he could do last week)
- ▶ Poorly focused and unorganized



See also:

- Speech & Language
- Literacy & Numeracy
- Fine Motor

SUBSIDY INFORMATION

ONTARIO CHILD CARE SUPPLEMENT FOR WORKING FAMILIES

If you are in a low-to-middle income family with children under age seven, you could qualify for the Ontario Child Care Supplement for Working Families. If you would like more information contact the Ministry of Finance at 1-877-533-2188 or www.fin.gov.on.ca

WHAT IF I ALREADY RECEIVE THE ONTARIO CHILD CARE SUPPLEMENT FOR WORKING FAMILIES?

If you are eligible to receive child care fee subsidy and are already in receipt of the Ontario Child Care Supplement for Working Families, it is in your best interest to notify the Ministry of Finance at the above telephone number or Website address in order to avoid a possible overpayment.

WHO IS RESPONSIBLE FOR CHILD CARE FEE SUBSIDY?

LEEDS & GRENVILLE: The United Counties of Leeds and Grenville Children's Services Department manages and determines eligibility for child care fee subsidies for residents of Leeds and Grenville under the authority of the Day Nurseries Act.

LANARK COUNTY: The County of Lanark Children's Services Department manages and determines eligibility for child care fee subsidies for residents of Lanark County and the Town of Smiths Falls under the authority of the Day Nurseries Act.

DO YOU QUALIFY FOR CHILD CARE FEE SUBSIDY?

Subsidies are available for children ranging in age from infant to twelve (12) years of age where the parent(s) is/are employed or enrolled in an educational or retraining program (exceptional circumstances may be considered). Child care fee subsidy applies only to contracted services which are licensed under the Day Nurseries Act.

ARE YOU FINANCIALLY ELIGIBLE FOR CHILD CARE SUBSIDY?

Eligibility is determined by your level of income as shown on Line 236 of your most recent Federal Notice of Assessment or net income as shown on your Canada Child Tax Benefit Notice. In some cases families are eligible for a partial subsidy, but this will be determined during your appointment.

HOW DO YOU MAKE AN APPOINTMENT?

You must call Children's Services to make an appointment or receive an application. Please be advised that there may be a waiting list at times.

Leeds and Grenville Counties:

613-342-3840 or 1-800-770-2170

Lanark County: 613-267-4200 ext 2302 or 2304 or 1-888-952-6275

Our offices are open daily from 8:30 a.m. to 4:00 p.m

WHAT DO YOU NEED TO BRING TO YOUR APPOINTMENT?

You must provide your most recent Federal Notice of Assessment or Canada Child Tax Benefit Notice (your eligibility cannot be determined without this document). To order either of these documents call 1-800-959-8281 and the Canada Revenue Agency will mail one to you.

For a list of licenced childcare programs in your area:

Residents of Lanark: call Lanark County Social Services at 613-267-4200 or 1-888-952-6275

Residents of Leeds and Grenville: call United Counties of Leeds and Grenville Social Services at 613-342-3840 or 1-800-770-2170

Example on How to Calculate:

Total Adjusted Annual Income for Applicant and Spouse (Income is on the Notice of Assessment from Revenue Canada or Child Care Tax Benefit Notice)	\$37,000.	\$69,000.
Income at 0% (\$0-\$20,000)	\$20,000 x 0% = \$0.00	\$20,000 x 0% = \$0.00
Income at 10% (\$20,000-\$40,000)	\$17,000 x 10% = \$1700.	\$20,000 x 10% = \$2000.
Income at 30% (\$40,000 +) (\$40,000-\$69,000)		\$29000 x 30% = \$8700.
Total annual parental contribution used for calculation	\$1700.	\$10700.
Divided by 12 months = Parental Monthly contribution	\$141.66	\$891.66

WHERE TO GO FOR HELP

If there are concerns in **any** area, advise the parent to contact any one of the following, as appropriate:

- their family physician
- their nurse practitioner
- the Health Unit's Health Action Line at 613-345-5685 or 1-800-660-5853
- any Ontario Early Years Centre:
 - **Lanark:**
613-283-0095 or 1-800-267-9252
 - **Leeds & Grenville:**
613-341-9044 or 1-866-433-8933

If the concerns pertain to a **child protection issue**, contact the local Children's Aid Society:

- Lanark County Children's Aid Society:
613-264-9991 or 1-866-664-9991
- Family and Children's Services of Leeds and Grenville: 613-498-2100 or 1-800-481-7834

For specific concerns, see the individual categories listed in this section. A physician's referral is not always required to contact individual agencies.

Abuse – pg.26 - 31

Please call your local Children's Aid Society immediately if the concerns relate to a child protection issue.

For residents of Lanark:

Lanark County Children's Aid Society
613-264-9991 or 1-866-664-9991

Interval House
613-257-5960 or 1-800-267-7946

For residents of Leeds and Grenville:

Family and Children's Services
of Leeds and Grenville
613-498-2100 or 1-800-481-7834

Interval House
613-342-4724 or 1-800-267-4409

Attachment – pg.8

For residents of Lanark:

Infant & Child Development Program, Lanark
Community Programs

Ages: 2 years and under
613-257-7121 or 1-800-667-2617

Open Doors for Lanark Children and Youth

Ages: 18 years and under
613-283-8260 or 1-877-232-8260

For residents of Leeds & Grenville:

Infant & Child Development Program

Ages: 2 years and under
613-345-1662

Child & Youth Wellness Centre

Ages: 18 years and under
613-498-4844 or 1-800-809-2494

Autism – pg.32

Families who suspect Autism but do not have a diagnosis should proceed towards assessment by having their family doctor make a referral requesting diagnostics for autism to either:

1. Children's Hospital of Eastern Ontario (CHEO)
613-737-7600
2. Ottawa Children's Treatment Centre (OCTC)
1-800-565-4839
3. Hotel Dieu, Child Development Centre
(Kingston) - 613-544-3400, ext. 3174

(Or hire the services of a private practice psychologist.)

Referral to the South East Region Autism Intervention Program can be made by completing the Autism Intervention referral*, Consent to Share Information* and submitting these with the assessment/diagnostic documentation to:

Coordinator, Behaviour Development and
Autism Intervention,
Lanark Community Programs,
30 Bennett Street,
Carleton Place ON K7C 4J9
1-866-257-7618, ext. 242

(*forms available at: <http://lcp-home.com/autism.php>)

For additional information, visit the autism Ontario website at www.autismontario.com, visit *Improving the Odds: Healthy Child Development* (Appendix K and L: **Checklist for Autism in Toddlers** (CHAT) at www.beststart.org/resources or the Geneva Centre for Autism at www.autism.net

Behaviour – pg.21

For residents of Lanark:

Open Doors for Lanark Children and Youth
Ages: 18 years and under
613-283-8260 or 1-877-232-8260

Behaviour Development Program, Lanark
Community Programs
Ages: 2 years and up
613-257-7619 or 1-800-667-2617

Infant & Child Development Program, Lanark
Community Programs
Ages: 2 years and under
613-257-7121 or 1-800-667-2617

Lanark Early Integration Program, Lanark
Community Programs
Ages: 2 years – 12 years
613-257-7121 or 1-800-667-2617

For residents of Leeds & Grenville:

Child and Youth Wellness Centre
Ages: 18 years and under
613-498-4844 or 1-800-809-2494

Developmental Services of Leeds and Grenville
613-345-1290 or 1-866-544-5614

Inclusive Child Care Program, Developmental
Services of Leeds and Grenville
Ages: Children from birth to 10 years of age with
an identified developmental delay or who are at
risk for later delays.
613-345-1290 or 1-866-544-5614

Dental – pg.25

If there are dental concerns, advise parents to
contact their dentist, or call:

Dental Services, Leeds, Grenville and Lanark
District Health Unit
613-345-5685, or 1-800-660-5853.

Children aged 0-14 years may be eligible for the

Children in Need of Treatment (CINOT) Program.

For additional information, visit www.oaphd.on.ca.
Baby Oral Health online video at: www.utoronto.ca/dentistry/newsresources/kids. Or refer to the
yellow pages of your local phone book.

Family Environmental Stressors – pg.37

Please call your local Children's Aid Society
immediately if the concerns relate to a child
protection issue.

For residents of Lanark:

Lanark County Children's Aid Society
613-264-9991 or 1-866-664-9991

Connections Program
Ages: 0-6 years
613-257-2779 or 1-888-284-2204

Interval House
613-257-5960 or 1-800-267-7946

For residents of Leeds and Grenville:

Family and Children's Services of Leeds and
Grenville
613-498-2100 or 1-800-481-7834

Interval House
613-342-4724 or 1-800-267-4409

Feeding & Swallowing – pg.24

A physician's referral is required.

Children's Hospital of Eastern Ontario (CHEO)
613-737-7600

Child Development Centre,
Hotel Dieu Hospital, Kingston
613-544-3400, ext. 3175

Fetal Alcohol Spectrum Disorder – pg.33

If there are concerns, advise parents to contact
their physician or if they do not have a physician,
contact:

Children's Outpatient Centre, Hotel Dieu
Hospital, Kingston
613-544-3400, ext. 3150 or 3151

For a diagnosis, a physician may make a referral
to: CHEO Genetics Clinic, Ottawa
613-737-2275

Medical Genetics, Kingston
613-533-6310

St. Michael's Hospital in Toronto has a FASD diagnostic clinic for people of all ages. Referrals are accepted from any source. The clinic is based on a multidisciplinary approach. The process begins by calling 416-867-3655 and requesting a questionnaire. It is recommended that a service provider assist the family with the questionnaire and include their contact information, as the questionnaire is lengthy and requires a thorough family history. Once this is filled in and mailed back, a clinic appointment will be made.

For a FASD Resource Guide, call the Health Action Line of the Leeds, Grenville and Lanark District Health Unit at 613-345-5685, or 1-800-660-5853

For additional information on FASD, visit the Public Health Agency of Canada at www.publichealth.gc.ca and www.alcoholfreepregnancy.ca as well as the website for the Leeds, Grenville and Lanark District Health Unit at www.healthunit.org

Fine Motor – pg.9

For residents of Lanark:

Infant & Child Development Program, Lanark Community Programs
Ages: under 3 years
613-257-7121 or 1-800-667-2617

Community Care Access Centre
Ages: over 3 years
613-283-8012 or 1-800-267-6041

If the child is in kindergarten, contact the teacher to connect with appropriate services.

For residents of Leeds & Grenville:

Infant & Child Development Program
Ages: under 3 years
613-345-1662

Community Care Access Centre
Ages: over 3 years
613-283-8012 or 1-800-267-6041

Inclusive Child Care Program, Developmental Services of Leeds and Grenville

If the child is in a ministry licensed daycare program 613-345-1290 or 1-866-544-5614

If the child is in kindergarten, contact the teacher to connect with appropriate services.

Getting Ready for Kindergarten – pg.39

Contact your local Ontario Early Years Centre

Lanark: 613-283-0095 or 1-800-267-9252

Leeds and Grenville:

613-341-9044 or 1-866-433-8933

Gross Motor – pg.10

For residents of Lanark:

Infant & Child Development Program, Lanark Community Programs

Ages: under 3 years

613-257-7121 or 1-800-667-2617

Community Care Access Centre

Ages: over 3 years

613-283-8012 or 1-800-267-6041

Lanark Early Integration Program, Lanark Community Programs

If the child is in a ministry licensed daycare program

613-257-7121 or 1-800-667-2617

If the child is in kindergarten, contact the teacher to connect with appropriate services.

For residents of Leeds & Grenville:

Paediatric Physiotherapy,
Brockville General Hospital

613-345-5645

Infant & Child Development Program

For children with global delays

613-345-1662

Inclusive Child Care Program, Developmental Services of Leeds and Grenville

If the child is in a ministry licensed daycare program

613-345-1290 or 1-866-544-5614

If the child is in kindergarten, contact the teacher to connect with appropriate services.

Hearing – pg.13

The first 2 years of life are the most important for speech and language development. By 2 years of age children should receive a hearing test if they don't seem to be developing speech and language at the normal rate.

Southeastern Region Infant Hearing Program
Kingston, Frontenac and Lennox & Addington
Public Health

613-549-1232, ext. 1145 or

1-800-267-7875, ext. 1145

Or visit their website at www.healthunit.on.ca.

Or refer to the yellow pages of your local phone book.

Intellectual & Developmental Disabilities – pg.35

If there are any concerns, advise the parent to arrange a referral to a paediatrician or psychologist through their family physician. If there is suspicion of a diagnosis of mental retardation, a referral can be made to:

Developmental Services of Leeds and Grenville
613-345-1290 or 1-866-544-5614

Lanark Community Programs
613-257-7121 or 1-800-667-2617

For more information about intellectual deficits and mental retardation, visit the American Association on Intellectual and Developmental Disabilities – AAIDD (formerly the American Association on Mental Retardation – AAMR) at www.aidd.org. Refer also to the Red Flags sections on Autism, Mild Traumatic Head Injury, Speech and Language, Behaviour and Learning Disabilities.

Learning Disabilities – pg.34

If there are concerns, advise the parents to contact their family physician, their child's school or:

Learning Disabilities Association of Kingston
613-546-8524

www.kingston.jkl.net/~ldak/index.htm

Learning Disabilities Association
of Ottawa Carleton

613-567-5864

www.ldao-c.ncf.ca

Literacy & Numeracy – pg.18 - 19

Language Express – Preschool Speech and Language Services

Ages: 0-5 years

613-283-2742 or 1-888-503-8885

www.language-express.ca

Early Literacy Specialists, Ontario Early Years Centres:

Lanark: 613-283-0095 or 1-800-267-9252

Leeds & Grenville: 613-341-9044
or 1-866-433-8933

Mild Traumatic Brain Injury – pg.36

If a parent reports changes in their child's behaviour, advise them to contact their family physician or paediatrician, who can make a referral to:

Rehabilitation Services, CHEO
613-737-7600, ext. 2500

Child Development Centre,
Hotel Dieu Hospital, Kingston
613-549-2680 (direct intake line) for a medical assessment and referral to the appropriate specialist.

Nutrition – pg.22

Registered Dietitians, Leeds, Grenville and Lanark District Health Unit

613-345-5685 or 1-800-660-5853

Postpartum Depression – pg.38

For initial assessment of PPD:

Lanark County Mental Health

613-283-2170

or their Crisis Line: 1-866-281-2911

Brockville Mental Health Centre

(Brockville Psychiatric Hospital)

613-345-1461

or their Crisis Line: 613-345-4600

Leeds, Grenville and Lanark District Health Unit

613-345-5685 or 1-800-660-5853.

For ongoing support: Postpartum Depression Support Groups are offered in both Lanark and in Leeds & Grenville once an initial assessment has been completed.

If you have reasonable grounds to suspect that a child is or may be in need of protection, promptly report your suspicions, concerns and the information on which they are based to your local Children's Aid Society.

Sensory – pg.14

For residents of Lanark:

Infant & Child Development Program,
Lanark Community Programs

Ages: under 3 years

613-257-7121 or 1-800-667-2617

Community Care Access Centre

Ages: over 3 years

613-283-8012 or 1-800-267-6041

Lanark Early Integration Program, Lanark Community Programs

If the child is in a ministry licensed day care program

1-800-667-2617

If the child is in kindergarten, contact the teacher to connect with appropriate services.

For residents of Leeds & Grenville:

Infant & Child Development Program

Ages: under 3 years

613-345-1662

Community Care Access Centre

Ages: over 3 years

613-283-8012 or 1-800-267-6041

Inclusive Child Care Program, Developmental Services of Leeds and Grenville

If the child is in licensed day care

613-345-1290 or 1-866-544-5614

If the child is in kindergarten, contact the teacher to connect with appropriate services.

Social/Emotional – pg.20

For residents of Lanark:

Open Doors for Lanark Children and Youth

613-283-8260 or 1-877-232-8260

Infant & Child Development Program, Lanark Community Programs

Ages: 2 years and under, with a developmental disability or at risk for a developmental disability

613-257-7121 or 1-800-667-2617

Lanark Early Integration Program,

Lanark Community Programs

For children attending a ministry licensed daycare program

613-257-7121 or 1-800-667-2617

The Lanark County Children's Aid Society

613-264-9991 or 1-866-664-9991

For residents of Leeds & Grenville:

Child and Youth Wellness Centre

613-498-4844 or 1-800-809-2494

Infant & Child Development Program

Ages: under 3 years

613-345-1662

Inclusive Child Care Program, Developmental Services of Leeds and Grenville

For children attending a ministry licensed daycare program

613-345-1290 or 1-866-544-5614

Family and Children's Services of Leeds and Grenville

613-498-2100 or 1-800-481-7834.

Speech & Language – pg.15 - 17

Language Express – Preschool Speech and Language Services

Ages: 0-5 years

613-283-2742 or 1-888-503-8885

www.language-express.ca

Early Literacy Specialists, Ontario Early Years Centres:

Lanark: 613-283-0095 or 1-800-267-9252

Leeds & Grenville: 613-341-9044
or 1-866-433-8933

Vision – pg.11

Current research suggests that approximately 1 in 6 children has a vision problem. Children born with poor vision do not know what “normal vision” is like. They often think everyone sees the same way they do. Therefore, do not wait for your child to tell you they have a vision problem.

The Ontario Association of Optometrists recommended frequency for children's eye examinations:

- 6 months of age
- 3 years of age and then
- Every 12 months or as recommended by the optometrist

For more information about vision loss, visit the Canadian National Institute for the Blind website at www.cnib.ca

If there are any concerns about a child's vision, advise the parent to arrange for a vision test with an optometrist, or contact their family physician for a referral to an ophthalmologist. Children up to 6 years of age who are diagnosed as blind or low vision by an ophthalmologist can be referred to:

Southeastern Ontario Blind-Low Vision Early Intervention Program
Kingston, Frontenac and Lennox & Addington Public Health

613-549-1232, ext. 1145

or 1-800-267-7875, ext. 1145

Or visit their website at www.healthunit.on.ca

Or refer to the yellow pages of your local phone book.

