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Authentic Assessment for Early Childhood Intervention: Best Practices
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CHAPTER 1

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What Are the Professional Standards for Assessment of Preschool Children?

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BEST-PRACTICE ISSUES

- Can parents contribute reliable and valid assessment information about their children?
- Is high-stakes testing a recommended practice in early childhood?
- Why are natural observations the preferred way to gather child performance information?
- Should assessment and instruction be related?
- Is it all right to "teach to the test" in early childhood intervention?
- Are standardized, norm-referenced tests to be used predominantly in early childhood?

Professionals and families have promoted some notable changes in assessment for young children with disabilities since the early 1980s. Yet, these changes are meager in comparison to fundamental transformations witnessed in early intervention/early childhood special education (EI/ECSE): use of natural settings, developmentally appropriate practices and family-centered methods. In this respect, assessment for early intervention has been *delayed* in its own development. Materials that are family friendly

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and that link assessment and teaching seem critical to early intervention; however, few changes have occurred in the process, style, and methods of assessment to complement inclusion or developmentally appropriate and family-centered practices (Neisworth & Bagnato, 2004).

Assessment is a pivotal event for families and their children; assessment results are used to include children in specialized interventions that can change their developmental destinies. Beyond the eligibility determination or *gatekeeping* purpose, assessment also is critical for program planning, monitoring (formative) progress, and for program (summative) evaluation. Given the importance of assessment, it is understandable that the materials and procedures for early childhood assessment are contentious. The professional literature, newsletters of parent organizations, and, indeed, the pages read by hearing officers, illustrate the assessment struggle.

The Recommended Practices included in this chapter emerged from focus groups and are supported by the literature. In addition, they reflect the ideas and experiences of many professionals and families with whom I have collaborated over several years. The practices also echo many suggestions and concerns of other professional standards, including those of the National Association for the Education of Young Children (NAEYC) and the National Association of Early Childhood Specialists in State Department of Education (NAECSSDE) (2003; see also Appendix B); the National Association of School Psychologists (NASP; Thomas & Grimes, 2002), the American Speech–Language–Hearing Association (ASHA; 1990), and the Association for Childhood Education International (ACEI; Perrone, 1991). Previously, I proposed a definition for early childhood assessment that is consistent with the recommendations reported in this chapter:

> Early childhood assessment is a flexible, collaborative decision-making process in which teams of parents and professionals repeatedly revise their judgments and reach consensus about the changing developmental, educational, medical, and mental health service needs of young children and their families. (Bagnato & Neisworth, 1991, p. xi).

GUIDING PRINCIPLES

The professionals and parents who participated in this effort repeatedly expressed two concerns. First, as principal stakeholders, parents and family members must play a vital and indispensable role in assessment from beginning to end. Second, assessment methods and materials must accommodate children's developmental and disability-specific characteristics. Because of the importance of these concerns, they are presented separately.

Parents as Partners

As professionals, we are committed to working with parents and others who know and care about the child. It is true, of course, that there can be obstacles to effective family participation. Families may be overwhelmed by their child's possible diagnosis and may be intimidated by jargon and differences in educational levels. Cultural differences, language barriers, and work, health, schedule, and transportation difficulties also can make collaboration difficult.

In addition to my legal and ethical responsibilities to partner with parents, there are sound professional and practical reasons for doing so. First, families provide valuable authentic and longitudinal information about their child that is not otherwise available (Diamond & Squires, 1993). Further, family members provide needed information about their circumstances and the possible impact on the child. More active involvement of parents in their child's program appears to be related to greater developmental progress (Ramey & Ramey, 1998). Not an isolated or perfunctory recommendation, parents as partners is a dominant theme that runs across all phases of the assessment and intervention sequence.

Developmental Appropriateness

Organizations representing young children (e.g., NAEYC, ACEI) have for some time advocated approaches and materials that match children's interests and developmental status. Early childhood professionals oppose the use of school-age demands and practices with children who are neither developmentally prepared for nor benefit from such imposition. Conventional standardized norm-referenced assessment materials and tasks are very often seen as entirely wrong even for use with children of typical development (Perrone, 1991). The *inappropriateness* of such materials and demands becomes greatly exacerbated when considering young children with special needs (Bagnato, Neisworth, & Munson, 1997):

> Assessment of infants and preschoolers remains dominated by restrictive methods and styles that place a premium on inauthentic, contrived developmental tasks; that are administered by various professionals in separate sessions using small, unmotivating toys from boxes or test kits; staged at a table or on the floor in an unnatural setting; observed passively by parents; interpreted by norms based solely on typical children; and used for narrow purposes of classification and eligibility determination. (p. 69)

The styles, methods, and content of assessment must become compatible with, rather than at odds with, the behavior and interests of young children. A fundamental precept of developmentally appropriate practice is

that teaching and assessment must take place in the child's *natural context* rather than being decontextualized (Bagnato & Neisworth, 2000):

> A developmental approach presumes a more whole-child view. Many developmental areas are sampled and child differences, from time to time, are highlighted so that the child's previous performance serves as the baseline for monitoring progress. Professionals use a flexible approach in choosing toys that are motivating for the child and are often the child's own. They are responsive to the fact that young children rarely sit still at tables or respond on command to typical structured tasks. A developmental approach acknowledges that professionals must adjust their own language, behavior, and expectations to the young child's level of developmental maturity. A more familiar play-based approach is used that does not force conformance to standardized procedures that are at odds with the typical behavior of young children. (p. 1)

New directions and professional standards for early childhood assessment must reflect eight critical qualities: assessment must be useful, acceptable, authentic, collaborative, convergent, equitable, sensitive, and congruent (Bagnato & Neisworth, 1999).

Utility

Assessment must be useful to accomplish the multiple and interrelated purposes of early care and education and early intervention. Assessment is critical for detecting possible problems and, through intervention, averting later more intractable and complex difficulties. Children must be able to access programs through flexible eligibility determination processes; assessment is crucial for planning individualized interventions, for monitoring progress through regular repeated assessments, and for documenting the impact of quality programs. Above all, assessment must have treatment validity—there must be an essential similarity or linkage among program goals, individual child objectives, and the developmental competencies that are assessed. Materials and methods of assessment must help families and professionals to identify instructional objectives and methods for helping.

Acceptability

The methods, styles, and materials for assessment must be mutually agreed upon by families and professionals. The objectives and methods suggested by assessment must be considered worthwhile and acceptable. Further, assessment should detect changes in behavior that are noticeable to caregivers in the home and early childhood environments. This standard of acceptability is an aspect of the wider construct usually referred to as social validity.

Authenticity

Contrived tasks and materials as well as unfamiliar people and circumstances are not optimal for true appraisals of what children really know and do. Tabletop testing with tiny little toys is often a task dreaded by the child, parents, and, indeed, the professional!

Psychometric items typically do not sample useful curricular content that could guide intervention. Observing children perform in their natural settings offers authentic information that is much more descriptive of the child. Rating scales, direct observation, curriculum-based checklists, and caregiver interview inventories are useful in helping professionals obtain a realistic appraisal of the child's strengths and intervention priorities.

Collaboration

Assessment methods and styles should promote teamwork among families and professionals. Parents and other family members are central partners in the assessment of their children; assessment materials should be chosen and used because they are written in understandable, family-friendly, jargon-free language to which anyone can respond. Assessment must promote the concept of parent–professional decision making in which *tests do not make decisions—people do*. Curriculum-based assessment can be used as a unifying approach that invites input from multiple team members, including family members.

Convergence

Functional, reliable, valid information on the status and progress of children can be obtained when typical behavior in everyday routines is observed repeatedly by several individuals—teachers, other professionals, and parents. Differences in such data are important to highlight so that areas of needed change or special emphasis in programming can be underscored. The pooling (convergence) of several perspectives (family, professional) provides a better information base.

Equity

Assessment must accommodate individual differences. The principle of equity is recognized (and mandated) as essential for instructional materials. For example, one would not use standard print material with children of low vision. Materials can be chosen that allow the child to demonstrate capabilities through several different response modes by using materials that can be changed in a flexible manner. When materials and procedures accommodate a child's sensory, response, affective, and cultural character-

istics they are equitable. Conventional materials have been standardized with children of typical development; to force fit these materials to atypical children violates not only the standards of equity and developmental appropriateness, but common sense.

Sensitivity

Professionals and families must be given the opportunity to use assessment materials that sample evidence of progressively more complex skill development so that even the smallest increment of change can be detected and celebrated. Children with more severe delays and impairments especially need assessment that is sensitive to small increments of progress. Many conventional instruments do not include a sufficient number of items to make possible sensitive measurement of progress.

Congruence

Materials must be designed for, and field validated with, the very children who will be assessed, including those with typical development and those with varying degrees of mild to severe disabilities. Early intervention, specifically, and early childhood education, generally, require specialized materials that address the emerging talents of young children at play in various home- and center-based educational settings. Early childhood assessment materials and methods must be developed specifically for infants, toddlers, and preschool children and match the style and interests typical of young children.

ORGANIZATION OF THE PRACTICES

The Recommended Practices in assessment are organized around five statements. They reflect the issues just discussed and include the following: (1) professionals and families collaborate in planning and implementing assessment; (2) assessment is individualized and appropriate for the child and family; (3) assessment provides useful information for intervention; (4) professionals share information in respectful and useful ways; and (5) professionals meet legal and procedural requirements and Recommended Practices guidelines. Two central themes or dimensions inform all of the practices: (1) family members are partners in assessment; and (2) materials and practices must be developmentally appropriate.

BEST-PRACTICE GUIDEPOINTS

Division of Early Childhood (DEC)
Recommended Practices and Examples: Assessment

♦ **Professionals and families collaborate in planning and implementing assessment.**

A1. Professionals provide families with easy access by phone or other means for arranging initial screening and other activities.
Example:
- *The family is provided a phone number or e-mail address that will always be answered promptly by a knowledgeable person.*

A2. Professionals ensure a single point of contact for families throughout the assessment process.
Example:
- *From the very first contact with a family, one team member is identified to serve as coordinator (i.e., the single point of contact) for all assessment activities from referral to the initiation of services.*

A3. Families receive a written statement of program philosophy regarding family participation in assessment planning and activities.
Examples:
- *A brochure or written statement about family involvement in assessment is provided to families.*
- *A staff member verbally explains the philosophy of assessment when the brochure or written statement is provided and clarifies any questions the family may have.*

A4. Professionals meet and collaborate with families to discuss family preferences and reach consensus about the process, methods, materials, and situations of assessment that will meet the child's needs best.
Examples:
- *Families and professionals jointly plan the specifics of the assessment including the location, time of day, and strategies for assessment.*
- *Professionals are careful to incorporate culturally and linguistically appropriate procedures into the plans.*

A5. Professionals solicit information from families regarding the child's interests, abilities, and specials needs.
Examples:
- *The team plans which assessments to use only after obtaining information from the family about what the child typically does and what the child likes to do.*
- *The team asks for and utilizes family suggestions for favorite toys, activities, and accommodations to use in the assessment.*

A6. Professionals review, with parental consent, agency information about the child and family.

Example:

- *The service coordinator requests and the team reviews records of the child's birth history and medical history, and information from other agencies.*

A7. Professionals and families identify team members and the team assessment style to best fit the needs and goals of the child and family.
Examples:

- *It is decided that the occupational therapist, speech–language pathologist, early childhood special educator, and family members will conduct the assessment using a transdisciplinary play-based model.*
- *The physical therapist and early childhood special educator make a home visit to assess the child in a familiar setting and in the context of familiar activities.*

A8. Families participate actively in assessment procedures.
Example:

- *The child's mother observes as the team assesses her daughter and answers questions about what the child typically does at home.*

A9. Families choose their roles in the assessment of their children (e.g., assistant, facilitator, observer, assessor).
Examples:

- *Families may choose to watch the assessment, to serve as an informant, to participate by interacting with the child, or to provide support to the child by staying nearby. Prior to the day of the assessment, a professional explains what each role entails so that families can choose which they wish to assume and will know what to expect on the assessment day.*
- *Family members observe the assessment activities and comment on their child's performance.*
- *Family members make a list of the words their child understands.*
- *A family member helps the child eat a snack while the occupational therapist observes the child's chewing and swallowing abilities.*

A10. With each family's agreement, professionals help families identify resources, concerns, and priorities related to their child's development.
Examples:

- *In meetings prior to the development of the individualized family service plan (IFSP) or individualized education plan (IEP), families share their concerns and priorities for their child as well as the resources available to help them with their child's development.*
- *The early interventionist shares checklists of possible needs and resources for the family to use.*

A11. Professionals, families, and other regular caregivers work as equal team members for purposes of assessment (i.e., give equal priority to family/caregiver's observations and reports, discuss assessment results, reach consensus about the child's needs and programs).
Example:

- *At the team meeting, the parent, early interventionist, speech–language pathologist, and physical therapist all identify current functioning and areas of need for the child. All information is considered in the assessment process rather than viewing some information as more "correct" than other information.*

A12. Program administrators encourage the use of assessment procedures that ensure consultation and collaboration among families and professionals (e.g., the whole team discusses qualitative and quantitative information and negotiates consensus to make decisions).
Example:

- *The assessment team has an agreed upon model of teaming and consensus building that is followed.*

♦ **Assessment is individualized and appropriate for the child and family.**

A13. Professionals use multiple measures to assess child status, progress, and program impact and outcomes (e.g., developmental observations, criterion/curriculum-based interviews, informed clinical opinion, and curriculum-compatible norm-referenced scales).
Example:

- *Available measures include observations, criterion curriculum-based instruments, interviews, curriculum-compatible norm-referenced scales, informed clinical opinion, and work samples.*

A14. Professionals choose materials and procedures that accommodate the child's sensory, physical, responsive, and temperamental differences.
Examples:

- *The child uses her augmentative communication device and adaptive equipment when her progress is assessed by the team.*
- *The child uses eye gaze to indicate choices on an assessment of receptive vocabulary.*

A15. Professionals rely on materials that capture the child's authentic behaviors in routine circumstances.
Examples:

- *Assessment includes observation of the child's engagement in familiar activities in his typical environment rather than only behavior in contrived situations.*
- *The assessment is conducted in the classroom the child currently attends.*
- *Family members identify the child's favorite toys and these are used for assessment activities.*
- *A family member and the child look at picture books together while the speech therapist records the child's communication skills.*

A16. To design IFSP/IEP goals and activities, professionals seek information directly from families and other regular caregivers using materials and procedures that the families themselves can manage.

Examples:

- *Families provide information about potential learning opportunities for their child that occur in daily routines and that are feasible given the other demands of the family.*
- *Families choose to complete a questionnaire or checklist to help identify goals and learning activities.*
- *Assessment for program planning includes strategies for gaining information from families and other caregivers so that the IFSP/IEP goals pertain to the child's natural environment.*

A17. Professionals assess children in contexts that are familiar to the child.
Examples:

- *The professional observes the child in his usual early care and education.*
- *A family member reports that the child has some challenging behaviors in the early evening. The professional schedules a home visit at that time to try to understand the issues and potential solutions.*

A18. Professionals assess a child after they have become familiar to him or her.
Examples:

- *The assessment team members spend time with the child in play or in an informal activity to establish familiarity prior to assessment.*
- *Individuals who are familiar with and to the child are identified as members of the assessment team.*

A19. Professionals gather information from multiple sources (e.g., families, professional team members, agencies, service providers, other regular caregivers).
Examples:

- *The teacher and the babysitter make a list of the words the child uses, says, signs, or gestures.*
- *The occupational therapist observes the child playing with toys in the classroom and then sets up a few testing items to clarify the child's performance.*
- *The child's physician, early care and education providers, babysitter, extended family members, and religious school teacher are also asked for input.*

A20. Professionals assess the child's strengths and needs across all developmental and behavioral dimensions.
Examples:

- *The team completes all sections of the curriculum-referenced instrument even though stated concerns are only in one domain.*
- *The team assesses a child across all developmental domains (i.e., social, motor, communication, adaptive, sensory, and cognitive) and all behavioral dimensions (e.g., temperament, problem solving, and self-regulation).*

♦ **Assessment provides useful information for intervention.**

A21. Families and professionals assess the presence and extent of atypical child behavior that may be a barrier to intervention and progress.
Example:

- *The team assesses the occurrence of problematic atypical behavior, challenging behavior, and self-stimulation in naturally occurring routines and activities throughout the day.*

A22. Professionals use functional analysis of behavior to assess the form and function of challenging behaviors.
Examples:

- *Over a couple of days, the team members identify what happens just before and after they observe challenging behaviors (e.g., crying, hitting, throwing objects) by the child. They discuss whether the behavior is meant to obtain attention, avoid a specific activity, or serve another function. Then the team plans strategies to reduce the behavior and evaluate their hypothesis.*
- *For a week, the child's mother and father write down what happens right before the child's tantrums and what happens afterward. The early interventionist reviews these notes with them, and they form a "best guess" about the purpose or function of the tantrumming behavior. Based on this information, the early interventionist helps the parents develop a plan for reducing the occurrence of the child's tantrums.*

A23. Program supervisors, in concert with the EI/ECSE team, use only those measures that have high treatment validity (i.e., that link assessment, individual program planning, and progress evaluation).
Examples:

- *The team uses curriculum-based instruments that link directly to the curriculum.*
- *Assessment tools used are those that provide information that directly assists with program planning.*

A24. Professionals assess not only immediate mastery of a skill, but also whether the child can demonstrate the skill consistently across other settings and with other people.
Examples:

- *The team assesses whether new words learned at home are also used in the caregiving setting.*
- *The team assesses the child's ability to walk in the classroom, on the playground, to and from the car, and so forth.*

A25. Professionals appraise the level of support that a child requires in order to perform a task.
Examples:

- *The team assesses whether or not a child can request juice independently or with varying amounts of help.*

- *The team assesses whether the infant lifts her head on her own in response to interesting sounds or sights.*
- *Professionals access the level of prompting, environmental modification, or reinforcement required for a child to consistently demonstrate a skill.*

A26. Professionals choose and use scales with sufficient item density to detect even small increments of progress (especially important for children with more severe disabilities).
Example:

- *A curriculum-based instrument has too few items to demonstrate progress of a child over time, so the team breaks down items on the measure into smaller steps to make progress more apparent.*

A27. Professionals and families rely on curriculum-based assessment as the foundation or "mutual language" for team assessments.
Example:

- *In conducting an evaluation to determine eligibility for special education, the team uses a curriculum-based instrument in addition to a norm-referenced instrument.*

A28. Professionals conduct longitudinal, repeated assessments in order to examine previous assumptions about the child, and to modify the ongoing program.
Examples:

- *The team completes the curriculum-based measure twice per year for each child.*
- *Teachers collect weekly data on a child's fine motor objectives.*
- *Family members and early care and education providers keep track of what the child eats to monitor caloric intake for a child who has trouble gaining weight.*

A29. Professionals report assessment results in a manner that is immediately useful for planning program goals and objectives.
Examples:

- *The team uses a curriculum-based measure in which items become learning objectives.*
- *The team report describes the child's needs and suggests learning activities.*

♦ **Professionals share information in respectful and useful ways.**

A30. Professionals report assessment results so that they are understandable and useful for families.
Examples:

- *Reports are translated into the dominant language of the family.*
- *Reports use minimal technical jargon and include definitions of terms if needed.*
- *Reports give specific information about the child's abilities and needs rather than just scores or developmental ages.*

A31. Professionals report strengths as well as priorities for promoting optimal development.
Example:
- *Team members always take the time to include information about a child's areas of strength in their reports as well as discussing areas of need.*

A32. Professionals report limitations of assessments (e.g., questions of rapport, cultural bias, and sensory/response requirements).
Examples:
- *Team members report the results of an assessment with caution due to the child's physical impairment, which may have prevented a valid assessment.*
- *The team decides that an assessment should be conducted in the child's dominant language as well as in English so that a comparison of the results can be made.*

A33. Professionals write reports that contain findings and interpretations regarding the interrelatedness of developmental areas (e.g., how the child's limitations have affected development; how the child has learned to compensate).
Examples:
- *A child who is visually impaired may currently be demonstrating a delay in vocabulary development due to his inability to see objects and people around him.*
- *A child whose speech is delayed may not be able to express all that she knows.*

A34. Professionals organize reports by developmental/functional domains or concerns rather than by assessment device.
Example:
- *The physical therapist, early interventionist, and speech–language pathologist write their report by organizing all of their information together by developmental domain.*

A35. Families have adequate time to review reports, ask questions, or express concerns before the team uses the information for decision making.
Example:
- *In advance of the team meeting, information is shared and family members are provided the opportunity to ask questions or express concerns with at least one member of the team.*

A36. Family members may invite other individuals to evaluation meetings or meetings to discuss children's performance or progress.
Example:
- *In preparation for the evaluation meeting, the service coordinator asks the family if they would like to invite anyone to attend. Those invited may include other family members, friends, spiritual advisors, or other professionals.*

♦ **Professionals meet legal and procedural requirements and meet Recommended Practice guidelines.**

A37. Professionals inform families about state EI/ECSE rules and regulations regarding assessment.
Example:

- *Written information about state regulations is given to families prior to the eligibility assessment in written form or through other formats. The family has the opportunity to talk with a team member about the regulations if there are questions.*

A38. Professionals, when required by regulations to apply a diagnosis, employ measures and classification systems that are designed and developmentally appropriate for infants and young children.
Example:

- Assessment teams have guidance from their state that makes disability categories appropriate for young children.

A39. Psychologists rely on authentic measures of early problem-solving skills (instead of traditional intelligence tests) that link directly to program content and goals and that sample skills in natural, rather than contrived, circumstances (e.g., play-based).
Examples:

- *The assessment team always includes an authentic measure of child functioning in assessment to determine eligibility.*
- *The psychologist observes the child in her early education setting as part of the assessment process.*

A40. Professionals, when appropriate, choose those norm-referenced measures that are developed, field validated, standardized, and normed with children similar to the child being assessed.
Example:

- *The assessment team is careful to choose instruments that are appropriate to each child rather than always using the same instruments for every child.*

A41. Professionals monitor child progress based on past performance as the referent rather than on group norms.
Examples:

- *The assessment team considers assessment information from at least three points in time to monitor child progress.*
- *Rather than comparing a child's performance on an instrument to other children at the same age, the team analyzes the child's rate of development in relation to his previous rate of development.*

A42. Professionals defer a definitive diagnosis until evaluation of the child's response to a tailored set of interventions.
Example:

- The assessment team is cautious about identifying a category of disability for a child on the basis of one assessment only and has the

option of using a "developmental delay" category so that services may be provided. More information will be learned about the child during intervention.

A43. Program administrators provide supervisory support for team members to enable them to maintain ethical standards and recommended practices.
Examples:

- *In-service opportunities are provided for team members so they can maintain the skills necessary for appropriate assessment.*
- *Team members are encouraged to complete quality assessments. The need to complete assessments quickly is not allowed to compromise the quality of those assessments.*

A44. Professionals and families conduct an ongoing (formative) review of the child's progress at least every 90 days in order to modify instructional and therapeutic strategies.
Example:

- *The team has review meetings scheduled every three months to review child progress and plan needed changes if identified.*

A45. Professionals and families assess and redesign outcomes to meet the ever changing needs of the child and family.
Example:

- *A child's mother is returning to work, necessitating changes in the service plan. The team makes the needed changes to the intervention plan as requested by the family.*

A46. Professionals and families assess the child's progress on a yearly (summative) basis to modify the child's goal plan.
Example:

- *The team summarizes the child's progress in preparation for the annual meeting to revise the IFSP or IEP.*

BEST-PRACTICE EVIDENCE

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