Latino Community Engagement for Early Childhood Screening: Ages 3–5

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Introduction:

The years leading up to kindergarten are critical periods of rapid growth and development in children. In Carver County and in all of Minnesota, early childhood screening is required within 30 days upon entrance into kindergarten, however screening before this period is beneficial. Early childhood screening allows early detection and diagnosis of developmental conditions with a greater chance to sufficiently address the issues and to improve outcomes. Screening assessments include vision, hearing, and developmental screening and evaluation of immunizations and physical growth risk factors (Minnesota Department of Education, 2015). The benefits of these assessments are clear, however, as Minnesota and Carver County become more culturally diverse, the programs, services, and best practices need to change in order to meet the needs of the community.

Minnesota depends on residents migrating into the state to keep the workforce stable. Roughly 24,000 immigrants find residence in Minnesota every year, and that number is growing (Brower & Egbert, 2015). Recent increases in immigration have been largely due to residents coming from Africa, Central America, and Mexico (Gould, Walker & Frazell, 2009). In the Metro Area, Carver County is expected to have the highest population growth by 2040. In 2013 the largest non-white population in Carver County was Latino residents who comprised an estimated 4.2% of the population (Carver County, 2015). Recently, the Carver County Department of Public Health has identified concerns of low numbers of children receiving early childhood screening. With a diversifying community, this report is intended to identify best practices on outreach and community based work in early childhood screening, with a focus on

Latino communities, to help guide the Carver County Department of Public Health in future programming.

Many children in the United States do not have regular access to a family physician and of those who do, only 85% are being screened (McBride, 2010). This is the reason why early childhood screening is important in schools. In schools we are able to reach more children earlier. Along with the direct benefits, screening is also financially beneficial. One program in Minnesota found that every dollar spent on early intervention had an eight dollar return (Berry, Garzon, Mack, Kanwischer & Beck, 2014). When we invest in the development of our children, we are benefiting society as a whole-- this investment leads to greater utilization of the education system and less encounters with the criminal justice system (Berry, et al., 2014).

Methods

In order to identify best practices on outreach and community based work in early childhood screening in Latino communities, we conducted a literature review of articles from 1990 to 2015. In our collection of literature, we limited selection to peer reviewed articles available through Google Scholar, PubMed, and the University of Minnesota MNCAT Discovery Library. In our search, we used key terms of “immigrant” and “diverse” “communities.” We narrowed our search by adding key terms of “barriers,” “strategies,” and “best practices.” Finally, we included specific terms to our search including “screening,” “children,” “ages 3-5,” “pre-school,” “school age,” “school setting,” “implementation,” “Hispanic,” “Latino,” “influences,” “access,” “mothers’ knowledge,” “parental assessment,” and “child development.” In total, we identified 18 articles that reveal potential barriers and strategies to early childhood screening.

There is limited published research covering early childhood screening specifically in schools. Most peer-reviewed articles were limited to screening in the primary care setting and

the tools used to assess and refer patients. Further, little research was available on the perceptions of early childhood screening by the community it serves. Research with the specific demographics and culture of Carver County is also limited and generalizations from other areas have been drawn to make recommendations for the region.

Findings

Our findings yielded a wide range of literature discussing economic and social barriers to health service utilization for Latino and immigrant families. The existing literature from 1990-2015 established that there was a clear need to improve access to health care services through programs and initiatives that addressed the socioeconomic and cultural limitations facing immigrant families (Smith, Kreutzer, Goldman, Casey-Paal & Kizer 1996).

A recurrent finding was the need to create programs that recognized that many immigrant families were low-income and did not have the same resources that their middle-income counterparts would in regards to time, money and transportation. Transportation to health services and appointments was a common barrier identified. Families may not have access to reliable means of transportation, impacting their ability to utilize services or programs not located within their immediate communities. Health service providers must consider the possibility that services may be desired, but are located too far away from their target populations for them to use. Another major barrier to accessing health services identified in the literature was health insurance coverage and the ability to pay medical bills (Smith et al., 1996; Flores et al., 1998; Lagerberg 2005, Denny et al., 2007). The economic burden associated with seeking health care services can be too large for low-income immigrant families. Although many children of immigrant families may be covered through federal health insurance plans, immigrant families still worry about additional costs that may arise when seeking additional

medical services. These perceived costs prevent families from accessing the medical system (Flores, Abreu, Olivar, & Kastner, 1998).

A second obstacle identified was language. The language barrier was noted as a major limiting factor to accessing services for immigrant families because it impacts the family's ability to seek care and also impacts how well they understand provider recommendations when they are able to find care. Families who are not proficient English speakers or who cannot fully understand written English may be unaware of their child's need for early childhood screening. If all informational material is presented through written media or communicated through unfamiliar technology, this problem is compounded. For example, when important material concerning the need for children to be screened is presented to immigrant families in a non-native language or with terminology that the parents are unfamiliar with, it prevents parents from understanding the information and following public health recommendations for their children. When programs do take steps to translate the material, there is still the issue of incorrect translations. When information is translated, it is imperative that materials be accurately translated by a translator who is proficient in the language. Incorrectly translated material further confuses immigrant families and may be more detrimental to engagement efforts (Denny, Itkonen, & Okamoto, 2007) .

Cultural differences were also identified as a major barrier to screening access. Many immigrant families perceive health conditions differently and hold different beliefs about the nature of health care. In the literature, it was noted that Latino and immigrant parents may not understand the purpose of early childhood screening. For example, many cultures believe that children are young and their bodies are "new", and therefore they are impervious to any defects-- a belief such as this would negate the need for screening. Frazier et. al (2011) conducted focus groups with parents in which parents stated that they didn't understand the

need for their children to get vision screenings because their eyes were “new”. The responses of the parents in this particular focus group strengthens the argument of cultural differences that create hesitancy to accessing preventative care and screening for children. Another cultural belief that impacts perceptions of early childhood screening, is the belief that each child develops differently, at their own pace. This belief challenges the idea of appropriate developmental stages and challenges the need for screening. In one study, Bronstein and Cote (2004) demonstrated that immigrant mothers tended to have lower proficiency of developmental benchmarks for their children . In another study, Lagerberg (2005) found that low-income parents were less likely to correctly identify developmental delays in their children than high-income parents. These two studies suggest that children from low-income immigrant families are at an increased risk of not having their developmental delays identified early by their parents. These findings,combined with results from Zuckerman et al. (2014) who found that immigrant families conceptualize autism in away that prevents its early diagnosis, present an unique set of challenges for public health professionals attempting to increase early childhood developmental screening rates in immigrant and Latino communities.

While financial, language, and cultural factors are the major barricades to access of early childhood screening services for immigrant, or more specifically Latino families, an additional factor that should be further investigated is the role that providers play. Berry et. al (2014) examined provider attitudes toward providing screening services and found that providers had many concerns about the availability of referral services. Additionally, organizational deficiencies made it difficult to identify a particular physician in a practice as the head of a screening program. These hesitations and shortcomings in the system prevented physicians from conducting screenings at an ideal rate. This article highlights a barrier to early childhood screening that gets little attention: provider reluctance and uncertainty in regards to the

screening process. Improving provider attitudes toward early childhood screening and addressing their concerns about the process may not fall within the scope of this particular project, but warrants further investigation and research.

Recommendations

Our research findings identified three major barriers and one peripheral barrier to health service utilization in Latino and immigrant communities. We make the following recommendations with the assumptions that our findings regarding barriers to health service utilization are the same influencing immigrant family engagement in early childhood screenings. An additional assumption that guides our recommendations is that the identified barriers are universal and exist in Carver County.

Our first recommendation is that all initiatives aimed at improving early childhood screening participation address the socioeconomic barriers faced by immigrant families. The most effective way to overcome these challenges would be to either provide transportation services to families or to have services available within target communities. Providing transportation to screening locations or providing mobile screening can increase the number of Latino children receiving early childhood screening services. Mobile screening units, provided at suitable times for families, would reach families who do not have enough time to go to health centers, as well as those who have no means of getting to screening locations. Another recommendation that addresses the socioeconomic needs of immigrant families is communication about the costs associated with screenings. Parents may assume the cost for screening is expensive because of lack of communication.

Our second recommendation is that well-trained translators who are proficient in language and culture be employed by all programs.This recommendation is intended to help

families by providing them information in their native languages. This would also prevent miscommunication between families and health departments that may arise when material is improperly translated. By employing qualified and dedicated translators that are also cultural specialists, the county can further make a clear commitment to the needs of its non-English speaking populations. Aside from the straightforward translation benefits, this would allow residents of these communities to see that the government of their city is truly committed to their well-being and engagement. It would be the responsibility of these cultural specialists to build meaningful and trusting relationships within the communities that they serve and engage parents in conversations about the importance of screenings. Carver County currently employs two cultural specialists, however we suspect there is too much work for these two employees to have a significant effect on screening utilization. More hires need to be made for these positions. These employees would allow the Carver County Public Health Department to increase immigrant parents' awareness of the importance of early childhood screening on a large scale.

Finally, an open dialogue between immigrant communities and health professionals is needed to address common misconceptions about the necessity of early childhood screening and to address availability of resources supporting families and children diagnosed with developmental delays and disabilities. Existing literature suggests that immigrant parents have cultural beliefs and understandings of child development that may prevent the early identification of physical and developmental problems in their school-aged children. One way to address these potentially harmful beliefs and present parents with information about early childhood screenings would be for the Public Health Department to hold community information sessions. These sessions would allow parents to share their concerns or questions regarding screening with public health personnel and allow health officials to present evidence-based

information to parents. The best way to address a specific population, is to gain understanding from them. This forum, if held in a venue at a time that reaches the majority of the community, would allow public health professionals to address communities in a more relaxed environment which may make attendees more receptive to the points being made.

Conclusion:

Accessibility and utilization of early childhood screening services in immigrant populations are crucial issues to evaluate, specifically in regards to a county with the demographic changes seen in Carver County. As discussed, Carver County is experiencing growth in its overall population, and growth in its Latino population. This growth includes an increase in Latino children who require access to early childhood screening services.

Evaluation of existing literature surrounding early childhood screening and barriers to such services has revealed major limitations in the current system of screening. As areas such as Carver County become more diverse, these programs need to be evaluated to ensure that they are accessible financially, structurally, and culturally. In order to improve access to early childhood screening by the Latino community, we need to ensure that the system is adequately targeting this group. We cannot simply expect the old system to work for a changing population.

The identified barriers to access and utilization of services need to be appropriately evaluated and addressed by adjusting the system. The aforementioned barriers that have been found in other communities include lack of financial resources, lack of appropriate communication tools, lack of transportation, and lack of education regarding the services. While the recommendations suggested in this literature review are based on the assumption that these barriers apply to Carver County, it is important to evaluate each system individually and adjust to the specific demographic and cultural needs of each community. This study was

limited in that we did not find any literature pertaining to Carver County specifically. Further, were not able to meet with the Latino families in the community to hear their perspective on barriers to screening.

Recommendations were developed based on a thorough literature review of research surrounding the benefits and barriers of access to childhood screening. These recommendations aim to improve the availability of screening resources by making them more comfortably accessible and easily understandable by the Latino population. These recommendations were developed under the assumption that it is in the best interest of the Latino children of the community to have access to screening services. In order to provide early screening to this specific population, special acknowledgement of the barriers to care for this population is necessary and adjustments in the system of care should be made. It is not enough to simply offer services. We need to ensure that the system best fits the population it is attempting to serve. Investing now in the development and continuation of early childhood screening services, targeted at the Latino population in Carver County, is crucial for long-term health outcomes of the growing population.

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Appendix

1. Tables and Figures

Table 3. Parents' Suggestions for Improving Early Identification of ASD

Domain	Suggestions	Sample Quotation(s)
Interpretation of early signs of ASD	Doctors should regularly review the early signs of autism with parents	I think it would be a good idea to have like commercials on television about the symptoms of autism, for instance[a]
	Early signs of ASD could be incorporated into prenatal advice	I think… [information] should be given to the parents and not wait until the parents ask for it
	Doctors should screen for autism at routine visits	
	Doctors should explain the purpose of screening and screening results to parents	
	Media campaigns should target early signs and symptoms of ASD	
	Information could also be disseminated through the early education system or through community nutrition and social support agencies	
Information needs about ASD	Information about ASD should be incorporated into parenting classes	If a Latino dad comes to his child's visit, I think the doctor needs to give him this information. Have it there in the room, like a magazine with big letters in Spanish so that the people will start to read it[a,b]
	Parenting classes should accessible to low-income families and provide child care	
	Written information should be at a low reading level and professionally translated into Spanish	Because as you say, Latinos are diagnosed late, you know? It will start with teachers. Preschool, kindergartens. Have like conferences with Latino families, you know, bringing everything in Spanish or something
	Information should be available in video format for parents with lower literacy level	
	Parents should be directed to reliable internet sources of information	
Health care access and quality	In-person interpreters should be provided whenever there is a concern about child development	I think especially if they already know that the kid has autism, then they need to consider their appointments a bit longer so they understand and give family some advice, and they should tell them where they can take their kids to get the help they need
	Providers should offer longer visits for children who have or are high risk for ASD	
	Providers should have at-risk or newly diagnosed families meet with a social worker or other person familiar with community resources	
	Providers should increase their ASD knowledge and confidence about discussing it with families	[Doctors] do not know exactly what's going on in their family. They [may] have another problem, you know, with [their] other kids. Maybe money or may be it's a single mom… each family is different, so I think they will [need] help by other resources, like a social worker. When you have a child like that, you need help, you know?
Community Mental Health Stigma	Providers should communicate sensitively about this issue with parents and give them time to come to terms with the information	I would say be very sensitive because this is not an easy thing for her. She's troubling with it. Probably… involve the whole family. Everybody's involved because… the other people's gonna interact with the child[b]
	Providers should involve all family members in discussions about ASD	
	Providers should offer psychological support to parents and family members of newly diagnosed children	
	Providers could connect families of newly diagnosed children with other families of children with ASD	
	Information about autism could be incorporated into elementary school curricula so that children and their parents will understand the condition better	

[a]Quotation was translated into English from Spanish. [b]Quotation from individual interview; all other quotations were from focus groups.

Zuckerman, K. et al. (2014). Conceptualization of Autism in the Latino Community and its Relationship With Early Diagnosis. Journal of Developmental & Behavioral Pediatrics, 35(8). Table 3

Table 3. Frequency of Reported Perceived Unmet Needs

Perceived Unmet Needs	Latino n = 42	Euro-American n = 42
Health problems[a]	Yes = 14	Yes = 6
	No = 28	No = 36
Rehabilitation therapy program[b]	Yes = 22	Yes = 0
	No = 20	No = 42
Information[b]	Yes = 29	Yes = 0
	No = 13	No = 42
Support group[b]	Yes = 23	Yes = 0
	No = 19	No = 42
Education program	Yes = 7	Yes = 4
	No = 35	No = 38
Equipment	Yes = 15	Yes = 12
	No = 27	No = 30
Day care[b]	Yes = 2	Yes = 17
	No = 40	No = 25
Respite[b]	Yes = 0	Yes = 15
	No = 42	No = 27
Home health aide[b]	Yes = 2	Yes = 8
	No = 40	No = 34
Recreational program[c]	Yes = 0	Yes = 7
	No = 42	No = 35

[a]Significant difference, $p < .05$.
[b]Significant difference, $p < .000$.
[c]Significant difference, $p < .007$.

Gannotti, M., Kaplan, L., Handwerker, W., & Groce, N. (2004). Cultural Influences on Health Care Use: Differences in Perceived Unmet Needs and Expectations of Providers by Latino and Euro-American Parents of Children with Special Health Care Needs. *Developmental and Behavioral Pediatrics, 25*(3). Table 3

TABLE 2. KIDI Items That the Majority of Immigrant Mothers Had Difficulty Answering

KIDI Item	Mothers Who Answered Correctly, %		
	All Immigrant Mothers	Japanese Immigrants	South American Immigrants
Development: physical and physiological			
A 4-mo-old lying on his (her) stomach can lift his (her) head	15	20	10
Altogether, the average newborn cries ~1–2 h out of every 24 h	36	37	36
Babbling ("a-bah-bah" or "bup-bup") begins at ~5 mo	49	50	48
Development: cognitive and perceptual			
One's IQ (intelligence) score stays the same from infancy through childhood	48	42	55
An infant will begin to respond to his (her) name at 10 mo	48	55	40
An 8-mo-old is most likely to be scared by an unfamiliar person wearing a mask	50	45	56
Infants have depth perception by 6 mo of age (can tell that they are on a high place)	19	25	13
2-mo-olds can tell some speech sounds apart	22	20	24
Development: emotional			
A baby of 6 mo will respond to someone differently depending on whether the person is happy, sad, or upset	44	42	45
Development: temperament and personality			
Some normal babies do not enjoy being cuddled	34	25	44
A baby's personality (individuality) is set by 6 mo of age	41	45	36
Parent-infant relationships			
Some mothers do not get really involved with their infants until the baby starts to smile and look at them	22	32	10
The way the parent responds to the baby in the first few months of life determines whether the child will grow up to be happy and well-adjusted or moody and a misfit.	26	20	34

Bornstein, M., & Cote, L. (2004). "Who is Sitting Across From Me?" Immigrant Mothers' Knowledge of Parenting and Children's Development. *Journal of Pediatrics , 114* (5). Table 2

Table 3. Mean Scores for Minority and Non-minority Groups

	Minority Mean	SD	Non-minority Mean	SD	*t*	*df*
Age, mo	26.28	4.42	25.20	4.48	−2.26*	341
M-CHAT	6.32	3.74	6.46	4.27	ns	180
Mullen VR T-score	32.76	12.94	35.75	12.66	2.15*	338
Mullen FM T-score	31.31	11.74	33.62	11.90	ns	337
Mullen RL T-score	27.07	10.07	32.71	14.01	4.30**	330.27
Mullen EL T-score	28.37	9.34	30.63	11.78	1.98*	337.01
Vineland Communication SS	77.81	13.29	80.13	13.03	ns	340
Vineland DLS SS	84.01	15.81	81.68	13.10	ns	340
Vineland Socialization SS	82.83	12.29	82.80	10.98	ns	340
Vineland Motor SS	85.64	12.42	87.01	12.47	ns	340
CARS	26.32	6.74	25.22	6.66	ns	338

*$p < .05$. **$p < .01$. CARS, Childhood Autism Rating Scale; DLS, daily living skills; EL, expressive language; FM, fine motor; M-CHAT, Modified Checklist for Autism in Toddlers; ns, not significant; RL, receptive language; SS, standard score; VR, visual reception.

Herlihy, L., Brooks, B., Dumont-Mathieu, T., Barton, M., Fein, D., Chen, C., & Robins, D. (2014). Standardized Screening Facilitates Timely Diagnosis of Autism Spectrum Disorders in a Diverse Sample of Low-Risk Toddlers. *Journal of Developmental & Behavioral Pediatrics, 35*(2). Table 3

2. Further Reading

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Shepard, L., Kagan, S., & Wurtz, E. (1998). *Principles and Recommendations for Early Childhood Assessments*. Washington DC: National Education Goals Panel.

(*Note: This is a good source on U.S. screening standards and the cultural values of the U.S. education system and screening. It might help put our system into perspective as just one take on education and childhood development)*

-Minnesota Department of Education- Early Childhood Screening
http://www.education.state.mn.us/MDE/StuSuc/EarlyLearn/EarlyChildScreen/index.html

"One of the greatest challenges in evaluating special education services for ethnically diverse groups is obtaining accurate, valid, reliable, and relevant information. This can be achieved by the right person asking the right questions of the right people in the right way at the right place and time." Jill Bevan-Brown

EARLY CHILDHOOD SCREENING

Best Practices

Barriers and recommendations for working with immigrant families to improve early childhood screening for ages 3-5

What is Early Childhood Screening?

- In Minnesota early childhood screening is required within 30 days of entrance into kindergarten and allows for early detection of developmental conditions. Screening at schools reaches more children earlier, particularly those that do not have a primary physician.

Screening Includes:

- -Vision
- -Hearing
- -Psychological Development
- -Immunizations
- -Physical Development

Every dollar spent on early intervention has eight dollar return.

Carver County is expected to have the highest population growth of the metro area to 2040. In 2013 the largest non-white population in Carver County was Latino residents who composed an estimated 4.2% of the population.

Carver County Public Health has identified concerns of low numbers of children receiving early childhood screening.

Identified Barriers

1. Knowledge

-Immigrant families are new to both the U.S. education system and the U.S. healthcare system. They lack information U.S. cultural development markers, screening requirements and screening outcomes. Providers also lack knowledge about immigrant families and their cultures.

2. Financial Barriers

-Many immigrant families face financial barriers that impact many areas of life. This has a large impact on healthcare access.

3. Cultural Beliefs and Practices

-Different cultures have different beliefs on health, childhood development and education, children with special needs, and healthcare.

4. Language

-Language barriers hinder understanding between providers and families on screening procedures and requirements, cultural beliefs and norms, and barriers to care.

5. Transportation and Time

-Families do not always have transportation to screening appointments and screening hours may be too limited.

6. Provider Attitudes

-Providers may be unwilling to work with immigrant families. Providers may also be skeptical about healthcare or educational needs being met after they are identified through screening.

Recommendations

1. Address the Socioeconomic Barriers that Immigrant Families Face

This includes:
- -Providing transportation and/or mobile screening units as necessary
- -Providing families with information on any cost associated with screening
- -Providing families with information on additional social service

2. Engage with Immigrant Families

There should be open dialogue between the school, healthcare providers, and families. Immigrant families and other minority families should have a voice in how this problem is approached and solved. All cultures should be treated as equally valid; opinions on the objectively "right" approach to healthcare and education should be avoided.

3. Utilize Translators and Cultural Specialists

This will help prevent miscommunication between families and providers and strengthen the connection between the school and the community. It will also convey the message to immigrant families that they are a priority to the school district and government. Without this, families may receive confusing information or no information at all and feel marginalized in the community. Cultural specialists will help the school understand the different cultures of community members. Culturally appropriate screening tools need to be used when possible.

4. Provide More Information

Families should be provided with complete information on screening well before they are expected to screen their children. This information needs to be correctly translated and in a format that is accessible to parents. This might require non-traditional methods of education such as radio talks, phone calls, or informational meetings through community organizations. Families need to know why screening is being done, how it's done, how the results are used, and what is done when a child is diagnosed with a developmental problem.

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