Red Flags -

A Quick Reference Guide for Early Years Professionals in Ottawa

Early Identification of Red Flags in Child Development From Birth to Age Six

Updated April 2016

Disclaimer Notice

Red Flags: a Quick Reference Guide for Early Years Professionals in Ottawa (*Red Flags Guide*) is a reference guide designed to assist **Early Years Professionals** in determining whether there is a need to refer families or caregivers to seek out additional advice, screening, assessment and/or treatment for their child.
It is not an assessment or diagnostic tool.

The information in the *Red Flags Guide* has been provided for professionals working with children up to the age of six years (Early Years Professionals). While every attempt has been made to ensure its accuracy, the information in this document is provided as an "as is" basis without warranty or condition.

The Red Flags Guide cannot substitute for the advice, formal assessment and/or diagnosis from professionals trained to properly assess the growth and development of infants, toddlers and children. The intent of this document is to assist Early Years Professionals in determining when to discuss with a family the need to seek out advice and/or treatment. This document should not be used to diagnosis or treat perceived growth or developmental limitations and/or other health care needs.

***The Red Flags Guide* is not an assessment or diagnostic tool. It does not replace the responsibility of a parent/caregiver to consult their family physician and/or appropriate professionals.**

The Red Flags Guide refers to websites, resources and other documents that are created or used by independent organizations. These references and documents are provided as a public service and do not imply that they have been reviewed, verified and/or validated by the Ottawa Red Flags Task Group.

Red Flags: a Quick Reference Guide for Early Years Professionals in Ottawa
IS NOT TO BE USED TO DIAGNOSE OR LABEL A CHILD

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Table of Contents

Introduction

The History of the Red Flags Guide

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

With permission from colleagues in Simcoe County, the document was reviewed and revised by the York region Early Identification Planning Coalition and supported by York Region Health Services through 2003. The first edition of the *Red Flags Guide* was released in the York Region in June 2004. Since that time, 14 other communities across Ontario have adapted the guide to their local regions.

Ottawa Red Flags Guide

In 2010, Ottawa Best Start Special Needs Working Group obtained permission from the York Region Early Identification Planning Coalition, through the York Region Health Services Department, to adapt the *Red Flags Guide* for Ottawa.

The Ottawa Red Flags Task Group led the review and revision of the document to reflect the most recent guidelines, research and best practices as well as local programming. Without the energy, effort and in-kind support from each of the representatives, this project would not be possible.

The Ottawa Red Flags Task Group includes representatives from:

- **Centre psychosocial**
- **Child and Youth Health Network for Eastern Ontario**
- **Children's Integration Support Services**, a program of Andrew Fleck Child Care Services
- **First Words Preschool Speech and Language Program**, Pinecrest Queensway Community Health Centre
- **Ottawa Public Health**

Acknowledgements

A special thanks to the Ottawa Best Start Steering Committee for financially supporting the translation, dissemination and training of the Ottawa *Red Flags Guide*.

The leadership provided by the Ottawa Best Start Special Needs Working Group was greatly appreciated.

We would also like to thank the many partner organizations who took time and effort to contribute to the Ottawa document. Their expertise and knowledge was instrumental in the completion of this document and have ensured that the guide will be useful for professionals who work with infants, children and their families in the Ottawa community.

Early Identification

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 years the first three years in particular, set the base for competence and coping skills that will affect learning, behaviour and health through the lifespan.

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 this period of intense growth and development of neural pathways is critical to ensure the best possible outcomes for the child.

What is Red Flags?

Red Flags is a quick reference guide for early years professionals.

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 help practitioners decide when and where to refer for additional services, formal assessment and or treatment at the earliest possible sign.

Who should Use the Red Flags Guide

This reference guide is intended for professionals working with young children and their families. We have assumed the reader has a basic knowledge of healthy child development. *Red Flags* will help professionals to identify when a child could be at risk of not meeting developmental milestones, triggering an alert for further investigation by the appropriate professional or discipline.

How to use the Red Flags Guide

Red Flags is designed to help practitioners identify potential developmental concerns for children six years of age and younger.

Red Flags:

- Can be used in conjunction with other screening tools, like the Nippissing District Developmental Screens™ to review developmental milestones and problem signs.
- Recognizes the importance of cultural competence in assessing child growth and development.
- Includes some indicators that focus on the parent/caregiver, or the interaction between the parent/caregiver and the child.
- Provides contact and referral information for Ottawa.

When considering making a referral for further assessment:

- **Err on the side of caution.** Refer for further assessment even if you are uncertain if the red flags noted are a reflection of a cultural variation or a real concern.
- **Aim for coordinated service.** If a child appears to have multiple domains requiring formal assessment by several disciplines, refer families to agencies that can help coordinate a collaborative and comprehensive assessment process.
- **Prepare families for anticipated costs.** If you make referrals to private sector agencies, let the family know that they may be responsible for costs incurred.

How to Talk to Parents and Caregivers about Sensitive Issues Related to Developmental Concerns

Sharing Sensitive News

One of the most challenging issues in recognizing a potential concern with a child's development is sharing this concern with the parents/caregivers. It is important to be sensitive when suggesting there may be a reason to have further assessment. You want parents/caregivers to feel capable and to be empowered to make decisions.

The way in which sensitive news is shared has both immediate and long term effects on the family (and child) in terms of how parents perceive the situation and how ready or willing they are to access support (TeKolste, 2009; First Signs, 2009). Many parents are not aware or may not recognize that their child is at risk.

Sharing sensitive news can be challenging both for the parents as well as the person delivering the news. Upon receiving sensitive news about their child, some parents might react with a variety of emotions including shock, anger, disbelief, and fear. Parents hearing sensitive news might also feel overwhelmed and might need time to process and then accept the information.

For the professional, sharing sensitive news with families is often challenging and may sometimes play out in a reluctance to initiate the discussion. Among barriers expressed by professionals are fears of the following:

- Causing the parents/caregivers pain and negative emotional reactions
- Parents being unready to discuss concerns
- Parents rejecting this information
- Being culturally inappropriate
- Lack of knowledge of resources
- Lack of time
- Own discomfort at addressing some issues/ subjects

There is no one way that always works best but there are some things to keep in mind when addressing concerns. It is hoped that the following framework will be useful in preparing professionals for sharing concerns in a clear, informative, sensitive and supportive manner, acknowledging the parents'/caregivers' perspectives and feelings. Presenting information in a professional manner lends credibility to your concerns (TeKolste, 2009; First Signs, 2009) and could be helpful to the parent. Make sure parents feel that they are not alone.

Plan to set the stage for a successful conversation:

- It is extremely helpful if you have previously set the expectation that part of your professional role is to monitor the development of all children in your care to ensure they get support if necessary to optimize their potential.
- Set up the meeting in a private space.
- Allow for as much time as might be necessary without interruption
- Developing a warm, trusting relationship with the parent/caregiver is helpful in easing the process of sharing concerns. It is most supportive if the staff member with the best relationship with the family is selected to share the information.
- Make sure you properly document your meeting and that your concerns have been documented.
- Ensure there is a plan for follow-up action with respect to referrals and follow-up meetings (First Signs, 2009).
- Begin with child's strengths and positive attributes.
- Start by explaining that it is helpful to get as much information as possible regarding a child's skills and areas to work on, so to better support the child, and the earlier the intervention, the better.

How to Talk to Parents and Caregivers about Sensitive Issues Related to Developmental Concerns

Empathize: Put yourself in the parents' and caregivers' shoes.

Empathy allows for the development of a trusting, collaborative relationship. It is important to acknowledge that the parents and caregivers are the experts in knowing their child, even though you have knowledge of child development. Ensure you listen carefully. Acknowledge and reflect their responses. When parents and caregivers have a chance to share feelings without feeling judged they might be more receptive to hearing sensitive information.

It is useful to begin the discussion with sensitive probing questions to find out what the parents already know and what their concerns are. Try to use open-ended questions (i.e. "Do you have any concerns?" "How do you feel about your child's progress?"). It is also important to find out how much detail the family wants to know.

If you give too much information when the parent is not ready, they may feel overwhelmed or inadequate. (First Signs, 2009)

Sharing the Information:

Be sensitive to a parent's/caregiver's readiness for information. You may want to offer information you have by asking parents what they would like to know first or what they feel they need to know first, as they may not be sure where to start.

Note that some cultural and language barriers may prevent the parents from openly or directly asking their questions.

When you are more of a resource than an authority, parents may feel less threatened. Give parents ample opportunity to ask questions.

Having a parent use tools such as the Nipissing District Developmental Screen may help open the way for discussion. It may help to specify that the screening tool is something given to many parents to help them understand their child's development and to learn about new activities that encourage growth and development and feeling good about themselves.

- Link what you are telling them with what they already know
- Avoid the use of professional jargon
- Make use of the written documentation you have gathered on their child's strengths and needs on age-based screening tools.
- Present the information in a neutral matter. State facts, advantages and disadvantages without presenting your personal beliefs, convictions or undermining other approaches of practices.
- Encourage parents to explore all possibilities and their options. Do not speak on behalf of an approach or an agency.
- Approach the opportunity for accessing extra help in a positive manner - e. g. "you can get extra help for your child so he will be as ready as he can be for school".
- Try to balance the concerns you raise with genuine positive comments 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 . .. ").*

Remember throughout the conversation that it is important to empathize with the parents/caregivers even if they are distressed, confrontational, angry or disagree with you (TeKolste, 2009; First Signs, 2009).

Planning the Next Steps:

Have the family participate fully in the final decision about what to do next. Your role is to provide information, support and guidance. The final decision is theirs. It is important to summarize the discussion, the agreed upon next steps as well as any questions for follow up.

Finally, if the parents suggest a "wait and see" approach, explore why they feel this way. Allow them to express and explore their previous experiences. Acknowledge if concerns are related to the professionals' agenda vs. the parents' agenda.

It may be important to offer reasons why it is not appropriate to "wait and see." Explain that early intervention can dramatically improve a child's development and prevent additional concerns such as behaviour issues, and that the "wait and see" approach may delay addressing a medical or developmental concern.

When possible, offer additional supports; perhaps, offer to accompany the parents and introduce them to the professional offering the care. Early intervention helps parents/caregivers understand child behaviour and health issues, and will increase confidence that everything possible is being done to ensure that the child reaches his full potential.

However, it is important that the parent is fully informed. If the parent is not ready, and needs more information, encourage further exploration of every approach.

If the parents refuse to provide care for their child and/ or refuse to give consent for intervention and you feel that the child may be in need of protection, your child protection concerns must be reported to the CAS.

Be genuine and caring. You are raising concerns because you want their child to do the best that they can, not because you want to point out "weaknesses" or "faults." Your body language is important; parents may already be fearful of the information (TeKolste, 2009; First Signs, 2009). It is important to acknowledge their fears as well as your own concerns and limitations.

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 further assessment is needed."*

Culturally Competent

Early years professionals have the privilege of working with families from many cultural groups. These families come with their various beliefs, values, and knowledge which influence their childrearing practices. Childrearing is what caregivers do on a daily basis in response to children's needs (Evans and Myers 1994). This, in turn, impacts a child's growth and development.

To be able to provide the best care and service to the families they work with, it is important for early years professionals to become culturally aware and culturally competent.

Culture is the pattern of beliefs, values, knowledge, traditions, and norms which are learned, shared, and may be handed down from generation to generation. A group of individuals is said to be of a specific culture if they share a historical, geographical, religious, racial, ethnic, or social context (Hate Crimes Community Working Group, 2006).

To be culturally aware involves the ability to stand back and become aware of one's own cultural values, beliefs, and perceptions (Quappe and Cantatore 2005).

Cultural competency means that the professional is aware that cultural differences and similarities exist and have an effect on your values, learning and behaviour. The components of cultural competency include valuing and recognizing the importance of one's own culture, valuing diversity, and being willing to learn about the traditions and characteristics of other cultures (Stafford, Bowman, Eking, Hanna and Lopoes-DeFede as cited in Mavropoulos 2000).

While cultural patterns will guide a culture as a whole, these patterns may or may not be followed by individual parents/caregivers, creating individual variations in childrearing practices. Culture is constantly changing, and being reshaped by a variety of influences, including for some, life experiences in Canada. Professionals must remember that their client's culture may be different than their own and must be aware of the significance of cultural behavior as it relates to parenting. Where there are concerns that cultural practices may be conflicting with Canadian child protection law, consultation with your Children's Aid Society is the best route.

The greatest resource for understanding each family's unique culture is the family itself. By acknowledging the family's origins and all the influences on their cultural expression and childrearing practices, the early years professional will be better able to provide culturally competent care.

Suggestions for a Successful Conversation:

- Try to learn more about the client's specific culture to prepare for conference/meeting
- Be respectful of customs (e. g. people from some cultures do not shake hands, so do not be offended if they do not extend their hand)
- Be respectful and open-minded and try to understand their perspective
- Consider involving a professional translator (language interpreter) to help overcome any language barriers

Duty to Report

We all share the responsibility to protect children from harm. As professionals working with children, you may come across situations where you suspect child abuse or neglect. Ontario's Child and Family Services Act (CFSA) states that anyone who has reasonable grounds to suspect that a child is, or may be, in need of protection must promptly report any suspicions to a children's aid society (CAS).

The report must be made directly to a CAS by the person who has the reasonable grounds to suspect abuse or neglect. You have to report directly to a Children's Aid Society and can not rely on anyone else to report on your behalf.

"Reasonable grounds" refers to the information that an average person, exercising normal and honest judgment, would need in order to make a decision to report.

It is important to remember your "ongoing duty to report". This means that even if a report has already been made about a child, you must make a further report to the Children's Aid Society if there are additional reasonable grounds to suspect that the child is or may be in need of protection. You must file an additional report if there are further reasonable grounds.

The Act recognizes that people working closely with children have a special awareness of the signs of child abuse and neglect, and a particular responsibility to report their suspicions.

Cultural practices of a particular group may sometimes conflict with Canadian law. In working with children of diverse cultures, early years professionals should be aware that families may include practices such as severe forms of corporal punishment. Professionals should remember that it is not their job to determine whether a suspicion of child abuse falls within a cultural context. Consultation with a Children's Aid Society is the best route. (Rimer, 2002)

Remember "if in doubt call to consult"!

Anyone who suspects that a child is or may be in need of protection should contact a Children's Aid Society immediately. In Ottawa, call 613 747 7800 at any time of the day or week.

To learn more, visit www.ontario.ca/children

Source: Originally from York Region Red Flags (2009) and reviewed in 2010 by Children's Aid Society of Ottawa with reference to Reporting Child Abuse and Neglect It's Your Duty. Your responsibilities under the Child and Family Services Act. Government of Ontario.

2

DOMAINS

The quality of early parent-child relationships has an important impact on a child's development and ability to form secure attachments. A child who has a secure attachment feels confident that they can rely on the parent/caregiver to protect them in times of distress. This confidence gives the child security to explore the world and establish trusting relationships with others.

The following items are considered from the **parent's/caregivers's perspective.**

If a parent/caregiver states that one or more of these statements describes their child, there may be attachment issues; consider this a red flag:

Babies

When a baby's needs are responded to, they in turn respond, and are easier to soothe. They will want to be near their caregiver and react to them. This secure attachment is the first way that babies learn to organize their actions. This is the foundation that allows your baby to explore the world and have a safe place to return to. Secure attachment also helps your baby learn how to trust others. It is an important part of developing healthy relationships for later in life.

How parents and caregivers respond to their baby can have an impact on the baby's:

- Developing brain
- Ability to control and manage emotions
- Ability to feel safe exploring their environment
- Ways of coping with new or stressful experiences
- Self-esteem and building relationships with others
- Future expectations and behaviours in these relationships

Toddlers

When a toddler's needs are responded to, they feel respected and loved, and will gain self-esteem. This allows them to learn how to think for themselves and make good choices. Through attachment, toddlers will learn different emotions and problem-solving skills. They will talk and share more. Secure attachment is an important part of developing healthy relationships for later in life.

Remember that all babies and toddlers are unique and have their own temperament. You cannot spoil a baby.

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

Red Flags: Early Identification in Leeds, Grenville & Lanark November 2007

Attachment

Problem Signs… if a parent/caregiver is frequently displaying any of the following, consider this a red flag:

- Being insensitive to a baby's communication cues.
- Is 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 their own emotions in a fearful or intense way.
- Infant Mental Health and Attachment: City of Ottawa Website

WHERE TO GO FOR HELP

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

- St. Mary's Home (613) 749-2491
- Centre Psychosocial 613-789-2240/ www.centrepsychosocial.ca
- Healthy Babies, Healthy Children, Ottawa Public
- Health Information: 613-580-6744

For more information:

- E- Mental Health www.ementalhealth.ca
- Ontario Early Years www.ottawa.ca/residents/childcare/ottawa/oeyc_en.html

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Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Crossroads Children's Centre, Language Instruction for Newcomers to Canada (LINC), St Mary's Home and Ottawa Carleton Headstart Association for Preschoolers.

Attention Difficulties

The key characteristics of attention difficulties such as poor attention control, impulsiveness, becoming easily distracted and a high activity level can all be seen in typically developing children. However, when these behaviours are excessive, they may negatively affect the child's ability to function in academic and social situations.

In deciding whether these behaviours are red flags warranting further intervention, please consider the following:

- Child's developmental age
- Factors such as stress and boredom
- Red flags for attention difficulties may be associated with attention deficit hyperactivity disorder (ADHD) or may potentially be signs of a learning disability or autism spectrum disorder (ASD). Therefore, red flags in a variety of developmental areas may need to be considered (e. g., speech, hearing, vision, fine motor, behaviour and sensory) to make appropriate referrals.

If a child exhibits several of the following characteristics over a long period of time, consider this a red flag:

Red flags if:

- Distracted very easily
- Difficulty concentrating on tasks for a reasonable length of time
- Difficulty paying attention to detail (often makes careless mistakes)
- Problems following instructions and completing activities
- Difficulty keeping track of personal belongings and materials
- Struggles to remember routines and organize tasks/activities
- Difficulty getting started on activities, particularly those that are challenging
- Does not seem to be listening when spoken to directly
- Often fidgets, squirms and turns around in seat
- Constantly on the go
- Makes a lot of noise even during play
- Talks incessantly when not supposed to talk
- Blurts out answers before hearing the whole question
- Becomes easily frustrated waiting in line or when asked to take turns
- Leaves seat when expected to stay in seat
- Runs or climbs excessively when it is not appropriate

WHERE TO GO FOR HELP

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

- Their family physician or paediatrician
- Healthy Babies, Healthy Children, Ottawa
- Public Health Information: 613-580-6744 TTY (613) 580-9656 www.parentinginottawa.ca healthsante@ottawa.ca
- Parent Resource Centre (613) 565-2467

For more information

- E- Mental Health www.ementalhealth.ca
- Ontario Early Years www.ottawa.ca/residents/childcare/ottawa/oeyc_en.html
- PADDC Parents of AD/HD Children Support Group the-adhd-info.tripod.com/id3.html
- Ottawa Area ADHD Network health.groups.yahoo.com/group/ADHD-NEO/

Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Crossroads Children's Centre, Language Instruction for Newcomers to Canada (LINC), St Mary's Home and Ottawa Carleton Headstart Association for Preschoolers.

Autism Spectrum Disorder (ASD)

Autism spectrum disorders are lifelong developmental disorders characterized by impairments in communication, social interaction, restricted repertoire of activities and interests. Associated features, which may or may not be present, can include difficulties in eating and/or sleeping, unusual fears, learning problems, repetitive behaviours, self-injury and unusual responses to sensory input.

Individual "flags" or concerns should not be considered in isolation. If a child presents with some of the following behaviours, consider this a red flag:

Social Concerns

- Does not smile in response to another person
- Poor eye contact - decreased eye contact with people, although may look intently at objects
- Lack of "joint engagement" (e. g. does not play Peek-a-Boo games)
- Lack of imitation (e. g. does not wave bye-bye)
- Limited showing, giving, sharing and directing of others' attention
- Delayed imaginative play – lack of varied, spontaneous make-believe play
- Prefers to play alone, decreased interest in other children
- Poor interactive play
- Loss or regression of social skills before the age of 36 months
- Prefers to do things for him/herself rather than ask for help
- Awkward or absent greetings

Communication Concerns

- Language is delayed or atypical
- Unusual language – (echolalia) e. g. repeating phrases from movies in a repetitive manner, echoing other people (beyond what is expected in normal development), repetitive use of phrases, odd intonation
- Inconsistent response or lack of response to his/her name or instructions (may respond to sounds, but not language)
- Decreased ability to compensate for delayed speech by gesturing/pointing
- Poor comprehension of language (words and gestures)
- Loss of language skills particularly between 15 and 24 months
- Inability to carry on a conversation

Behavioural Concerns

- Repetitive hand and/or body movements: finger wiggling, hand and arm flapping, tensing of fingers, complex body movements, spinning, jumping, etc.
- Severe, repeated tantrums due to interruption of routine, interruption of repetitive behaviour, or unknown causes/triggers
- Unusual sensory interests - visually squinting or looking at things out of the corner of the eye; smelling, licking, mouthing objects (beyond age 3); hypersensitive hearing
- Repetitively engaging in a narrow range of interests
- Insistence on maintaining sameness in routine, activities, clothing, etc.
- Unusual preoccupation with objects (e. g., light switches, fans, spinning objects, vertical blinds, wheels, balls)
- Unusual response to pain (high or low tolerance)

Feeding and associated skills

- As an infant, rarely explores toys by mouthing
- By one year of age, does not express interest in licking or tasting birthday cake
- Refuses toothbrushing
- Between 15-18 months shows significant dropping of previously accepted foods
- Difficulty managing new textures, especially transition from pureed foods to family foods
- Refusal to eat new foods even if they are developmentally appropriate for the child, and consistent with other foods that are accepted
- Tendency to eat foods that are only white or beige in colour
- Refusal to eat currently accepted foods when presented in a new way or when food brand is changed
- Refusal to touch wet foods with fingers and reluctance to self-feed using a spoon

WHERE TO GO FOR HELP

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

- Their family physician or paediatrician
- CHEO www.cheo.on.ca/en/autism
- For children under 6 years of age, Ottawa Children's Treatment Centre (OCTC) Intake (613)-737-0871 ext. 4425
  Web: www.octc.ca Email: intake@octc.ca

  *Family members, physicians, as well as healthcare professionals can make referrals.

For more information:

- Autism Ontario Ottawa Chapter www.autismontario.com/Ottawa
- Geneva Centre for Autism www.autism.net
- Autism Canada www.autismcanada.org
- American Academy of Pediatrics www.aap.org/healthtopics/autism.cfm

Sources: Adapted from York Region Red Flags (2009) and reviewed in 2010 by Ottawa Children's Treatment Centre, Children's Hospital of Eastern Ontario - Autism Program.

Behaviour

Children engage in one or more problem behaviours from time to time. Some factors should be considered in determining whether the behaviour is of concern on its own or as part of a more complex situation. These include:

- Behaving in a manner that presents immediate risk to self or others
- Frequency of the behaviour
- Severity of the behaviour
- Number of problematic behaviours that are occurring at one time
- Significant change in the child's behaviour
- Withdrawal

If a child presents any 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 inedible items
- Intentional vomiting (when not ill)
- Potentially harmful risk taking (e.g. running into traffic, setting fires)

Aggression

- Excessive temper tantrums; excessive anger, or threats
- Hits, kicks, bites, scratches others, pulls hair
- Bangs, slams objects, does damage to property
- Cruelty to animals
- Hurting those less able/bullies others

Difficulties with 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
- Embarrassing behaviour in public; undressing in public
- Touches self or others in inappropriate ways; precocious knowledge of a sexual nature
- Flat affect, inappropriate emotions, unpredictable angry outburst, disrespectful or striking female teachers are examples of post trauma red flags for children who have witnessed violence

Noncompliance

- Oppositional behaviour
- Running away

Life Skills

- 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

Repetitive Behaviours

- Hand-flapping, hand wringing, rocking, swaying
- Repetitious twirling; repetitive object manipulation

WHERE TO GO FOR HELP

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

- Their family physician or paediatrician
- Crossroads Children's Centre (613)-723-1623, extension 232 www.crossroadschildren.ca
- Centre Psychosocial 613-789-2240 www.centrepsychosocial.ca
- Mobile Crisis Line 613-260-2360 or 1-877-377-7775

*Parents, caregivers, or a licensed child care program with the parent/caregiver's written consent, may contact the Positive Outcomes Program, Children's Integration Support Services: (613)-736-5355 ext 244 Web: www.afchildcare.on.ca Email: cissa@afchildcare.on.ca

- Crossroads Children's Centre: (613) 723-1623, extension 232 www.crossroadschildren.ca

For more information:

E-Mental Health www.ementalhealth.ca

Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Crossroads Children's Centre, Language Instruction for Newcomers to Canada (LINC), St Mary's Homeand Ottawa Carleton Headstart Association for Preschoolers.

Child Maltreatment

According to Ontario legislation, a child may be in need of protection when there are reasonable grounds to suspect that the actions, or lack of actions, of a parent or caregiver has caused harm or created a risk of harm to a child.

- Harm or risk of harm may be physical, emotional or sexual in nature.
- Abuse refers to an act that results in harm to a child.

Emotional Harm:

Serious anxiety, depression, withdrawal, self-destructive or aggressive behaviours resulting from the actions, failure to act or neglect on the part of the parent or caregiver

This includes children being exposed to adult conflict and partner violence

Physical Harm:

Any physical injury that may be apparent or not, including but not limited to bruises, welts or fractures

Sexual Harm:

Any inappropriate touching, molestation or exploitation, including child pornography

Neglect:

Harm or risk of harm resulting from failure to adequately care for, provide for, supervise or protect a child. It may be a single incident or more likely, a pattern of neglectful behaviours.

Failure to Provide Treatment:

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 the treatment;

The child has a mental, emotional or developmental condition that, if not remedied, would seriously impair the development of the child.

Although not conclusive, the presence of one or more of the following indicators should alert parent/caregivers and professionals to the possibility of child abuse or neglect. These indicators should not be taken out of context or used individually to make unfounded generalizations.

Pay special attention to duration, consistency, and pervasiveness of each indicator. Also keep in mind the age of the child; e.g. a two year old child requires more hands-on help getting dressed than a 12 year old child.

If you suspect child abuse or neglect, you are legally obligated to consult with or report to the Children's Aid Society of Ottawa at (613) 747-7800 (*Also see the Duty to Report section of this document*). Professionals must also report any incidence of a child witnessing family violence (*see Witnessing Family Violence in this document*).

When in doubt, always consult!

Note: For related medical issues, contact the family physician or paediatrician. Acute injuries may require that the child be taken to the emergency department at the closest hospital.

Emotional Harm: Possible Indicators

Emotional harm of a child refers to serious anxiety, depression, withdrawal, self-destructive or aggressive behaviours resulting from the actions, failure to act or neglect on the part of the parent or caregiver. This includes children being exposed to adult conflict and partner violence.

Emotional abuse includes yelling, screaming, threatening or bullying a child, humiliating a child, showing little to no physical affection, saying that everything is the child's fault, withdrawing attention, confining the child to a closet or dark room or tying the child to a chair.

Physical Indicators in Children

- Child does not develop as expected
- Often complains of nausea, headaches, or stomach aches without any obvious reason
- Wets or dirties pants
- May have "unusual" appearance (e.g. strange haircuts, dress, decorations)
- Bedwetting, nonmedical in origin
- Child fails to thrive

Behavioural Indicators in Children:

- Is unhappy, stressed out, withdrawn, aggressive or angry for long periods of time
- 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 (e.g. too neat, too clean)
- Displays extreme inhibition in play
- Tries really hard to get attention
- Tries to hurt oneself (e.g. cutting)
- Criticizes oneself a lot
- Does not participate because of fear of failing
- May expect too much of him/herself so gets frustrated and fails
- Is afraid of what the adult will do if he or she does something the adult does not like
- Runs away from home
- Has a lot of adult responsibility
- Does not get along well with other children
- Discloses abuse

Child Maltreatment – Emotional Harm

Behaviours Observed in Adults who Abuse Children

- Often rejects, insults or criticizes the child, even in front of others
- Talks about the child as being the cause for problems; states that "things are not turning out the way I wanted"
- 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
- Refuses to help the child (when the child requires help e.g. when getting dressed)
- 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 television, 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/she can do (physically)
- Does not provide food, clothing and care for one child, as well as provides for the other child(ren) in the same family

If you suspect child abuse, you are legally obligated to consult with or report to:

The Children's Aid Society of Ottawa:
To report child abuse or neglect: (613) 747-7800
Web: www.casott.on.ca Email: yourcasquestion@casott.on.ca

Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Children's Aid Society of Ottawa and Ottawa Public Health.

Physical Harm: Possible indicators

Physical harm to a child refers to any physical injury that may be apparent or not, including but not limited to bruises, welts or fractures.

Physical abuse includes beating, slapping, hitting, pushing, throwing, shaking, burning

Physical Indicators in Children

- Presence of several injuries that are in various stages of healing
- 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
- Bite marks, cuts, bruises, or welts in the shape of an object
- Burns (e.g. from a cigarette, in the pattern of an object like an iron)
- Wears clothes to cover up injury, even in warm weather
- Patches of hair are missing
- Signs of possible head injury like: swelling and pain, nausea or vomiting, feeling dizzy or bleeding from the scalp or nose
- Signs of possible injury to arms and legs e.g. pain, sensitive to touch, cannot move properly or limping
- Pain with breathing
- Difficulty raising arms
- Cuts and scrapes inconsistent with normal play (e.g. bruises on face, torso, upper back, head)
- Signs of female genital mutilation (e.g. trouble going to the bathroom)
- Fractured or missing front teeth

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 go home
- Does not want to be touched
- Is away a lot and upon return there shows signs of a healing injury
- Does not demonstrate skills as expected
- Does not get along well with other children
- Tries to hurt him/herself (e.g. cutting oneself, suicide)
- Discloses corporal punishment, hitting that results in injuries, abuse, or threats

Child Maltreatment - Physical Harm

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"
- Does not show love toward the child
- Delays seeking medical attention for injuries or illnesses

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Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Children's Aid Society of Ottawa and Ottawa Public Health

Sexual Harm: Possible Indicators

Sexual abuse happens when a parent or other person in charge sexually molests or uses a child for sexual purposes or knowingly fails to protect a child from sexual abuse.

Sexual harm includes any inappropriate touching, fondling, molestation, any sexual act between an adult and a child, including intercourse, exposing a child to adult sexual activity or sexual exploitation including child prostitution or child pornography

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 or swelling

Behavioural Indicators in Children

- Engages in sexual behaviour that is beyond the child's age and stage of development
- Inappropriate knowledge of sexual acts or copying adult sexual behaviour
- Details of sex in the child's drawings or writing
- Inappropriate sexual behaviours with other children or adults
- Fears or refuses to go to a parent, relative, or friend for no clear reason
- Does not trust others
- Is very compliant or extremely aggressive
- 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 clingy
- 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 (e.g. uses drugs or alcohol, eating disorder, suicide)
- Discloses sexual abuse, exposure to pornography, or inappropriate touching from adult or older caregiver

Behaviours Observed in Adults who Abuse Children

- May be very protective of the child resulting in the child being isolated from adults and peers
- 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
- Allows or tries to get the child to participate in a sexual behaviour

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The Children's Aid Society of Ottawa:
To report child abuse or neglect: (613) 747-7800
Web: www.casott.on.ca
Email: yourcasquestion@casott.on.ca

Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Children's Aid Society of Ottawa and Ottawa Public Health.

Child Maltreatment - Neglect

Neglect: Possible indicators

Neglect refers to harm or risk of harm resulting from failure to adequately care for, provide for, supervise or protect a child. It may be a single incident or more likely, a pattern of neglectful behaviours.

Physical Indicators in Children

- An infant or young child may: not be growing as expected, be losing weight, have a "wrinkly old face", look pale, not be eating well
- Not dressed properly for the weather
- Unattended physical problems, medical or dental needs
- Dirty or unwashed
- Bad diaper rash or other skin problems
- Always hungry
- Lack of medical and/or dental care
- Signs of deprivation which improve with a more nurturing environment (e.g. hunger, diaper rash)
- Often found in solitary position (e.g. alone in a car seat or crib)

Behavioural Indicators in Children

- Does not show skills as expected
- Takes care of a lot of their own needs on their own
- Has a lot of adult responsibility at home
- Appears to have little energy due to lack of sleep or proper nutrition
- Cries very little when a child would be expected to cry (appropriate for age)
- 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
- Hoards and hides food
- Discloses neglect (e.g. says there is no one at home)

Behaviours Observed in Adults who Neglect Children

The adult:

- 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, or describes the child as demanding
- May attribute adult negative motivations to actions of child - e.g. reports that the child is out to get the parent/caregiver, or that the child does not like the parent/caregiver
- 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
- Is not very interested in the child's life (e.g. fails to use services offered or to keep child's appointments, does not do follow up about concerns that are discussed

If you suspect child abuse, you are legally obligated to consult with or report to:

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To report child abuse or neglect: (613) 747-7800
Web: www.casott.on.ca
Email: yourcasquestion@casott.on.ca

Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Children's Aid Society of Ottawa and Ottawa Public Health.

Witnessing Family Violence

Family violence is the result of an imbalance of power. The aim of the perpetrator or abuser is to intimidate, frighten, and gain control. The well-being and development of the children in homes where there is family violence can be severely compromised.

Witnessing family violence refers to the multiple ways in which a child is exposed to family violence, i.e., directly seeing and/or hearing the violence, being used by the perpetrator, and/or experiencing the physical, emotional, and psychological results of the violence.

Physical Indicators in Children

- The child does not develop as expected
- Often complains of nausea, headaches, or stomach aches without any obvious reason, has medical ailments
- Fatigued due to lack of sleep or disrupted sleep
- May suffer serious unintended injuries
- May exhibit signs and symptoms of post traumatic stress disorder
- Rigid body when experiencing stress
- Shows signs of physical harm, whether deliberate or accidental, during or after a violent episode

Behavioural Indicators in Children

- May be aggressive and have temper tantrums, destructiveness
- May show withdrawn, depressed, and nervous behaviors (e.g. clinging, whining, excessive crying)
- Acts out what has been seen or heard between the parents/caregivers; discloses family violence; may act out sexually
- Tries too hard to be good and to get adults to approve
- Is afraid of: someone's anger, own anger (e.g. killing the abuser), self or other loved ones being hurt or killed, being left alone and not cared for
- Problems sleeping (e.g. cannot fall asleep, afraid of the dark, does not want to go to bed, nightmares)
- Overly responsible
- May believe that:
  - It is all right for men to hit women
  - Violence is a way to win arguments
  - Men are bullies who push women and children around
  - Big people have power they often misuse
  - Women are victims and can't take care of themselves
- Bed-wetting (inappropriate for age)
- Hoards food
- Tries to hurt oneself (e.g. cutting)
- Cruel to animals
- Stays around the house to keep watch, or tries not to spend much time at home; runs away from home
- Difficulties at school
- Takes the job of protecting and helping the mother, siblings
- Does not get along well with other children

Child Maltreatment – Witnessing Family Violence

Behaviours Observed in Adults

The abusive partner:

- Has trouble controlling self
- Uses power games, intimidation
- Instills fear through looks, actions
- Has trouble talking and getting along with others
- Uses threats and violence (e.g. threatens to hurt, kill or destroy someone or something that is special; is cruel to animals)
- Is physically, emotionally and economically controlling of his/her partner
- Forces the child to watch a parent/partner being hurt
- Insults, blames, and criticizes the partner/ abused in front of others; distorts reality
- Jealous of partner/abused talking or being with others
- Does not allow the child or family to talk with or see others
- Uses money to control behaviour and withholds basic needs
- Uses drugs and/or alcohol

The abused partner:

- Holds the belief that men have the power and women have to obey
- Is not able to care properly for the children because of isolation, depression, trying to survive, or because the abuser uses money to control behaviour and withholds basic needs
- Seems to be frightened, humiliated and full of shame with a heightened sense of powerlessness
- Discloses family violence
- Discloses that the abuser assaulted or threw objects at someone holding a child

If you suspect that a child is exposed to serious adult conflict and/ partner violence, you are legally obligated to consult with or report to:

The Children's Aid Society of Ottawa:
To report child abuse or neglect: (613) 747-7800
Web: www.casott.on.ca
Email: yourcasquestion@casott.on.ca

Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Children's Aid Society of Ottawa and Ottawa Public Health.

Family/Environmental Stressors

The environment in which a child grows and learns can greatly impact the development of a child, physically, cognitively, behaviourally and emotionally and has lasting effects on that child throughout their lifespan.

There are two main characteristics of the child's environment that this section refers to the physical and emotional environment as well relationships in the child's life. The child's physical surroundings include elements such as the condition of the child's home and the safety of the child's neighbourhood. The relationship the child has with his/her caregiver(s) is often the most significant factor in their growth and development.

Family stressors can include poverty or the accessibility of basic needs, such as availability of appropriate and sufficient nutrition, shelter, clothing; marital breakdown, addictions or illness. Children can also experience more extreme forms of family stress such as witnessing or suffering abuse or neglect.

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

Parental Factors

- History of abuse – parent or child
- Bullying behaviours
- Severe, chronic or capacity-reducing health problems
- Substance abuse
- Partner abuse
- 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
- Lack of parent literacy or lack of school completion

Social/Family Factors

- Family breakdown
- Recent immigration
- Geographic isolation
- Lack of cultural, linguistic community
- Frequent changes in home location
- Frequent changes in school district
- Multiple births
- Several children close in age
- A special needs child
- An unwanted child
- Personality and temperament challenges in child or adult
- Mental or physical illness, or special needs of a family member
- Lack of a support network or caregiver relief
- Inadequate social services or supports to meet family's needs
- A series of losses in a short time frame
- Recent death of a parent/child
- Substandard shelter or no fixed address over a time frame

Child Maltreatment – Familv/Environmental Stressors

Economic Factors

- Inadequate income
- Unemployment
- Over employment – needing to work multiple jobs
- Business failure
- Debt

WHERE TO GO FOR HELP

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

- Children's Aid Society of Ottawa ww.casott.on.ca yourcasquestion@casott.on.ca
- Parenting in Ottawa Drop Ins www.parentinginottawa.com/en/dropins.asp
- Ottawa Public Health Information: (613) 580-6744 TTY (613) 580-9656 Email: healthsante@ottawa.ca
- Healthy Babies, Healthy Children program 613-580-6744 or toll-free 1-866-426-8885
- Community Information Centre of Ottawa: Call 2-1-1 Email: info@cominfo-ottawa.org Web: www.cominfo-ottawa.org
- Kids Help Phone 1-800-668-6868 www.KidsHelpPhone.ca

For child protection services, call the Children's Aid Society of Ottawa (613) 747-7800. Web: www.casott.on.ca Email: yourcasquestion@casott.on.ca

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Sources: Adapted from York Region Red Flags (2009) reviewed in 2010 by Children's Aid Society of Ottawa Crossroads Children's Centre, Language Instruction for Newcomers to Canada (LINC), St Mary's Home, Ottawa Carleton Headstart Association for Preschoolers and Ottawa Public Health.

Dental Health

Poor oral care can result in the development of early childhood tooth decay (ECTD) even before the first tooth erupts.

Dental problems in early childhood can impact general growth and cognitive development of a child. Dental problems can interfere with a child's sleep, appetite, eating patterns and cause poor school behaviour and negative self-esteem. Access to dental care as well as good oral hygiene habits from the start are important.

ECTD often begins on a child's top front teeth just under the lip. Chalky white or brown spots may be early signs of tooth decay.

Risk factors for early childhood tooth decay…the presence of one or more of these risk factors should be considered a red flag:

Exposure of teeth to fermentable carbohydrates (e.g. formula, juice, milk and breast milk) through:

- Prolonged feeding sessions with a bottle, sippy cup or plastic bottles with straws
- Retaining the nipple in an infant's mouth for prolonged periods when not actively drinking during breastfeeding
- High sugar consumption in infancy
- Sweetening pacifiers/soothers
- Long term use of sweetened medications
- Using a bottle beyond one year of age
- Going to sleep with a bottle with anything but water
- Frequent snacks containing sugar or cooked starch (cariogenic snacks) without oral hygiene. Examples of cariogenic foods and drinks:
  - Sugar and chocolate confectionary, candy
  - Sugared breakfast cereals
  - Fruit in syrup, jams, preserves and honey
  - Cakes, buns, pastries, biscuits
  - Soft drinks, sugared milk-based beverages, fruit cocktails, punches and drinks
  - Potato chips

Physiological Factors:

- Factors associated with poor enamel development, such as prenatal nutrition, poor prenatal health and malnutrition of the child
- Possible enamel deficiencies related to prematurity or low birth weight
- Lack of exposure to fluoridated water
- Window of infectivity: transfer of oral bacteria from parent/caregiver to the child between 19 and 31 months of age, through frequent intimate contact or sharing utensils

Other Risk Factors:

- Poor oral hygiene – ineffective or infrequent brushing (less than twice per day)
- Sibling history of early childhood tooth decay
- Lower socioeconomic status
- Limited access to dental care
- Limited or poor parenting skills and child management
- Parent's lack of dental knowledge
- Lack of routines for mealtime and hygiene
- Late first visit to a dentist
- Developmental delays
- Cancers

Dental Health

The Child's First Visit

The Canadian Dental Association recommends that a child's first visit to a dentist should occur at one year of age.

For more information, visit http://www.cda-adc.ca/en/oral_health/cfyt/dental_care_children/first_visit.asp

WHERE TO GO FOR HELP

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

- Their dentist
- Ottawa Public Health Dental Services
  613-580-6744 ext. 23510
- Ottawa Public Health Dental Clinics
  - West – 613-580-9631
  - South/East – 613-580-9632
  - Downtown – 613-580-9633

  *The child may be eligible for the Children In Need of Treatment Program (CINOT) web: www.mhp.gov.on.ca/en/healthy-communities/dental or the Healthy Smiles Ontario (HSO) Program. Web: www.ontario.ca/page/get-dental-care
- Ottawa Dental Society at 613-523-3876

For more information:
www.ottawa.ca/en/residents/public-health/healthy-living/access-dental-care

Free Dental Screening Schedule: http://ottawa.ca/en/residents/public-health/healthy-living/access-dental-care#screening

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Ottawa Public Health.

Feeding and Swallowing

Normal feeding and swallowing skills are important for overall health, adequate growth and successful development in many areas such as communication and sensory motor skills. Parents and professionals must consider the critical and sensitive periods related to the developmental feeding and swallowing milestones and be aware of the typical milestones for feeding skills in a child.

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

0-3 months

- Uses a rhythmic sucking pattern (suck, swallow, breath pattern) with sucking bursts of 6 – 20 sucks (lasting up to 30 seconds) and pauses of
- 5 -10 seconds between sucking bursts
- Infant pauses to breath after each swallow and over time the breathing rate becomes deeper and more relaxed during the feed
- Latches on appropriately to breast or bottle
- Uses negative pressure to create an effective suck at breast or bottle without losing the seal (no leaking)
- Infant uses the tongue effectively to move/ extract fluid from the breast or bottle without signs of stress or fatigue
- Does not show signs of stress or fatigue during breast or bottle feeding.
- Infant effectively uses a protective cough or gag if the feed flow rate is too fast
- Infant feeds in less than 45 minutes

4-6 months

- Sucking bursts lengthen to include twenty or more sucks from the breast or bottle before pausing
- Maintains latch and sucking on breast or bottle
- Prepares for nipple with open mouth and tongue is nicely cupped around nipple

6-8 months

At about 6 months your baby is ready to start eating solid foods. Breastmilk is all your baby needs for the first 6 months. Solid foods give your baby extra energy, iron and other nutrients needed for healthy growth. Solid foods also help your baby learn how to eat and enjoy new flavours and textures.

- Baby begins to hold bottle and feeds in less than 45 minutes.
- Baby shows an interest in solid foods and opens mouth and leans forward when solids are offered.
- Swallows thicker pureed foods and tiny, soft, slightly noticeable lumps.
- Food is not pushed out by the tongue, but minor loss of food will occur
- Tongue moves up and down to mash food upwards onto hard palate,, with no side to side movement
- Munches/chews on soft or dissolvable solids
- Does not yet use teeth and gums to clean food from lips
- Baby may orally explore food and use upper lip to clean spoon
- Cup is introduced
- Starting Solid Foods: At about 6 months your baby is ready to start solid foods. Your baby is ready when she:
    - Has good head control.

  - Can sit up and lean forward.
  - Can pick up food and try to put it in her mouth.
  - Can turn her head away to let you know she is full.
- Continue to breastfeed throughout the day and night, because breastmilk is still the most important food for your baby at this age.

9-12 months

- Baby is fed in upright position
- Strong, rhythmical suck predominates and longer sequences of suck swallow breathe at bottle and breast
- Baby begins to experiment drinking liquids from cup or sippy cup
- Baby usually takes up to three sucks before stopping or pulling away from the cup to breathe
- Can hold a soft cracker between the gums or teeth without biting all the way through
- Begins to transfer food from the center of the tongue to the side
- Uses side to side tongue movement with ease when food is placed on the side of the mouth
- Begins to self-feed, reaching for finger food using full hand grasp and then pincer grip and brings food to mouth
- Uses upper lip to remove food from spoon
- Baby beginning to manage a variety of food textures such as lumpy, blended foods and soft table foods

12-18 months

- Longer drinking sequences from the cup, maybe up to 30 ml at a time
- Baby beginning to be weaned from bottle
- Baby shows desire for independent feeding by holding cup, spoon and finger feeding
- Begins to eat finely chopped table foods.
- Some coughing and choking may occur if the liquid flows too fast
- Beginning to self-feed without a utensil
- Able to bite a soft cracker
- May lose food or saliva while chewing
- Tongue lateralization matures (the ability to consistently transfer food from the centre to the sides of ones mouth)
- Rotary chew emerges at approx. 12 months and is mature by approximately 15 months of age

18 months

- Tongue does not protrude from the mouth, cup rim is stabilized by jaw
- Minimal loss of food or saliva during swallowing, but may still lose some during chewing
- Attempts to keep lips closed during chewing to prevent spillage
- Able to bite through a hard cracker
- Begins to use a spoon to self feed
- Baby may drool if cutting teeth
- Removes food from lips with tongue, teeth or fingers

2 years

- Well developed coordination of swallowing with breathing control
- Chewing motion is rapid and skilful from side to side without pausing in the centre or midline of the tongue
- No longer loses food or saliva when chewing
- Will use tongue to clean food from the upper and lower lips
- Able to open jaw to bite foods of varying thicknesses
- Cup drinking improves with increased jaw stability
- Begins to drink a variety of liquids using an open cup or straw

WHERE TO GO FOR HELP

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

- For babies up to 3 months of age: Well Baby Drop Ins (613) 580-6744 ext. 28020 TTY (613)580-9656
- Their family doctor or pediatrician
- Parenting in Ottawa Home Visits: 613-PARENTS [(613) 727-3687] Toll free: 1-866-426-8885
  Monday to Friday from 8:30 am to 4:30 pm www.parentinginottawa.com/en/Home-Visits.asp
  Parenting in Ottawa Drop Ins: www.parentinginottawa.com/en/dropins.asp
- First Words - Preschool Speech and Language: Screening Clinics (613) 580-6744 ext. 28020
- Health Babies, Healthy Children Program, Ottawa Public Health Information: (613) 580-6744; toll-free 1-866-426-8885

For more information on support for breastfeeding:

- Ottawa Public Health Information Line
  (613) 580-6744 or 1-866-426-8885, Monday to Friday, 9 a.m. to 4 p.m.
- Telehealth Ontario: Access to expert advice and support for breastfeeding
  1-866-797-0000; 24 hours a day, 7 days a week
- Ottawa Breastfeeding Buddies: Mother-to-mother telephone support program for pregnant or new breastfeeding mothers
  To register: (613) 580-6744 ext. 23932 Email: ottbreastfeedingbuddies@ottawa.ca
- La Leche League Canada: 1-800-665-4324 Web: www.lllc.ca
  Ottawa Chapte: (613)-238-5919 Email: lllcottawa@gmail.com
- For private lactation consultant services, visit: www.ovlc.net.
  *There is a fee for these services.

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Ottawa Children's Treatment Centre, CommuniCare Therapy, Children's Hospital of Eastern Ontario, First Words Preschool Speech and Language Program and Carefor Health and Community Services.

Fetal Alcohol Sprectrum Disorder (FASD)

Fetal alcohol spectrum disorder (FASD) is an umbrella term for the range of harm that is caused by alcohol use during pregnancy. It includes several medical diagnostic categories including fetal alcohol syndrome (FAS). FASD is preventable, but not curable. **Early diagnosis and intervention can make a difference.**

Most children with FASD have no external physical characteristics. Only 20% of children have facial dysmorphology. Children exposed prenatally to alcohol, who do not show physical/external or facial characteristics, may suffer from equally severe central nervous system damage. The following are characteristics of children with FASD:

If a child presents with any of the following…consider this a red flag.

Infants

- Low birth weight; failure to thrive; small size; small head circumference, and ongoing growth retardation
- Disturbed sleep, irritability, persistent restlessness
- Failure to develop routine patterns of behaviour
- Prone to infections
- Erratic feeding schedule: may not experience feelings of hunger
- May be floppy or too rigid because of poor muscle tone
- May have one of the following birth defects: congenital heart disease, cleft lip and palate, anomalies of the urethra and genitals, spina bifida
- Facial dysmorphology – the characteristic facial features include small eye openings, flat mid-face, thin upper lip, flattened ridges between base of nose and upper lip; ear anomalies

Toddlers and Preschoolers

- Developmental delays
- Slow to acquire skills
- Sleep and feeding problems persist
- Memory impairment: may have poor recall and will fill in the blanks
- Hypo-sensitivity: may not sense extreme temperatures or pain
- Excessively "busy"
- Sensory hypersensitivity (irritability, stiffness when held or touched, refusal to brush hair or teeth, over-reaction to injury)
- Late development of motor skills – clumsy and accident prone
- Late development or regression of speech and language

Junior Kindergarten/Senior Kindergarten

- Learning and neuro-behavioural problems (easily distracted, poor memory, impaired learning, impulsive)
- Discrepancy between good expressive and poor receptive language (is less capable than he/she looks)
- Attention deficit and/or hyperactivity; extreme tactile and auditory defensiveness
- Sensory integration disorders – may seek or avoid tactile or auditory input
- Information processing problems
- Difficulty reading non-verbal cues; unable to relate cause and effect; poor social judgment
- Less mature than expected for their age; may seek out younger children or toys
- Attachment issues: may be inappropriately friendly with strangers; may take things belonging to others

WHERE TO GO FOR HELP

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

- Their family physician or paediatrician to be referred to CHEO Genetics Clinic for diagnosis
- Fetal Alcohol Spectrum Disorder Group of Ottawa call 613 737-1122 or 613 446-4144
- Wabano Centre for Aboriginal Health, Fetal Alcohol Spectrum Disorder Support Group www.wabano.com 613 748-0657 x 214

For more information:

Fetal Alcohol Spectrum Disorder Coalition of Ottawa www.fasdottawa.ca

- Best Start: Alcohol and Pregnancy/Substance use Web: www.beststart.org/resources-and-research/
- Canadian Centre on Substance Abuse www.ccsa.ca
- Let's Talk FASD, Ottawa: VON Canada, 2007. www.von.ca

Sources: Adapted from York Region Red Flags (2009) and reviewed in 2010 by Wabano Centre for Aboriginal Health.

Fine Motor

Fine motor skills involve the coordination of small muscle movements in the fingers and the hands that enable a child to complete tasks such as grasping and manipulating small objects, dressing, feeding oneself, cutting and writing. Many activities depend on the coordination of gross and fine motor skills and vision.

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

By 2 months - 3 months

- Holds an object momentarily if placed in hand
- Opens and shuts hands

By 4 months

- Holds breast or bottle with 1 or both hands
- Brings hands or toy to mouth
- Brings hands to the middle of the body while lying on the back
- Puts hands on knees

By 6 months

- Eats from a spoon (e.g. infant cereal)
- Reaches for a toy when lying on the back
- Uses hands to reach and grasp toys
- Holds a bottle to mouth by self

By 9 months

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

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 three or more blocks
- Scribbles with crayons
- Eats foods without coughing or choking
- Puts items into a container
- Can match shape-sorters
- Uses one hand more often than the other
- When wrist is flexed, the arm moves as a unit, fisted hand (Palmar supinate power grasp)

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 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
- Child able to perform "immature digital pronated grasp" – wrist out, thumb down, tool held with fingers, no web space, arm moves as a unit
- Does finger plays while singing little songs

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 3-part person (head, legs and arms or head, trunk and legs or stick person)

By 6 years

- Draws person with head, facial parts, arms, legs, trunk, hands and feet

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

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

- Their family physician or paediatrician
- Parent may be referred to Community Care Access Centre for assessment by an occupational therapist, or to a private occupational therapist

Sources: Adapted from York Region Red Flags (2009) and revised by Ottawa Children's Treatment Centre and CommuniCare Therapy with reference to Beery™ VMI Stepping Stones Parent Checklist

Gross Motor

Gross motor skills refer to the coordination of the large muscle groups of the body involving the arms, the legs, the feet or the entire body. They are important for major body movements such as crawling, walking, sitting, jumping, lifting, kicking and throwing a ball. The development of motor control serves two distinct purposes. The first is the ability to stabilize the body in space (posture and balance) and the second is the ability to move in space. Perception (information about the body and the environment), cognition (thinking) and motor processes (muscles working together) all play a role in the production of movement.

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 the tummy
- Brings both hands simultaneously to midline of chest or face when on back
- Pushes legs down when feet are put on a surface; kicks feet

By 4 months

- Keeps head in line with the middle of the body and brings hands to chest when lying on the back
- Lifts head and supports self on forearms on the tummy
- Holds head steady when supported in a sitting position
- Rolls from stomach to back; sits with a little support at the waist

By 6 months

- Rolls from the back to the stomach or from the stomach to the back
- Pushes up on hands when on the tummy
- Sits on the floor with support
- Sits with support of a highchair
- Sits briefly while leaning on hands
- Pulls self to a sitting position from lying on back
- Puts most of weight on legs when adult supports

By 9 months

- Sits on the floor without support
- Moves self forward on the tummy or rolls continuously to get an item
- Stands with support
- Balances on hands and knees
- Sits for over five minutes without using hands to support
- Turns trunk when sitting by self
- Walks one or two steps when adult holds both hands

By 12 months

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

By 18 months

- Walks alone
- Crawls up stairs
- Plays in a squat position
- Sits in small chair; walks up three stairs, two feet per step, when one hand is held

By 2 years

- Walks backwards or sideways pulling a toy
- Jumps with both feet leaving the floor at the same time
- Pushes a little stroller or wagon, steers and backs it up
- Kicks a ball

By 3 years

- Stands on one foot briefly
- Climbs stairs with minimal or no support
- Kicks a ball forcefully
- Pedals a riding toy
- Runs on toes with both feet leaving ground

By 4 years

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

By 5 years

- Hops on one foot, 8 to 10 hops in a row
- 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 the body; or body too stiff or too floppy)
  Years Professionals

WHERE TO GO FOR HELP

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

- Their family physician or paediatrician
- Parent may be referred to Community Care Access Centre for assessment by a physiotherapist, or to a private therapist

Sources: Adapted from York Region Red Flags (2009) and reviewed by Ottawa Children's Treatment Centre and CommuniCare Therapy with reference to Beery™ VMI Stepping Stones Parent Checklist.

Healthy Active Living

Activity in the early years is an important part of healthy development. It helps to build a child's confidence and self-esteem, improves basic movement skills and imagination as well as supports social interaction with peers and adults. Active living helps to set a child on the right path for long-term health and healthy behaviours.

Physical literacy is the key to healthy active living. Physical literacy refers to the development of fundamental movement skills that allow children to move confidently and with control in a wide range of physical activity situations.

It is essential that children have opportunities to practice and learn fundamental movement skills through movement and play. Children need their parents and caregivers to provide opportunities and encouragement related to these skills.

Structured play refers to adult-led activities.

Unstructured play refers to child-led activities where the adult monitors for safety.

Screen time refers to time spent in front of a "screen", being inactive (e.g. watching television, using the computer and playing video games).

Recommendations to help promote healthy active living:

Less than one year

- Zero screen time

1 – 2 years

- Toddlers should engage in a total of at least 30 minutes of **structured** physical activity each day.
- Toddlers should engage in at least 60 minutes -- and up to several hours -- per day of **unstructured** physical activity and should not be sedentary for more than 60 minutes at a time, except when sleeping.
- Zero screen time

3 – 5 years

- Limit screen time to 1 hour a day
- Preschoolers should have at least a total of 60 minutes of structured (facilitated) physical activity each day.
- Preschoolers should engage in at least 60 minutes -- and up to several hours -- of unstructured physical activity each day.
- Preschoolers should not be sedentary for more than 60 minutes at a time, except when sleeping.

General recommendations:

- Encourage families to make and enforce rules about screen time and keep televisions out of bedrooms
- Be a role model for children
- At least half of the physical activity by children should be "active play"
- Encourage outdoor play, even in winter
- Provide safe, supervised but unstructured play spaces for active play
- Encourage families to eat dinner together more than 5 nights a week
- Children get adequate sleep (10.5 hours or more a night)
- Ensure physical activity as part of a child's daily routine
- Provide a variety of movement opportunities for children throughout the day.
- Children are visual learners at this stage, they often learn by watching, then doing. Adult demonstration of movement skills is important
- Physical activity is fun. Promote inclusive games and avoid competition.
- Ensure success. If a child can't perform a task or skill, break it down so that they can complete and master the skill.
- Remember that active video games do not replace active play

It is recommended that children increase the time they currently spend on physical activity by 30 minutes a day to increase over time to 90 minutes or more a day.

Where to get more information

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

- Ontario Early Years Centres: www.oeyc.edu.gov.on.ca
- City of Ottawa, Parks, Recreation and Cultural Services Department http://ottawa.ca/residents/parks-and-recreation
- Hand in Hand program (Financial support for City of Ottawa programs) http://ottawa.ca/residents/funding/recreation_culture_assistance_en.html
- Ottawa Public Health Information Line: 613-580-6744 TTY (613) 580-9656
- Parenting in Ottawa Web: parentinginottawa.ca Email: healthsante@ottawa.ca
- The Champlain Cardiovascular Disease Prevention Network (CCPN) Know More, Do More campaign www.knowmore-domore.ca
- Heart and Stroke Foundation of Ontario www.heartandstroke.on.ca
- YMCA YWCA Ottawa www.ymcaywca.ca/Children/
- Canadian Sport for Life www.canadiansportforlife.ca

Sources: developed and reviewed by Children's Hospital of Eastern Ontario, Ottawa Public Health, Heart and Stroke Foundation of Ontario with reference to 2010 Active Healthy Kids Canada Report Card, National Association for Sport and Physical Education Active Start: A Statement of Physical Activity Guidelines for Children From Birth to Age 5 (2nd Edition) and Centres for Disease Control and Prevention. How Much Sleep do I Need?.

Hearing

Hearing helps to enable infants and children to learn language and helps to stimulate brain development. It is important to identify and address hearing problems as soon as possible.

Undetected hearing loss is one cause of delayed language development. Delayed language development can lead to behaviour and emotional problems and to later academic problems in school.

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 in response 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
- Makes different cries for different needs (I'm hungry, I'm tired)
- Watches your face when you talk
- Smiles and laughs in response to your smiles and laugh
- Imitates coughs or other sounds (ah, eh, buh)

7-12 months

- Turns or looks up when her/his name is called
- Responds to noises like telephone ringing or knock at the door
- Responds to the word "no"; listens when spoken to
- Expresses what he/she wants through sounds and gestures (raising arms to be picked up)
- Babbles and repeats sounds (babababa, duhduhduh)
- Understands common words like "cup", "shoe", "mom"
- Responds to requests such as "want more", "come here"
- Plays social games with you like peek-a-boo
- Enjoys being around people

By 12 months

- Follows simple one-step directions (sit down)
- Looks across the room to something you point to
- Uses three of more words
- Uses gestures to communicate (waves bye-bye, shakes head "no")
- Gets your attention by using sounds, gestures and pointing while looking at your eyes
- Brings toys to show you
- "performs" for attention and praise
- Combines many sounds as through talking – abada baduh abee
- Shows interest in simple picture books

By 18 months

- Turns toward you when you call child's name from behind
- Follows simple commands
- Responds with words or gestures to simple questions - "Where's teddy?", "What's that?"
- Understands the concepts of "in and out", "off and on"
- Points to several body parts when asked
- Tries to 'talk' by pointing, reaching and making noises
- Knows sounds like a closing door and a ringing phone
- Makes at least four different consonant sounds - b, n, d, g, w, h • Uses at least 20 words
- Demonstrates some pretend play with toys - gives teddy a drink, pretends a bowl is a hat
- Enjoys being read to and looking at simple books with you
- Points to pictures using one finger

By 24 months

- Follows two-step directions - "Go find your teddy bear and show it to Grandma"
- Listens to a simple story
- Forms words and sounds easily and effortlessly
- People can understand his or her words 50 to 60 per cent of the time
- Learns new words every week
- Uses 100 or more words • Uses at least two pronouns - "you", "me", "mine"
- Consistently combines two or more words in short phrases - "daddy hat", "truck go down"
- Enjoys being with other children
- Begins to offer toys to peers and imitates other children's actions and words
- Shows early literacy skills such as holding books the right way up, turning pages, "reading" to stuffed animals or toys and/or scribbling with crayons

By 30 months

- Understands the concepts of size (big/little) and quantity (a little, a lot, more)
- Listens to a simple story
- Remembers and understands familiar stories
- Puts sounds at the start of most words
- Produces words with two or more syllables or beats - "ba-na-na", "com-pu-ter", "a-pple"
- Uses some adult grammar - "two cookies", "bird flying", "I jumped"
- Learns new words every week
- Uses more than 350 words
- Uses action words - run, spill, fall
- Begins taking short turns with other children, using both toys and words
- Shows concern when another child is hurt or sad
- Combines several actions in play - feeds doll then puts her to sleep; puts blocks in train then drives train and drops blocks off
- Recognizes familiar logos and signs - McDonalds golden arches, stop sign
- Learns new words every week

Hearing

By 3 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
- Understands "who," "what," "where" and "why" questions
- Creates long sentences using five to eight words
- Talks about past events (e.g. trip to Grandparents' house, day at childcare)
- Tells simple stories
- Is understood by most people outside of the family, most of the time
- Shows affection for favourite playmates
- Engages in multi-step pretend play (e.g. pretending to cook a meal, repair a car, etc.)
- Aware of the function of print (e.g. in menus, lists, signs)
- Beginning interest in, and awareness of, rhyming

By 4 years

- Pays attention to a story and answers simple questions
- Hears and understands most of what is said at home and school
- Follows directions involving three or more steps (e.g. "First get some paper, then draw a picture, last give it to Mom")
- Family, teachers, babysitters, and others think he or she hears fine
- Is understood by strangers almost all of the time
- Speaks clearly enough to be understood most of the time by anyone
- Uses adult-type grammar
- Tells stories with a clear beginning, middle and end
- Talks to try to solve problems with adults and other children
- Demonstrates increasingly complex imaginative play
- Able to generate simple rhymes (e.g. "cat-bat")
- Matches some letters with their sounds (e.g. "letter T says 'tuh')

By 5 years

- Speaks clearly enough to be understood most of the time by anyone
- Follows group directions (e.g. "All the boys get a toy")
- Understands directions involving "if…then" (e.g. "If you're wearing runners, then line up for gym")
- Describes past, present and future events in detail
- Uses almost all of the sounds of their language with few to no errors
- Seeks to please his/her friends
- Shows increasing independence in friendships (e.g. may visit neighbour by him/herself)
- Knows all the letters of the alphabet
- Identifies the sounds at the beginning of some words (e.g. "Pop starts with the 'puh' sound")

Red Flag:

If a child is experiencing any of the following, consider this a potential concern:

- Early babbling stops
- Ear pulling (with fever or crankiness)
- Does not respond when called
- Frequent or recurrent ear infections, draining ears
- Loud talking
- Presence of a speech and/or language delay,
- A family history of hearing loss
- Infectious diseases that cause hearing loss (for example, meningitis, measles, and cytomegalovirus [CMV] infection)
- Medical treatments that may have hearing loss as a side effect, including some antibiotics and some chemotherapy agents
- Poor school performance

WHERE TO GO FOR HELP

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

- Their family doctor for a referral to an audiologist
- Local audiologist (listing of private audiologists www.osla.on.ca
- Eastern Ontario Infant Hearing Program: (613) 688-3979 ext. 3453 or 1-866-432-7447
  Web: www.pqchc.com/children-family-services/infant-hearing-program/

For more information

- Can your baby hear? Ministry of Children and Youth Services
  www.children.gov.on.ca/htdocs/English/topics/earlychildhood/hearing/brochure_hear.aspx
- First Words Preschool Speech and Language Program of Ottawa Intake office: (613) 737-7600 ext. 2500
  Web: www.firstwords.ca Email: first.words@pqchc.com

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by First Words Preschool Speech and Language Program and Centre Jules-Léger with resources from Can your baby hear? Ontario Ministry of Children and Youth Services.

Learning Disabilities

Learning disabilities (LDs) are brain-based processing difficulties that affect:

- Getting information into the brain
- Making sense of this information
- Storing and later retrieving this information (memory), or
- Getting this information back out

LDs can interfere with learning basic academic skills such as reading, writing, and math in children with otherwise average thinking and reasoning abilities.

Learning disabilities are usually not diagnosed in young children. Some difficulties may be noted during the pre-school years - for example, language processing difficulties or the failure to meet certain developmental milestones.

Development in infants and children varies in terms of rates and patterns of maturation. For some children, differences and delays in abilities are temporary and are resolved during the normal course of development. For other children, delays may persist in different domains of functioning.

Risk indicators for later development of learning disabilities:

- **Delay in cognitive skills**
  - Not demonstrating object permanence
  - Limited understanding of means–ends relationships (e.g. using a stool to reach a cookie jar)
  - Lack of symbolic play behavior
- **Delay in comprehension and/or expression of spoken language**
  - Limited receptive vocabulary
  - Reduced expressive vocabulary ("late talkers")
  - Difficulty understanding simple (e.g. one-step) directions
  - Monotone or other unusual prosodic features of speech
  - Infrequent or inappropriate spontaneous communication (vocal, verbal, or nonverbal)
  - Immature syntax
- **Delay in emergent literacy skills**
  - Slow speed for naming objects and colors
  - Limited phonological awareness (e.g. rhyming, syllable blending)
  - Minimal interest in print
  - Limited print awareness (e.g. book handling)
- **Delay in perceptual-motor skills**
  - Problems in gross or fine motor coordination (e.g. hopping, dressing, cutting, stringing beads)
  - Difficulty coloring, copying, and drawing
- **Attention and behavior**
  - Distractibility/inattention
  - Impulsivity
  - Hyperactivity
  - Difficulty changing activities or handling disruptions to routines

It is important to remember that risk indicators do not necessarily predict later learning problems, particularly when only a single indicator is present.

However, if there are risk indicators present, a child's development should be carefully monitored and he/she should be provided with high quality learning opportunities. Children who do not respond adequately to these opportunities may be at increased risk for learning disabilities and require referral for targeted screening and/or comprehensive evaluation.

WHERE TO GO FOR HELP

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

- Learning Disabilities Association of Ottawa-Carleton 613 567 5864 /
- Their family physician or paediatrician
  Web: www.ldaottawa.com Email: www.ldaottawa.com

Source: Adapted from the York Region Red Flags (2009) and revised by Learning Disabilities Association of Ontario with reference to Operationalizing the New Definition of Learning Disabilities for Utilization within Ontario's Educational System, Learning Disabilities Association of Ontario, 2001 and Learning Disabilities and Young Children: Identification and Intervention, National Joint Committee on Learning Disabilities, 2006.

Literacy

Family literacy includes the way parents, caregivers, children and family members use literacy at home and in their community. It occurs naturally during the routines of daily living and helps adults and children 'get things done' - from lullabies to shopping lists, from stories to the passing on of skills and traditions. Parents and caregivers have always been their children's first and most important teachers.

NOTE: For English language learners, it will be essential to speak with the primary caregiver about the child's language and literacy skills in their first language. An interpreter may be needed to ensure that there is clear communication between teacher and family.

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

0-3 months

- Listens to adult's voice
- Makes cooing or gurgle sounds

4-8 months

- Imitates sounds heard
- Makes some sounds when looking at toys or people
- Brightens to sound, especially to people's voices
- Seems to understand some words (e.g. daddy, bye-bye)

9-12 months

- Responds to simple verbal requests accompanied with a gesture (e.g. come here)
- Babbles a series of different sounds (e.g. ba, da, tongue clicks, dugu-dugu)
- Makes sounds to get attention, to make needs known, or to protest
- Shows interest in looking at books

12-18 months

- Follows simple directions (e.g. "Throw the ball")
- Uses common expressions (e.g. "all gone," "oh-oh")
- Says five or more words; words do not have to be clear
- Identifies pictures in a book (e.g. "Show me the baby")
- Holds books and turns pages
- Enjoys being read to and sharing simple books with you

By 2 years

- Asks for help using words or actions
- Joins two to four words together (e.g. "want cookie," "more milk please")
- Learns and uses new words; may mostly be understood by family
- holds books the right way up and turns pages
- Asks for favourite books to be read over and over again

By 3 years

- Can be understood by strangers approximately 80% of the time
- Uses longer sentences (e.g. five to eight words)
- Continues to learn and use new words in spoken language
- Sings simple songs and familiar rhymes
- Demonstrates how books work (e.g. holds book, turns pages, points and talks about pictures)
- Demonstrates an interest in books
- Holds a pencil or crayon and uses it to draw/ scribble
- Joins in repetitive sections of familiar book when being read to (e.g. "You can't catch me, I'm the Gingerbread Man!")

By 3½ -4½ years

- Can be fully understood by most adults when speaking
- Speaks in complete sentences using some details
- Uses and gains new vocabulary in spoken language
- Recites familiar nursery rhymes and/or sings familiar songs
- Understands the concept of rhyme; generates simple rhymes
- Reads a book by memory or by making up the story to go along with the pictures
- Can guess what will happen next in a story
- Retells some details of stories read aloud but not necessarily in order
- Holds a pencil and uses it to draw and/or print his/her first name along with other random letters
- Follows one and two-step directions
- Describes personal experiences

By 4½ - 5½ years

- Uses complete sentences (that sound almost like an adult)
- Uses and gains new vocabulary in spoken language
- Knows parts of a book and demonstrates appropriate book handling skills (e. g. front and back of back, holds book right way up, turns pages in correct order)
- Understands basic concepts of print (e. g. difference between letters, words, how the text runs from left to right and top to bottom)
- Makes predictions about stories; retells the story in proper sequence
- Re-reads simple patterned texts (i. e. poems, chants, pattern books) and points to the individual words while reading
- Reads some familiar vocabulary by sight (high frequency words)
- Points to and says the name of most letters of the alphabet when randomly presented (upper and lower case)
- Identifies the sounds of the beginning of some words (in spoken language)
- Claps syllables in words (e. g. bi-cy-cle)
- Recognizes and generates rhyming words
- Prints his/her own name
- Beginning to write simple messages using a combination of pictures, symbols, letters, sounds, and/or familiar words
- Makes connections between his/her own experiences and those of storybook characters

WHERE TO GO FOR HELP

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

- First Words: Preschool Speech and Language Program of Ottawa: (613) 737-7600 ext. 2500 Web: www.firstwords.ca Email: first.words@pqchc.com
- Ottawa Public Health at (613) 580-6744 ext. 28020
- Early Literacy Specialists of Eastern Ontario: (613) 565-2467 ext. 232 /233 www.parentresource.on.ca/en/ottawaprc/Early_ Literacy_Specialists_p556.html
- Ottawa Community Coalition for Literacy (613) 233-3232 Web: www.occl.ca Email: info@occl.ca

For more information:

- Ottawa Public Library 613-580-2940 http://bibliootawalibrary.ca/
- Parent Family Literacy Centres Ottawa Carleton District School Board: (613) 721-1820 Web: www.ocdsb.ca/par/pflc/Pages/default.aspx
- Ottawa Catholic School Board: (613)224-2222 Web: www.ocsb.ca/board/admin/departments

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by First Words Preschool Speech and Language Program, Algonquin College, Early Childhood Education Program, Parent Resource Centre and Ottawa Carleton Headstart Association for Preschoolers.

Mild Traumatic Brain Injury

Changes in behaviour may be related to a mild traumatic brain injury (e.g. falls, accidents, medical treatment, sports injuries, 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
- Nausea
- Vomiting
- Balance problems
- Vision problems (blurred or double vision)
- Fatigue
- Sensitivity to light
- Sensitivity to noise
- Dazed
- Stunned

Cognitive

- Feeling mentally "foggy"
- Feeling slowed down
- Academic difficulties
- Difficulty concentrating
- Difficulty remembering
- Forgetful of recent information
- Confused about recent events
- Memory impairment or reduced learning speed
- Answers questions slowly
- Repeats questions
- Develops problems finding words or generating sentences consistently

Emotional

- Irritability
- More emotional
- Sad
- Nervousness

Sleep

- Drowsiness
- Sleeping more than usual
- Sleeping less than usual
- Difficulty falling asleep

WHERE TO GO FOR HELP

If there are concerns, advise the parent or caregiver to contact their family physician or paediatrician for a medical assessment or Children's Hospital of Eastern Ontario (CHEO).

For more information on head injuries:

- CHEO Concussion Clinic – www.cheo.on.ca/en/concussionclinic
- ThinkFirst Canada - www.parachutecanada.org/thinkfirstcanada
- Center for Disease Control and Prevention: Heads Up to High School Sports - www.cdc.gov/headsup/highschoolsports/index.html
- Centers for Disease Control and Prevention: Heads Up to Health Care Providers - www.cdc.gov/headsup/providers/index.html

Head Injury

A child of any age who has a direct or indirect hit, blow or force to the head or body could have a concussion. A concussion, also known as a mild traumatic brain injury (MTBI), changes the way the brain works.

Common Causes:

- Falls
- Motor vehicle crashes
- Bicycle crashes or other sports/activity injuries
- Struck by/against events(e.g., colliding with a moving or stationary object)
- Assault (including forceful shaking)

Injury prevention

- Infants and toddlers should play where it is safe and be supervised by a responsible adult
- Never leave your child unattended on high surfaces (e.g., changing table, countertop)
- Use an approved infant/toddler car seat that is appropriate for the age and size of the child
- Toddlers should wear appropriate protective gear during sports and recreational activities (e.g., a properly fitted helmet while riding a bicycle).
- Toddlers should only participate in age-appropriate sport activities
- Be cautious in and around swimming areas.
- Make your home safe.

RED FLAGs

If any of the following symptoms develop, go to the emergency department/seek further medical help immediately:

- Large bumps, bruises or unexplained swelling on the head
- Increased drowsiness or cannot be awakened
- Headaches worsen or neck pain
- Persistent vomiting
- Blood or fluid in the ear
- Pupils are unequal in size
- Seizures

WHERE TO GO FOR HELP:

- Contact Family Physician
- CHEO Concussion Clinic:
  Referred to by physician
  Web: www.cheo.on.ca/en/concussionclinic
- Telehealth Ontario: 1-866-797-0000
  Web: www.parachutecanada.org

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Children's Hospital of Eastern Ontario.

Nutrition

Proper nutrition is extremely important for the overall health, growth, and development in all children, but especially in those aged 0 to 5 years. These five years are crucial years of brain and body development and are the most rapid years of growth a child ever experiences.

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

Birth-6 months

- Infants are not fed whenever they show signs of hunger
- During the first four months, infant not being fed frequently
- Cow's milk or other preparations are given instead of breastmilk or **iron-fortified** infant formula
- Infant is fed using a propped bottle
- Infant cereal is given in a bottle
- Powdered infant formula is used prior to two months of age
- For the first four months, water for infant formula is not brought to a rolling boil for one minute and equipment is not being sanitized
- Private well water used for infant feeding is not being regularly tested
- Infant formula is not being mixed at the correct dilution
- Breastfed or partially breastfed infant is not receiving a vitamin D supplement
- Liquids (including water and juice) or solids other than breastmilk or iron-fortified infant formula are given before four months (preferably six months)
- Unsafe foods are given (e. g. honey, cow's milk, herbal tea)

6 Months: Time for Iron-rich Foods

Babies are ready to start eating solids when they can sit up in a chair, hold their head up, lean forward, and follow food with their eyes. Once solids gave been started, breastfeeding should continue for up to 2 years and beyond.

- Breastfeeding should continue with the addition of a daily vitamin D supplement of 400 I.U.
- At this stage, babies are ready for soft, lumpy, tender, cooked food.
- Puréed food is not necessary.
- When any new food is started, watch for signs of allergic reaction.
- Use a spoon to feed. Give 1 teaspoon or less. Slowly give more.
- Start with once a day in the morning. Then increase to twice day.
- Give both meat (and alternatives) and infant cereal as first solid foods.
- Start finger foods like soft fruit (banana, mango), toast crust, shredded cheese, and scrambled egg.

Meat and Alternatives:

- Serve meat and alternatives cooked, mashed, finely minced, or scrambled. Try beef, pork, chicken, fish, legumes, eggs, and tofu.

Grain Products:

- Babies should try single grain iron-fortified infant cereal (rice, barley, oatmeal). Start by giving cereal mixed with lots of liquid (water or expressed breast milk) and slowly use less liquid.

Vegetables and Fruit:

- Serve any cooked and finely mashed vegetable or fruit. Also, serve raw, soft pears, bananas, or peaches.

Milk and Alternatives:

- Examples include: shredded cheese, full fat yogurt, cottag cheese, and ricotta cheese (at least 2% M.F.).

- Common food allergens such as peanuts, fish, wheat, milk products, soy, and whole eggs can be given from 6 months of age. When starting these foods, give only 1 per day and wait 2 days before starting another common food allergen.

Parenting in Ottawa, Healthy Eating, 2015

Red Flags

- After 5 days, has less than 6 wet diapers each day
- Within the first 2 weeks, loses less than 10% of their birth weight
- Not being fed based on feeding cues
- Infant formula not prepared and stored properly
- Cow's milk or homemade formula given
- Water, juice or other liquids given
- Infant cereal or other pureed foods given in a bottle
- Uses propped bottle
- Honey is given
- Breastfed or partially breastfed infant drinking less than 1000 mL (32 oz.) formula is **not** receiving a vitamin D supplement

7-8 Months: Time for More Texture

- Babies are ready for more textured foods when they can bite off food, pick up food with fingers, and drink from open cup (spilling is okay).
- Continue to breastfeed and give a daily vitamin D supplement of 400 I.U.
- Give small, bite-sized finger foods. You can try cooked ground meat, fish, egg, noodles, rice, toast, soft vegetable or fruit, and cheese.
- Offer food 2 to 3 times per day.

Meat and Alternatives:

- Continue with iron-rich meats, eggs and legumes. Semi-solid or minced is best.
- Try giving your baby a thin spread of nut butter on bite-sized toast.

Grain Products:

- Start mixed grain infant cereals.
- Try rice, pasta, dry cereals, and dry toast. Whole grain is best.

Vegetables and Fruit:

- Offer pieces of cooked vegetables. You can also try soft, raw vegetables and fruit.

Milk and Alternatives:

- Continue with yogurt, cottage cheese, and ricotta cheese.
- You can try giving small pieces of other cheeses.
- Give water in an open cup. Spilling is okay.
- Avoid products that contain raw or undercooked meat, eggs, poultry or fish. You should also avoid giving your baby unpasteurized products, including dairy, eggs, juices or cider.

Parenting in Ottawa, Healthy Eating, 2015

Nine to Twelve Months: Time to Chew

- Babies are ready to chew, pick up food and put into mouth, control food in mouth, hold spoon, cup.
- Breastfeed and give a daily vitamin D supplement of 400 I.U.
- Family food can be is grated, finely chopped, in pieces, or strips.
- Offer food 3 to 4 times per day.

Meat and Alternatives:

- Should be served in way that babies can feed themselves, with a spoon or fingers.

Grain Products:

- Small pieces of whole grain bread, rice, couscous, pita, and pasta.

Vegetables and Fruit:

- Any soft vegetable or fruit. Serve cooked or raw.

Milk and Alternatives:

- Babies can slowly start on whole cow's milk (3.25% M.F.), once a wide variety of foods are being eaten
- Offer milk or breast milk after food
- Offer water and milk in an open cup

Parenting in Ottawa, Healthy Eating, 2015

Red Flags

- Has less than 6 wet diapers each day
- By 7 months, not eating iron-containing foods daily
- Infant formula not prepared or stored properly
- Cow's milk or homemade formula given
- Consumes juice frequently throughout the day (more than 125 mL)
- Regularly consumes fruit drinks, pop, coffee, tea, cola, hot chocolate, and/or other vegetarian beverages or herbal teas
- Infant cereal or other pureed foods given in a bottle
- Uses propped bottle
- Honey is given
- Feeding is forced or restricted
- Breastfed or partially breastfed infants drinking less than 1000 mL of formula is **not** receiving a vitamin D supplement
- By 10 months, lumpy textures not consumed
- Consumes large amounts of fluids (More than 750 mL of milk a day; more than 175 mL of juice a day)
- Not supervised during feeding.

Toddlers 12 to 24 months

Offer a variety of food from each of the 4 food groups in Canada's Food Guide every day. Toddlers should decide how much to eat from what is served. There is no recommended number of servings for each food group for this age.

Trying new foods

- Toddlers should be encouraged to try new foods and should be offered the same food as the rest of the family at mealtimes and snacks.
- They should be offered new foods often and served alongside food they already like. Your toddler may need to try a food many times before they like it.
- Toddlers are more willing to try new foods when they are relaxed.

Mealtimes should be pleasant.

- Avoid pressuring or bribing your toddler to eat as it can make them less willing to eat and prevent them from knowing when they are hungry and full.

Offer healthy drinks

- Toddlers should drink water between meals and snacks and when your toddler is thirsty.
- Toddlers should be offered 2 cups of homogenized milk (3.25% M.F.) each day, or less if breastfeeding. Too much milk can leave your toddler feeling too full for other healthy foods.
- Toddlers should eat fruit instead of juice. Children do not need juice.

- Sipping on milk, juice, or watered down juice between meals may cause tooth decay.

Parenting in Ottawa, Healthy Eating, 2015

2-3 year olds

- Eat as a family.
- Parent and caregivers should set an example by eating a variety of food.
- Limit juice to no more than 125-175 mL (4 to 6 oz.) per day. Serve vegetables and fruit instead.
- Include at least 3 to 4 food groups in meals. See Canada's Food Guide for more information.
- Offer foods multiple times to encourage toddlers to try them. It may take 10 - 15 times before they try the new food.

- Offer new foods one at a time along with at least 1 food the toddler likes.
- Toddlers' appetites will vary from day to day. Scheduled meals and snacks should be 2-3 hours apart so that they arrive to the table hungry.
- Toddlers as early as 2 years of age can be included in meal and snack preparation depending on their age, developmental stage, and interest.
- Children 2 to 3 years old like to explore with their senses. They can help you with simpler tasks such as washing vegetables and fruit, adding items to dishes, and smelling herbs and spices.

Parenting in Ottawa, Healthy Eating, 2015

3-4 year olds

- Eat as a family.
- Parents should set an example by eating a variety of food.
- Limit juice to no more than 125-175 mL (4 to 6 oz.) per day. Serve vegetables and fruit instead.
- Include at least 3 to 4 food groups in meals. See Canada's Food Guide for more information.
- Offer foods multiple times to encourage trying them. It may take 10 to 15 times before they try the new food.
- Offer new foods one at a time along with at least 1 food your preschooler likes.
- Expect your preschooler's appetite to vary from day to day. Schedule meals and snacks 2-3 hours apart so that they arrive to the table hungry.

Parenting in Ottawa, Healthy Eating, 2015

Red Flags

- Does not eat a variety of table foods from the 4 food groups
- Consumes a large amount of fluids and very little food (More than 750 mL of milk a day; more than 175 mL of juice a day)
- Regularly consumes fruit drinks, pop, coffee, tea, cola, hot chocolate, and/or other vegetarian beverages or herbal teas.
- Feeding is forced or restricted

Parents and caregivers should be encouraged to be role models to their young children, and to instil lifelong healthy eating habits.

General Risk Factors

- Serial growth measurements have unexpectedly crossed two or more percentiles downwards (failure to thrive)
- Parents not recognizing and responding to the child's verbal and non-verbal hunger cues
- Use of bottles made from bisphenol A (BPA)
- Suspected or diagnosed food allergy or food intolerance which results in food restrictions
- Problems with sucking, chewing, swallowing, gagging, vomiting or coughing during or following eating
- Suffers from tooth or mouth problems that make it difficult to eat or drink
- Frequent constipation and/or diarrhea
- Follows a special diet that limits or includes special foods
- Excludes all animal products, including milk and eggs
- Unsafe or inappropriate foods are given (e. g. raw eggs, unpasteurized milk or cider, herbal tea, pop, fruit drink, coffee, caffeinated drinks, alcohol, foods that are choking hazards)
- Eats non-food items
- Infant or child is not supervised when eating
- Grazing or child consumes small amounts of food or beverages many times during the day instead of sitting down to eat meals and snacks at scheduled times
- Family uses pressure, reward or punishment to get child to eat
- Family has problems with inadequate food storage or cooking facilities
- Family is unable to obtain adequate food (e. g. due to financial constraints)
- Parent or caregiver uses a highly restrictive approach to feeding

- Caregiver feeds child in inappropriate position (on back for bottle after 6 months)
- Feeding refusal or behavioural issues that make feeding time lengthy or challenges for the caregiver

General risk factors that indicate the intervention of a registered dietitian or other primary health care providers

- Family is experiencing problems around feeding – mealtimes are unpleasant; infant/child refuses many foods, or drinks excessive fluids throughout the day so is not hungry at mealtimes. Parents are possibly force feeding or offering inappropriate amounts of food.
- Parents have distorted issues with their own eating and/or body image.
- Infant/child has medical problems that make eating or drinking a problem such as swallowing issues, gagging or choking, etc.
- Infant/child has other health problems that may be related to diet such as iron deficiency anemia, constipation, obesity, or body image issues.
- Family has different beliefs related to foods (e.g. the use of herbal products, exclusion of food groups such as meat and meat alternatives, use of unsafe products such as unpasteurized milk).
- Family is low income. In order for families to access foods that will nourish them they need to have enough money.

WHERE TO GO FOR HELP

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

- Their family physician or paediatrician
- To speak directly with a registered dietitian at EatRight Ontario: 1-877-510-510-2 www.eatrightontario.ca/en/default.aspx
- Ottawa Public Health Information Line 613-580-6744
- Health Babies, Healthy Children Program, Ottawa
- City of Ottawa Public Health Information: (613) 580-6744; TTY (613) 580-9656 Toll-free 1-866-426-8885
- Parenting in Ottawa
  Drop Ins Web: www.parentinginottawa.com/en/dropins.asp
  Home Visits Web: www.parentinginottawa.com/en/Home-Visits.asp
  Email: healthsante@ottawa.ca
- Private lactation consultants, Occupational Therapists or Dieticians

For more information:

- Health Canada – Food and Nutrition www.hc-sc.gc.ca/fn-an/nutrition/index-eng.php
- Ottawa Public Health website www.ottawa.ca/residents/health/living/nutrition/ services/index_en.html
- Ontario Early Years Centres www.ontarioearlyyears.ca
- CCPN's Know More, Do More! Campaign Web: www.ccpnetwork.ca/en_priorities_schoolchildren.php

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Ottawa Public Health, Children's Hospital of Eastern Ontario and Heart and Stroke Foundation of Ontario using Pediatric Nutrition Guidelines for Primary

Health Care Providers (May, 2008) Ontario Society of Nutrition Professionals in Public Health (OSNPPH) – Family Health Nutrition Advisory Group.

Postpartum mood Disorders (PPmD)

Postpartum mood disorders (PPMD) are complications that can occur within the first year after a child is born. PPMD can have serious effects on the mother, infant and family. If left untreated, they may hinder the mother's ability to meet her own needs, baby's needs, to read her baby's cues and to respond sensitively. Without intervention this could place the child's health and development at risk.

Common postpartum mood disturbances include "baby" blues, postpartum depression and postpartum psychosis (*Postpartum Depression: A Guide for Front-Line Health and Social Service Providers, CAMH 2005*). Postpartum anxiety can also impact or interfere with a mother's daily life and normal functioning.

The presence of any one of the following risk factors should alert health professionals that the mother may need intervention related to **Postpartum Mood Disorders:**

- Depression during pregnancy
- Anxiety during pregnancy
- Personal and/or family history of depression
- Lack of a support system (perceived or received)
- Recent stressful life events (relationship breakdown, death of loved one)
- Maternal personality (Worrier, anxious, "nervous")
- Low self-esteem
- Relationship difficulties

If the mother states, her partner or you observe one or more of the symptoms, consider this a red flag:

- Not feeling herself
- Is sad and tearful
- Feels exhausted, but unable to sleep or sleeps excessively
- Has changes in eating or sleeping pattern
- Feels overwhelmed and cannot concentrate
- Has no interest or pleasure in activities previously enjoyed
- No interest or pleasure in infant
- Feels hopeless or frustrated
- Feels restless, irritable, frustrated or angry
- Feels extremely high and full of energy
- Feels anxious
- Feels guilty and ashamed, thinks she is not a good mother
- Is not attaching with the baby or is afraid to be alone with the baby
- Has scary thoughts about the baby
- Has disturbing nightmares or flashbacks
- Avoids people, places or events
- Has thoughts about hurting self or baby

Postpartum mood Disorders (PPmD)

Very rarely women will have Postpartum Psychosis. This is the most severe and rare form of postpartum mood disorder.

While rare, this is a serious illness with risks to the mother and baby. Symptoms include:

- Onset of symptoms is rapid, (in many cases within 48 to 72 hours after birth) and most cases develop within the first two weeks postpartum
- Extreme depressed or elated mood (high / mania)
- Can exhibit bizarre or disorganized behaviour
- Can be confused or perplexed
- Psychotic symptoms (such as delusions – perhaps, mother believes she or baby has super powers or feelings of persecution), hallucinations - hearing noises/voices or seeing things that are not present)

If the mother has any of the above thoughts or feelings, do not wait. Get help right away. Do not leave the mother alone.

If the mother is able to give consent, and with her permission, call a significant other to ask for help

If the mother is able to give consent, and with her permission, call her Family Physician or emergency services (911)

If unable to get consent, or to contact an identified significant other

Call the Distress Centre 613-238-3311 (Open 24 hours a day to provide immediate support)

Call 911

WHERE TO GO FOR HELP

If there are concerns, contact, or advise the woman or family to contact:

- Their family physician or paediatrician
- 2-1-1
- Telehealth Ontario 1-866-797-0000
  TTY: 1-866-797-0007
- Local hospital emergency department
- Ottawa Public Health Info Line at:
  (613) 580-6744 TTY: 613-580-9656 (To speak with a nurse and for a referral to the Healthy Babies, Healthy Children Program)
  Web: www.parentinginottawa.ca
  Email: healthsante@ottawa.ca
- Family Services Ottawa 613-725-3601
  Email: intake@familyservicesottawa.org
  Web: www.familyservicesottawa.org
- Distress Centre – Ottawa and region (24/7)
  (613) 238-3311
- In cases where a child may be in need of protection, contact the Ottawa Children's Aid Society (613) 747-7800 Web: www.casott.on.ca
  Email: yourcasquestion@casott.on.ca

For more information:

Canadian Mental Health Association www.cmha.ca

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Ottawa Public Health and Family Services à la famille Ottawa with reference to Ross, L.E., Dennis, L.E., Blackmore, E.R., and Stewart D. (2005) Postpartum depression; a guide for front-line health and social service providers. Centre for Addiction and Mental Health.

School Readiness

There is no single or simple factor that determines whether a child is ready to begin school. A child's development needs to be evaluated in several different areas of development. A child's ability to think logically, speak clearly, and interact well with others are all critically important to success in school.

The following will help determine if a child is physically, socially, and cognitively ready to begin attending school:

The child should be able to:

- Get dressed with help
- Go to the bathroom independently
- Open lunch items
- Be away from parents/caregivers
- Ask for help
- Share and take turns with other children
- Follow routines
- Communicate so a teacher and other students can understand
- Listen and follow directions
- Understand basic safety rules
- Attempt to try new things
- Take part in group activities

If the child presents with one or more 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
- History of speech and language delays
- Difficulties with pre-literacy skills (e. g. rhyming)
- Inconsistent performance (can not do what he/she could do last week)
- Poorly focused and disorganized

WHERE TO GO FOR HELP

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

- The Elementary Teacher's Federation of Ontario (ETFO) www.etfo.ca/Resources/ForParents/SchoolReadiness/Pages/default.aspx
- Early Literacy Specialists of Eastern Ontario: (613) 565-2467 ext. 232 /233 www.parentresource.on.ca/en/ottawaprc/Early_Literacy_Specialists_p556.html

For more information:

- Ottawa Carleton District School Board (613)-596-8211 www.ocdsb.edu.on.ca
- Ottawa Catholic School Board (613) 224-2222 www.occdsb.on.ca
- Conseil des écoles publiques de l'Est de l'Ontario (613) 742-8960 www.cepeo.on.ca
- Conseil des écoles catholiques du centre-est (613) 744-2555 www.ceclf.edu.on.ca

Ontario Early Years Centre
www.ontarioearlyyears.ca

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by First Words Preschool Speech and Language Program, Algonquin College- Early Childhood Education Program, Parent Resource Centre and Ottawa Carleton Headstart Association for Preschoolers

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 adaptive responses.

Problem signs…if a child's responses are exaggerated, extreme 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/seeks to make noise for noise sake
- Seems to be "in his/her own world"

Visual

- Children over three – 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
- Shows preference for certain foods

Movement and Body Position

- Continually seeks out all kinds of movement activities (e. g. 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 with head upside-down off sofa)
- Seeks out hugs or will lean into others or objects

Touch

- Becomes upset during grooming (e. g. 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
- Touches others or everything around them
- Prefers to go barefoot or undresses

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

If there are concerns, advise the parent/caregiver to contact their family physician or paediatrician.

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Ottawa Children's Treatment Centre and CommuniCare Therapy.

Sleep

Sleep is an important aspect in child development. Sleep helps brain development and specifically, the development of memory, attention, creativity and higher level of organizational functioning. Consequences of inadequate sleep in young children can include mood changes, cognitive functioning (i.e. memory and attention) or learning impairments.

Good sleep habits at an early age help to lay the foundation to healthy behavioral patterns that contribute to overall healthy development. If established early, healthy sleeping behaviors are more likely to continue throughout an individual's life span. Talking with parents and caregivers about sleep in the same manner as you address growth and development, can help parents develop realistic sleep expectations for their child.

Red flags that may interfere with a child's sleep and functioning include:

- Child has allergies or asthma
- Child has a history of enlarged tonsils or adenoids
- Child tends to be a mouth breather
- Family history of obstructive sleep apnea or loud snoring
- Child has loud snoring with breathing pauses during sleep and is identified as having enlarged adenoids and or tonsils
- Excessive daytime sleepiness (naps beyond age 6 yrs)
- Difficulty waking in the morning – even after a seemingly good night sleep
- Failure to thrive, chronic respiratory symptoms
- Learning, behavioural or mood issues, particularly in a child who snores, has respiratory pauses during sleep or sleep disruption
- In toddlers, separation anxiety leading to difficulty separating at night time and bedtime resistance
- Difficulty initiating sleep or maintaining sleep
- Parasomnias (sleep terrors or sleepwalking) where safety could be compromised or when they occur nightly
- Failure of behavioural interventions to improve sleep problems
- Child complains of aches and pains
- Child has tendency to be accident prone
- Nightmares that trigger fear of going back to sleep
- Bed wetting
- Morning headaches

Sleep Guidelines

While we all have unique sleep patterns and needs, the following are considered general guidelines for this age group.

0 – 2 months	16 – 18 hours of sleep per day
2 – 6 months	14 – 16 hours of sleep per day
6 months – 1 year	14 hours of sleep per day
Toddler 1 – 3 years	10 – 13 hours of sleep per day
Preschool 3 – 5 years	10 – 12 hours of sleep per day
School-aged Children 6 – 10 years	10 – 12 hours of sleep per day

WHERE TO GO FOR HELP

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

- Their family physician or paediatrician
- Caring for kids. Information for parents from Canada's paediatricians
  Web: www.caringforkids.cps.ca
- Ottawa Public Health (613) 580-6744
  TTY (613) 580-9656 www.ottawa.ca
  Web: parentinginottawa.ca
  Email: healthsante@ottawa.ca

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Children's Hospital of Eastern Ontario with reference to Take Charge of Your Child's Sleep: The All-in-One Resource for Solving Sleep Problems in Kids and Teens Judith Owens, MD and Jodi Mindell, PhD; and Centres for Disease Control www.cdc.gov/sleep/how_much_sleep.htm

The relationship that children have with their primary caregiver(s) during their early years, significantly impacts their social and emotional growth and behavioural and personality development. Children's early relationships in life influence their lifelong abilities to build trusting relationships, develop coping mechanisms to deal with everyday situations, and interact within their social environment. Unhealthy or a lack of attachment can lead to emotional issues and attachment disorders.

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/Caregiver and child do not engage in smiling and vocalization with each other
- Parent/Caregiver ignores, punishes or misreads child's signals of distress
- Parent/Caregiver pulls away from infant or holds infant away from body with stiff arms
- Parent/Caregiver is overly intrusive when child is not wanting contact
- Child is not comforted by physical contact with parent/caregiver

8 - 18 months

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

18 months – 3 years

- Child and parent/caregiver 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/caregiver when distressed or after separation
- Child is excessively distressed by separation from parent/caregiver
- Child freezes or moves toward parent/caregiver by approaching sideways, backwards or circuitously
- Child alternates between being hostile and overly affectionate with parent/caregiver
- Parent/Caregiver seems to ignore, punish or misunderstand emotional communication of child
- Parent/Caregiver uses inappropriate or ineffective behaviour management techniques
- Sensory issues, limited food preferences, avoiding certain textures

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 five to 10 minutes
- Child cannot become engaged in self-directed play
- Child is threatening, dominating, humiliating, reassuring or sexually intrusive with adult
- Parent/Caregiver uses ineffective or abusive behaviour management techniques

WHERE TO GO FOR HELP

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

- Their family physician or paediatrician
- Healthy Babies, Healthy Children, Ottawa Public Health Information: 613-580-6744
- Parent Resource Centre (PRC) 613-565-2467 ext. 222 parentresource.ca
- Parenting in Ottawa Crop Ins Web: www.parentinginottawa.com/en/dropins.asp
  Email: healthsante@ottawa.ca
- Crossroads Children's Centre 613-723-1623, extension 232 Web: www.crossroadschildren.ca
- Centre Psychosocial 613-789-2240 www.centrepsychosocial.ca
- First Words: Preschool Speech and Language Program of Ottawa: (613) 737-7600 ext. 2500
  Web: firstwords.ca Email: first.words@pqchc.com
- Ottawa Children's Treatment Centre (OCTC): Available for children under 6 years of age
  Intake (613) 737-0871 ext. 4425 Web: octc.ca Email: intake@octc.ca
- For a list of private Language Pathologists and Audiologists of Ontario: Web: www.caslpo.com
- Speech-Language & Audiology Canada Web: www.sac-oac.ca

For more information

- Hanen Centre Web: www.hanen.org
- Ontario Association for Families of Children with Communication Disorders (OAFCCD)
  Web: www.oafccd.com
- Ontario Early Years Centre Web: www.oeyc.edu.gov.on.ca
- Ottawa Public Health (613) 580-6744 TTY (613) 580-9656 Web: www.ottawa.ca
  Web: parentinginottawa.ca
  Email: healthsante@ottawa.ca
- E- Mental Health www.ementalhealth.ca
- Parent's Lifeline of Eastern Ontario
  www.pleo.on.ca

Sources: Originally from York Region Red Flags (2009) and reviewed in 2010 by Crossroads Children's Centre, Language Instruction for Newcomers to Canada (LINC), St Mary's Home and Ottawa Carleton Headstart Association for Preschoolers.

The first years of life are very important for learning speech and language skills. Very early in their lives, children begin to learn to understand what you are saying, make sounds of their own and develop speech and language skills. These skills help children make friends and are critical to a child's ability to learn to read and write. Communication skills are vital to a child's future success.

About one in 10 children needs help developing normal speech and language skills. The following developmental milestones show some of the skills that mark children's progress as they learn to communicate.

Healthy Child Development…if a child is missing one or more of these expected age outcomes, consider this a red flag:

By 6 months

- Turns to source of sounds
- Startles in response to loud noises
- Makes different cries for different needs with varying pitch and intensity (i. e. hungry, tired)
- Watches your face as you talk
- Smiles/laughs in response to your smiles and laughter
- Imitates coughs or other sounds (e. g. "ah, " "eh, " buh")

By 9 months

- Responds to his/her name
- Responds to the telephone ringing or a knock at the door
- Understands being told "no"
- Gets what he/she wants through gestures (e. g. reaching to be picked up)
- Plays social games with you (e. g. peek-a-boo)
- Enjoys being around people
- Babbles and repeats sounds such as "babababa" or "duhduhduh"

By 12 months

- Follows simple one-step directions (e. g. "sit down")
- Looks across the room to a toy when an adult points at it
- Consistently uses three to five words, even if not clear
- Uses gestures to communicate (e. g. waves hi/bye, shakes head "no")
- Gets your attention using sounds, gestures and pointing while looking at your eyes
- Brings/extends toys to show you
- "Performs" for social attention and praise
- Combines lots of sounds together as though talking (e. g. "abada baduh abee")
- Shows an interest in simple picture books

By 18 months

- Understands the concepts of "in and out", "off and on"
- Points to several body parts when asked
- Responds with words or gestures to simple questions (e. g. "Where's teddy? ", "What's that? ")
- Uses at least 20 words consistently, even if not clear
- Makes at least four different consonant sounds (e. g. p, b, m, n, d, g, w, h)
- Enjoys being read to and sharing simple books with you
- Points to pictures using one finger
- Demonstrates some pretend play with toys (e. g. gives teddy a drink, pretends a bowl is a hat)

Speech and Language

By 24 months

- Follows two-step directions (e. g. "Go find your teddy bear and show it to Grandma")
- Uses 100 or more words
- Uses at least two pronouns (e. g. "you, ""me, ""mine")
- Consistently combines two to four words in short phrases (e. g. "Daddy hat, ""truck go down")
- Forms words/sounds easily and effortlessly
- Words are understood by others 50 per cent to 60 per cent of the time
- Enjoys being around other children
- Begins to offer toys to peers and imitate other children's actions and words
- Holds books the right way up and turns pages
- "Reads" to stuffed animals or toys
- Scribbles with crayons

By 30 months

- Understands the concepts of size (big/little) and quantity (a little/a lot, more)
- Uses some adult grammar (e. g. "two cookies, ""bird flying, ""I jumped")
- Uses over 350 words
- Uses action words (e. g. run, spill, fall)
- Produces words with two or more syllables or beats (e. g. "ba-na-na, ""com-pu-ter, " "a-pple")
- Puts sounds at the start of most words
- Begins taking short turns with peers, using both words and toys
- Shows concern when another child is hurt/sad
- Combines several actions in play (e. g. feeds doll and then puts them to sleep, puts blocks in train then drives train, drops blocks off)
- Recognizes familiar logos and signs involving print (e. g. golden arches of McDonalds, "Stop" sign)
- Understands and retells familiar stories

By 3 years

- Understands "who, ""what, ""where" and "why" questions
- Creates long sentences using five to eight words
- Talks about past events (e. g. trip to Grandparents' house, day at childcare)
- Tells simple stories
- Is understood by most people outside of the family, most of the time
- Shows affection for favourite playmates
- Engages in multi-step pretend play (e. g. pretending to cook a meal, repair a car, etc.)
- Aware of the function of print (e. g. in menus, lists, signs)
- Beginning interest in, and awareness of, rhyming

By 4 years

- Follows directions involving three or more steps (e. g. "First get some paper, then draw a picture, last give it to Mom")
- Uses adult-type grammar
- Tells stories with a clear beginning, middle and end
- Talks to try to solve problems with adults and other children
- Is understood by strangers almost all of the time
- Demonstrates increasingly complex imaginative play
- Able to generate simple rhymes (e. g. "cat-bat")
- Matches some letters with their sounds (e. g. "letter T says 'tuh')

By 5 years

- Follows group directions (e. g. "All the boys get a toy")
- Understands directions involving "if…then" (e. g. "If you're wearing runners, then line up for gym")
- Describes past, present and future events in detail
- Uses almost all of the sounds of their language with few to no errors
- Seeks to please his/her friends
- Shows increasing independence in friendships (e. g. may visit neighbour by him/herself)
- Knows all the letters of the alphabet
- Identifies the sounds at the beginning of some words (e. g. "Pop starts with the 'puh' sound")

Problem signs…if a child is experiencing any of the following, consider this a red flag:

Speech and Language

- Any loss of previously obtained skills, language or social skills at any age
- A child does not meet a developmental milestone
- Inconsistent or no response when name is called
- Rarely engages socially (e. g. lack or limited smiling or eye contact)
- Child is over-sensitive or under-sensitive to touch, textures, movement or sound
- More interested in looking at objects than people's faces
- Lack of sound imitation: child is unusually quiet; doesn't attempt to say sounds or words
- Repeated ear infections
- Has difficulty following directions
- Acts frustrated when trying to communicate
- Lack of interest in toys or plays with them in an unusual way (e. g. lining up, spinning, opening/closing parts rather than using the toy as a whole)
- Preoccupation with unusual interests such as light switches, doors, fans, wheels
- Echoes others' phrases or sentences out of context or without understanding (for example parent/caregiver says "put on your shoes"; child responds "put on your shoes")
- Repeats in "whole phrases" or "scripts" from television shows or books, when these do not seem relevant to the situation
- Unusual interest in letters or numbers and/or may show some ability to recognize words in print – but no clear indication of comprehension
- Inflexible with routines; has compulsions or rituals (has to perform activities in a special way or certain sequence: is prone to temper tantrums if rituals are interrupted)

Stuttering:

- Parents/Caregivers report child "stutters" using repetitions of words (e. g. "I-I-I") or syllables (e. g. "da-da-daddy"), sound prolongations (e. g. "mmmommy) or blocks (e. g. "b----all").
- Avoids certain words, situations or talking
- Has been stuttering for more than 6 months
- Struggles physically to get words out
- Is aware of difficulties and/or has mentioned the stuttering

Speech and Language

Voice:

- Ongoing hoarse voice or unusual voice quality

Oral Motor Skills:

- Excessive drooling which persists beyond 18 months of age
- Problems with swallowing or chewing, or gagging when eating foods with certain textures (See Feeding and Swallowing section of this document)

WHERE TO GO FOR HELP

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

- First Words - Preschool Speech and Language Program of Ottawa:
  - For a child aged 0 to eligibility for senior kindergarten with ***speech and/or language delay only***
  - Direct parent to a First Words screening clinic (613) 580-6744 ext. 28020 or fax a request to the First Words Intake office at (613) 738-4893
  - www.firstwords.ca
- Ottawa Children's Treatment Centre (OCTC):
  - Child aged 0 to eligibility for senior kindergarten with ***speech and/or language delay and developmental concerns*** (i. e. play, socializing, motor skills)
  - Direct parent to call (613) 737-0871 ext. 4425 or fax request to (613) 738-4841
- For a list of private-Language Pathologists working in Ottawa:
  - Ontario Association of Speech-Language Pathologists and Audiologists at 1-800-718-6752 / www.osla.on.ca
  - College of Speech-Language Pathologists and Audiologists of Ontario (www.caslpo.com)
  - Canadian Association of Speech-Language Pathologists and Audiologists (www.caslpa.ca)
- Their family physician or paediatrician

For more information:

- Hanen Centre (www.hanen.org)
- Ontario Association for Families of Children with Communication Disorders (OAFCCD)
- Ontario Early Years Centres (www.ontarioearlyyears.ca)
- Ottawa Public Health Information (613) 580-6744

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Ottawa Children's Treatment Centre, CommuniCare Therapy, First Words Preschool Speech and Language Program using references from Your Baby's Speech and Language Skills from Birth to 30 Months (September 2009) Ministry of Children and Youth Services, and Your Preschool Child's Speech and Language Development (September 2009) Ministry of Children and Youth Services.

A child who is blind or has low vision is at significant risk for difficulties in all areas of development, including communication and language, fine and gross motor skills, coordination, understanding and thought processes and social development.

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

By 6 weeks

- Stares at surroundings when awake
- Briefly looks at bright lights/objects
- Blinks in response to light
- Eyes and head move together
- Produces tears when crying

By 3 months

- Eyes glance from one object to another
- Eyes follow a moving object/person
- Stares at caregiver's face
- Looks at hands
- Prefers coloured toys to black and white

By 6 months

- Eyes move to inspect surroundings
- Eyes move to look for source of sounds
- Swipes at or reaches for objects
- Looks at more distant objects
- Smiles and laughs when he or she sees you smile and laugh

By 12 months

- Eyes turn inward as objects move close to the nose
- Watches activities in surroundings for longer time periods
- Looks for a dropped toy
- Visually inspects objects and people
- Creeps towards favourite toy
- Watches fast moving objects
- Watches and retrieves a rolling ball up to 10 feet away

By 2 years

- Uses vision to guide reaching and grasping of objects
- Looks at simple pictures in a book and will turn the book or picture to the corrected upright position
- Points to objects or people
- Looks for and points to pictures in books
- Looks where he or she is going when walking and climbing
- Will point to body parts (nose, hair, eyes) on self or others when requested

By 3 years

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

By 4 years

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

By 5 years

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

Vision

Problem signs…if a child is experiencing any of the following, consider this a red flag

- Swollen or encrusted eyelids
- Bumps, sores or styes on or around the eyelids
- Drooping eyelids
- Does not make eye contact by three months of age
- Does not watch or follow an object with the eyes by three months
- Haziness or whitish appearance inside the pupil
- Frequent "wiggling""drifting" or "jerky" eye movements, misalignment of the eyes (eye turns or crossing of eyes)
- Lack of coordinated eye movements
- Drifting of one eye when looking at objects
- Turning or tilting of the head when looking at objects
- Squinting, closing or covering of one eye when looking at objects
- Excessive tearing when not crying
- Excessive blinking or squinting
- Excessive rubbing or touching of the eyes
- Avoidance of, or sensitivity to, bright lights
- Excessive staring at both artificial light sources (windows, overhead lighting)

WHERE TO GO FOR HELP

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

- Blind - Low Vision Early Intervention Program
  (613) 688-3979 or to fax a request to
  (613) 820-7427; TTY: (613) 820-7427;
  Toll free: 1-866-432-7447
  pqchc.com/children-family-services/blind-low-vision/

  * The program is designed for children who are born blind or with low vision and their families; from birth to Grade 1.

For more information and additional resources:

- Canadian National Institute for the Blind (CNIB): Seeing beyond vision loss Web: www.cnib.ca
- Ontario Association of Optometrists
  www.optom.on.ca

Sources: Adapted from York Region Red Flags (2009) and revised in 2010 by Ottawa Children's Treatment Centre, Centre Jules Léger, Ontario Foundation for Visually Impaired Children and First Words Preschool Speech and Language Program using references from Services for children who are blind or have low vision (2008) Government of Ontario.

3

RESOURCES

Appendix A
OTTAWA COMMUNITY RESOURCES

For more information on community services, programs and agencies, please visit the following resources:

Community Information Centre of Ottawa

The Community Information Centre of Ottawa (CICO) is a free, bilingual service linking community members and organizations with community resources in many different ways:

211

211 is an information and referral service connecting callers to the full range of non-emergency community, social, government and health services programs.

The service is free, confidential and multilingual (150 languages). It is staffed by certified Information and Referral Specialists and is available 7 days a week.

By phone, dial 2-1-1 or 613-241-INFO (4636)

Directory of Ottawa Community Services (Blue Book)

The Directory of Ottawa Community Services is published by the Community Information Centre of Ottawa and can be purchased in hard copy or in electronic format (.pdf).

For more information on ordering the book, please contact the Community Information Centre of Ottawa by dialing 211 or 613-241-4636 or email: info@cominfo-ottawa.org

e- Blue Book

e-Blue Book is a bilingual online directory of Ottawa Community Services.
http://www.cominfo-ottawa.org/directories.html

City of Ottawa 3-1-1 telephone service

3-1-1 is the City of Ottawa's customer service line for municipal services such as road repairs, garbage removal, or social housing.

Get service in 170 languages: ask the 3-1-1 agent for an interpreter.

By phone, dial 3-1-1
(613) 580-2400 (standard local number)
(613) 580-2401 (TTY service for the Deaf, Deafened, and Hard of Hearing)

The Incredible Directory

The Incredible Directory is a convenient and easy-to-use directory that inventories resources and services for parents, children, childcare providers, and professionals working with families in the Ottawa area.

To contact the Parent Resource Centre:

By phone: (613) 565-2467 ext 411
Toll Free 1-888-565-2666

Online: www.incredibledirectory.ca

ementalHealth.ca

eMentalHealth.ca is a non-profit initiative of the Children's Hospital of Eastern Ontario (CHEO) dedicated to improving the mental health of children, youth, and families. Provides anonymous, confidential, and trustworthy information, 24 hours a day, 365 days a year.

Online: www.ementalhealth.ca

Appendix B
SCREENING TOOLS

A developmental screen is a short checklist of important skills that a child should master by a particular age. It is **not a diagnostic tool** nor is it a formal assessment of the child's skills. Rather, it is a quick check to help identify children who may need extra help with learning age-appropriate skills or who may require further assessment.

The Nipissing District Developmental Screen (NDDS) is an innovative developmental screening tool available to healthcare or childcare professionals working with infants and children up to six years of age.

The NDDS explores:

- Gross motor
- Fine motor
- Vision
- Hearing
- Communication, speech and language
- Social-emotional
- Self-help skills
- Cognitive skills

Developing screens also help parents to:

- Learn more about their child's development
- Recognize their child's skills and abilities
- Identify developmental areas that may need extra attention
- Plan intervention strategies
- Promote early identification

The tool examines developmental stages at: 1 & 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 30 months, 3 years, 4 years, 5 years and 6 years.

The NDDS is available in English, French, Spanish, Chinese and Vietnamese.

For more information or to access the Nipissing District Developmental Screen in Ontario please visit www.ndds.ca.

Source: Adapted from ndds.ca Nipissing District Developmental Screen (2011) www.ndds.ca.

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