Early intervention for children with disabilities and those at psychosocial risk is facilitated by screening—a brief method for sorting those who probably have difficulties from those who probably do not (Frankenburg, 1974). Most screening tests do not make discrete identification among types of conditions but are instead designed to detect a range of common disabilities, i.e., intellectual disability (ID), learning disabilities, and language impairment. Such tools are referred to as broadband measures. Narrow-band screens (e.g., those for ADHD or autism) are typically developed on and used with referred samples and are beyond the scope of this chapter.

Screening tests are typically administered by paraprofessionals via screening fairs, by educators and psychologists at school entrance, and through child-find programs funded by the Individuals with Disabilities Education Act (IDEA). Even more common is the use of screens in public health departments and pediatric clinics. Professionals in such settings have contact with almost all children prior to kindergarten and are exhorted by their professional societies to deploy screens during routine health supervision visits (American Academy of Pediatrics [AAP], 2001; National Association of Pediatric Nurse Practitioners, 2000). Indeed, Medicaid recipients and those receiving services under the State Children’s Health Insurance Programs are entitled by law to comprehensive health, developmental, and mental health screening (Centers for Medicare & Medicaid Services, 1989).

Such policies recognize that development (1) is malleable and easily influenced by the transactions of caretakers and environments (Aylward, 1996; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). Children with psychosocial risk factors (e.g., those whose parents have less than a high
school education, mental health problems, frequent stressful life events, do not provide mediated learning experiences for their children), often exhibit delays, below average performance, or disabilities. Thus developmental status occurs on a continuum making a single effort to discrimination of those with and without probable disabilities challenging, although not impossible, and (2) has age-related manifestations, meaning that skills as well as problems often manifest with age. Children without any early signs of developmental problems may exhibit deficits as they grow older (Bell, 1986). Thus most professional groups suggest repeated, routine developmental screening including some effort to identify those at-risk as well as those with true disabilities. In health care, this generally involves efforts at detection during each of the 12 well-child visits recommended for children between 0 and 5 years of age. In nonmedical settings, routine screening is somewhat less common because repeated contact with children may be limited. Even so, more than 60% of all children under age 5 attend day care, preschool, or Head Start and so are available for multiple screenings.

The varied settings and skills of those using screening measures has resulted in a proliferation of tools—some of good quality—some not. The publication of screening instruments is a largely unregulated industry, at least in the United States. Other countries, notably Canada, require evidence of test accuracy and thus provide consumers and purchasers more guidance in selection of measures (Canadian Psychological Association, 1996). To aid readers in critically examining tools, a summary of standards for screening test construction follows (AAP, 2001; American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1999).

**STANDARDS FOR SCREENING TEST CONSTRUCTION**

Screening test construction involves both traditional and unique psychometry. Nevertheless, screens should adhere to standards for any other educational and psychologist test including evidence of:

(a) **Standardization.** This should include a large nationally representative population (rather than a referred population). Ideally, the sample should be a naturalistic one and not a concatenation of groups known to be either normal or abnormal (because this generally eliminates gradations in functioning that characterize children to whom screening tests are applied (e.g., those with below average but not disabled performance).

(b) **Reliability.** Information should be included on internal consistency, interrater reliability, and test–retest reliability. Stability (longer-term test–retest reliability) is sometimes included although given the rapid changes in developmental performance set against a small set of items; stability indicators are not likely to be strong or meaningful.